

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date(s): 08/24/22 & 08/25/22</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>At this Emergency Preparedness survey, Lutheran Community Home was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 116 certified beds. At the time of the survey, the census was 77.</p> <p>Quality Review completed on 08/30/22</p> <p>The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:</p>	E 0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Lutheran Community Home respectfully requests desk review or paper compliance in lieu of a post survey revisit. Supporting documentation will be provided demonstrating the correction of the deficiencies and the steps planned to prevent reoccurrence.</p>	
E 0041 SS=F Bldg. --	<p>482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>			

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	<p>Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p>			

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	<p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors in the main building (Building 01).</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Director from 9:45 a.m. to 2:20 p.m. on 08/24/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the main building was not available for review. Based on interview at the time of record review, the Maintenance Director stated documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the main building has one Cummins diesel fired emergency generator located outside the building on the south side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 154 kW.</p> <p>This finding was reviewed with the Executive</p>	E 0041	<p>E 041 LTC Emergency Power It is the policy of this facility to implement the emergency power system inspection, testing, and maintenance requirements.</p> <p>Corrective Action: The thirty-six month period emergency generator testing for the main building generator was completed on September 2, 2022. (Attachment titled Four Hour Load Test). This test is scheduled to be completed every thirty-six months going forward.</p> <p>Monitoring of Corrective Action: The required every thirty-six month testing will be monitored by the Quality Assurance Performance Improvement Committee to ensure ongoing compliance with the regulations. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>	09/09/2022

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K 0000 Bldg. 01	<p>Director and the Maintenance Director during the exit conference.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date(s): 08/24/22 & 08/25/22</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>At this Life Safety Code survey, Lutheran Community Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The facility consisted of two separate one story buildings. The original building, Building 01, was determined to be Type II (222) construction and was fully sprinklered. Forest Path, Building 05, was determined to be Type V(111) construction and was fully sprinklered. Each building has a fire alarm system with smoke detection in the corridors and in areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms in Building 01 and has smoke detectors hard wired to the fire alarm system in Building 05. Each resident sleeping room was surveyed except for resident sleeping rooms in Building 05 due to Covid-19 concerns.</p>	K 0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Lutheran Community Home respectfully requests desk review or paper compliance in lieu of a post survey revisit. Supporting documentation will be provided demonstrating the correction of the deficiencies and the steps planned to prevent reoccurrence.</p>	
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K 0211 SS=E Bldg. 01	<p>The facility has a capacity of 116 and had a census of 77 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage and maintenance services which was not sprinklered.</p> <p>Quality Review completed on 08/30/22</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 2 of 12 means of egress. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during an initial walk through of the facility from 9:25 a.m. to 9:40 a.m. on 08/24/22, two large upholstered chairs were stored in the service corridor in the path of egress from the D Wing. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the two large upholstered chairs were still stored in the service corridor in the path of egress from the D Wing. In</p>	K 0211	<p>K 211 Means of Egress It is the policy of this facility to maintain the means of egress free from obstructions.</p> <p>Corrective Action: The two large upholstered chairs and the wheeled weigh scale were removed from the hallways on 9-07-2022 to maintain means of free egress. (Attachments titled Cherry Blvd Hallway Picture and Service Hallway Picture). All staff were educated on the means of free egress and that items should not be stored in the hallways. (Attachment titled Life Safety Survey 2022).</p>	09/09/2022

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K 0291 SS=C Bldg. 01	<p>addition, a wheeled weigh scale was stored in the corridor outside resident Room 304. The wheeled weigh scale projected 55 inches into the corridor which measured 94 inches in width as measured with a measuring tape. Based on interview at the time of the observations, the Executive Director and the Maintenance Director stated the upholstered chairs are awaiting to be cleaned and agreed the upholstered chair storage in the service corridor and the wheeled weigh scale stored in the corridor did not maintain the means of egress free from obstructions.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30</p>	K 0291	<p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds and will observe for stored items that might prevent free egress. Any items noted at that time will be removed and the appropriate staff education will occur to prevent reoccurrence. (Attachment titled Weekly Safety Rounds). The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>K 291 Emergency Lighting It is the policy of this facility to document monthly testing for all battery backup lights that includes the duration of the test.</p> <p>Corrective Action: The appropriate monthly testing of the emergency battery backup</p>	09/09/2022

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	<p>seconds, except as otherwise permitted by 7.9.3.1.1(2).</p> <p>(2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Emergency Lights and Exit Signs" documentation with the Executive Director and the Maintenance Director during record review from 9:45 a.m. to 2:20 p.m. on 08/24/22, monthly functional testing documentation for all battery operated lights in the facility within the most recent twelve month period did not state the duration of the test. Based on interview at the time of record review, the Maintenance Director stated all battery operated lights in the facility are tested on a monthly basis but agreed the aforementioned light testing documentation did not state the lights are tested for not less than 30 seconds. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, over twenty battery operated lights were in the main building (Building 01). Each battery operated light operated when its respective test button was pushed or when the circuit breaker controlling the</p>		<p>lights was occurring for the required duration but the documentation did not list the required duration. The duration of the test was added to the documentation of the monthly test. (Attachment titled Monthly Emergency Lights and Exit Lights).</p> <p>Monitoring of Corrective Action: The monthly testing will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months to ensure ongoing compliance with the regulations. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>	

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K 0353 SS=E Bldg. 01	<p>light was turned off.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 HVAC (Heating, Ventilation and Air Conditioning) rooms in the Alzheimer's wing. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling</p>	K 0353	<p>K 353 Sprinkler System Maintenance and Testing It is the policy of this facility to maintain the ceiling construction in HVAC rooms.</p> <p>Corrective Action: The contractor who completed the replacement of the air conditioning unit returned to the building on September 2, 2022 to repair/cover</p>	09/09/2022

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K 0355 SS=F Bldg. 01	<p>above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the Mechanical Room by the Staff Development Coordinator's office in the Alzheimer's wing.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, numerous holes and penetrations were noted in suspended ceiling tiles in the Mechanical Room by the Staff Development Coordinator's office in the Alzheimer's wing. Based on interview at the time of the observations, the Maintenance Director stated the air conditioning unit in the room was replaced in July 2022 which was most likely the cause of the holes and the penetrations in the suspended ceiling tiles.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 68 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers,</p>	K 0355	<p>the holes and penetrations in the suspended ceiling tiles in the Mechanical Room. (Attachments titled Dogwood Avenue Mechanical Room Pictures).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds and will monitor for any ceiling tile holes or penetrations. If noted, those will be corrected. (Attachment titled Weekly Safety Rounds). The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>K 355 Portable Fire Extinguishers It is the policy of this facility to ensure that all portable fire extinguishers are inspected at</p>	09/09/2022

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	<p>2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means:</p> <ol style="list-style-type: none"> (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (4) In a cabinet or wall recess. <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the ABC portable fire extinguisher located in the Sprinkler Shut Off room by the laundry room was freestanding on the floor and was not securely installed. All monthly, annual and 6-year maintenance documentation affixed to the extinguisher and was up to date. Based on interview at the time of the observations, the Maintenance Director stated the extinguisher had been secured on a wall mounted hanger in the room but agreed the extinguisher was freestanding on the floor in the room and was not securely installed.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p>least monthly.</p> <p>Corrective Action: The Maintenance Department staff received education on September 6, 2022 regarding the need to check all portable fire extinguishers monthly. (Attachment titled Fire Extinguisher Installation and Tag Training 2022). The department staff developed a map that includes all portable fire extinguishers that need checked to ensure that no fire extinguishers are overlooked. (Attachments titled Fire Extinguisher Map LCH and Fire Extinguisher Map Forest Path).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will randomly check fire extinguisher tags to ensure that none are missed. The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
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K 0361 SS=E Bldg. 01	<p>NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.</p> <p>18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during an initial walk through of the facility from 9:25 a.m. to 9:40 a.m. on 08/24/22, the corridor door to the Therapy Room was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the</p>	K 0361	<p>compliance with the regulations.</p> <p>K 361 Corridors - Areas Open to Corridor It is the policy of this facility to not prop doors open.</p> <p>Corrective Action: The wedge holding the door open to the Therapy Room was removed during the survey. (Attachment titled Therapy Room Door Picture). All staff were educated on the facility policy and life safety regulation to not prop doors open. (Life Safety Survey 2022 Staff Education).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will check doors to ensure that none are propped open. The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve</p>	09/09/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2022
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K 0363 SS=E Bldg. 01	<p>observations, the Executive Director and the Maintenance Director agreed the corridor door to the Therapy Room was propped open with a wedge placed on the floor under the door.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door</p>		<p>months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>		

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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274
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	<p>frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during an initial walk through of the facility from 9:25 a.m. to 9:40 a.m. on 08/24/22, the corridor door to the Therapy Room was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the corridor door to the Therapy Room was propped open with a wedge placed on the floor under the door.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p>	K 0363	<p>K 363 Corridor - Doors It is the policy of this facility that corridor doors have no impediment to closing and latching.</p> <p>Corrective Action: The wedge holding the door open to the Therapy Room was removed during the survey. (Attachment titled Therapy Room Door Picture). All staff were educated on the facility policy and life safety regulation to not prop doors open. (Life Safety Survey 2022 Staff Education).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will check doors to ensure that none are propped open. The results of the Safety Rounds will be monitored by the Quality Assurance</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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K 0372 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier,</p>	K 0372	<p>Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>K 372 Subdivision of Building Spaces - Smoke Barrier Construction It is the policy of this facility to ensure that there are no penetrations in smoke barriers. Corrective Action: The contractor who completed the replacement of the air conditioning unit returned to the building on September 2, 2022 to repair/cover</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2022
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
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K 0374 SS=E Bldg. 01	<p>the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of the Mechanical Room by the Staff Development Coordinator's office in the Alzheimer's wing.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, a large rectangular open ended HVAC duct penetrated the ceiling smoke barrier of the Mechanical Room by the Staff Development Coordinator's office in the Alzheimer's wing. Based on interview at the time of the observations, the Maintenance Director stated the HVAC ductwork had been for an air conditioning unit which was recently replaced. An operating air conditioning unit was noted in the room which had the date 07/23/21 written on the unit. The Maintenance Director agreed the new air conditioning unit was not hooked up to the existing rectangular HVAC ductwork which did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie</p>		<p>the holes and penetrations in the suspended ceiling tiles in the Mechanical Room. (Attachments titled Dogwood Avenue Mechanical Room Pictures).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds and will monitor for any ceiling tile holes or penetrations. If noted, those will be corrected. (Attachment titled Weekly Safety Rounds). The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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	<p>Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the corridor smoke barrier door set by Room 300.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, a one half in diameter hole was noted above the door handle in the north door of the corridor door set by Room 300. A one quarter inch in diameter hole was also noted below the door handle in the door. Based on interview at the time of the observations, the Maintenance</p>	K 0374	<p>K 374 Subdivision of Building Spaces - Smoke Barrier Doors It is the policy of this facility to maintain smoke barrier doors so that they restrict movement of smoke for at least 20 minutes.</p> <p>Corrective Action: The one half inch in diameter hole above the door handle in the north door of the corridor door set by Room 300 and the one quarter inch in diameter hole in the same door was repaired. (Attachment titled Cherry Blvd Smoke Barrier Door Picture).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will check doors to ensure there are no openings. The results of the</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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K 0761 SS=F Bldg. 01	<p>Director agreed the north door in the aforementioned corridor door set would not restrict the movement of smoke.</p> <p>This finding was reviewed with the Executive Director of Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>1. Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and</p>	K 0761	<p>Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>K 761 Maintenance, Inspection & Testing - Doors It is the policy of this facility to ensure an annual inspection of all fire door assemblies.</p> <p>Corrective Action: The Soiled Utility Room at Forest Path was added to the list of fire doors that require an annual inspection. (Attachment titled Fire Doors Requiring Annual Inspection). The annual inspection of the Soiled utility Room at Forest Path was completed on September 6, 2022. (Attachment titled Soiled Utility Room at Forest Path Annual Inspection).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will report on the corrective action monthly for</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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	<p>understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.</p> <p>NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified:</p> <ol style="list-style-type: none"> (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility blueprint</p>		<p>twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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	<p>documentation, annual "Fire/Smoke Door Inspection" documentation dated 06/21/22 and monthly "Fire Door Check Form" documentation with the Executive Director and the Maintenance Director during record review from 9:45 a.m. to 2:20 p.m. on 08/24/22, annual inspection documentation of fire door assemblies in the facility did not include all fire-rated assemblies in the facility and also did not verify the inspection included all items under NFPA 80, Section 5.2.4.2. The "Fire/Smoke Door Inspection" documentation dated 06/21/22 only included the fire door set at the B Wing exit to Assisted Living and did not include all fire doors identified in the facility based on blueprint documentation. The "Fire Door Check Form" documentation is a monthly check of fire doors in the facility but it did not include the corridor door to the oxygen storage room and did not verify the fire doors inspected included all items under NFPA 80, Section 5.2.4.2. Based on interview at the time of record review, the Executive Director and the Maintenance Director stated the facility has one oxygen storage room and agreed the corridor door to the oxygen storage room was not included in annual fire door inspection documentation and the monthly "Fire Door Check Form" inspection documentation did not verify fire door inspections included all items under NFPA 80, Section 5.2.4.2. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, a single leaf fire-rated corridor door to the oxygen storage room in the service corridor was noted. The door was equipped with a 90 minute fire resistance rating label affixed to the hinge side of the door. Fifty-six 'E' type oxygen cylinders were stored in the room.</p> <p>This finding was reviewed with the Executive</p>			

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	<p>Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain fire-rated door hardware on 1 of 6 fire barrier doors. LSC Section 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. This deficient practice could affect over 2 staff and visitors in the service corridor.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the bottom hinge was missing on the corridor door to the oxygen storage room in the service corridor. The missing hinge was the cause of numerous holes in the door frame and corridor door where the hinge should have been attached. The door was equipped with a 90 minute fire resistance rating label affixed to the hinge side of the door. Fifty-six 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the fire rated door to the oxygen storage room was missing the bottom hinge for the door.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the</p>			

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K 0918 SS=F Bldg. 01	<p>exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274
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	<p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors in the main building (Building 01).</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Director from 9:45 a.m. to 2:20 p.m. on 08/24/22, thirty-six month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the main building was not available for review. Based on interview at the time of record review, the Maintenance Director stated documentation of supplemental load testing for four hours within</p>	K 0918	<p>K 918 Electrical Systems-Essential Electrical Systems It is the policy of this facility to perform a thirty-six month four hour load test on the emergency generator.</p> <p>Corrective Action: The thirty-six month period emergency generator testing for the main building generator was completed on September 2, 2022. (Attachment titled Four Hour Load Test). This test is scheduled to be completed every thirty-six months going forward.</p> <p>Monitoring of Corrective Action: The required every thirty-six month testing will be monitored by the Quality Assurance Performance Improvement Committee to ensure ongoing compliance with the regulations. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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K 0920 SS=E Bldg. 01	<p>the most recent three year period was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the main building has one Cummins diesel fired emergency generator located outside the building on the south side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 154 kW.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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	<p>temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Executive</p>	K 0920	<p>K 920 Electrical Equipment - Power Cords and Extension Cords It is the policy of this facility to ensure that extension cords are not used as a substitute for fixed wiring.</p> <p>Corrective Action: The issues with the power strips in Rooms 202 and 204 were corrected. (Attachments titled Room 202 Picture and Room 204 Picture). An audit was performed on all rooms to ensure that there were no other issues. All other issues identified were corrected at the time of the audit. All staff were educated on this regulation so that as room arrangements are changed or families bring in items that staff can ensure that this regulation is followed correctly. (Attachment titled Life Safety Survey 2022).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will check rooms to ensure that no issues are identified with the use of power strips. If issues are identified, they will be corrected at that time.</p>	09/09/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274
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K 0000 Bldg. 05	<p>Director and the Maintenance Director during a tour of the facility from 9:10 a.m. to 12:20 p.m. on 08/25/22, the resident bed, a clock, a CD player and a chair were plugged into a power strip on the floor two and one half feet from the resident bed in Room 204. The UL listing of the power strip was 1363A. In addition, the resident bed and a clock were plugged into a power strip on the floor one and one half feet from the resident bed in Room 202. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was being used as a substitute for fixed wiring at the aforementioned two locations.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date(s): 08/24/22 & 08/25/22</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>At this Life Safety Code survey, Lutheran Community Home was found not in compliance</p>	K 0000	<p>The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274
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	<p>failed to ensure 2 of 5 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors in Forest Path (Building 05).</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 1:20 p.m. on 08/25/22, the affixed maintenance tag for the ABC type portable fire extinguisher located in the mezzanine of the Forest Path building where the main fire alarm control panel is located had missing monthly inspection documentation for April 2022 through July 2022. In addition, the affixed maintenance tag for the kitchen K Class portable fire extinguisher located in the kitchen</p>		<p>It is the policy of this facility to ensure that all portable fire extinguishers are inspected at least monthly.</p> <p>Corrective Action: The Maintenance Department staff received education on September 6, 2022 regarding the need to check all portable fire extinguishers monthly. (Attachment titled Fire Extinguisher Installation and Tag Training 2022). The department staff developed a map that includes all portable fire extinguishers that need checked to ensure that no fire extinguishers are overlooked. (Attachments titled Fire Extinguisher Map LCH and Fire Extinguisher Map Forest Path).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will complete Weekly Safety Rounds. (Attachment titled Weekly Safety Rounds). During these rounds, they will randomly check fire extinguisher tags to ensure that none are missed. The results of the Safety Rounds will be monitored by the Quality Assurance Performance Improvement Committee monthly for twelve months. The Maintenance Supervisor or designee will report on the corrective action monthly for twelve months to the Quality</p>	

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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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K 0761 SS=F Bldg. 05	<p>was also missing monthly inspection documentation for June 2022 and July 2022. Based on interview at the time of the observations, the visiting Maintenance Director agreed the aforementioned portable fire extinguisher locations had missing monthly inspection documentation.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of 1 of 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall</p>	K 0761	<p>Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.</p> <p>K 761 Maintenance, Inspection & Testing - Doors It is the policy of this facility to ensure an annual inspection of all fire door assemblies.</p> <p>Corrective Action: The Soiled Utility Room at Forest Path was added to the list of fire doors that require an annual inspection. (Attachment titled Fire Doors Requiring Annual Inspection). The annual inspection of the Soiled utility Room at Forest Path was completed on September 6, 2022. (Attachment titled Soiled Utility Room at Forest Path Annual Inspection).</p> <p>Monitoring of Corrective Action: The Maintenance Supervisor or designee will report on the</p>	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 05 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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	<p>be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.</p> <p>NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified:</p> <ol style="list-style-type: none"> (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. <p>This deficient practice could affect all residents, staff and visitors in Building 05 (Forest Path).</p> <p>Findings include:</p>		corrective action monthly for twelve months to the Quality Assurance Performance Improvement Committee who will monitor the plan for future compliance with the regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>05</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2022
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274
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	<p>Based on review of facility blueprint documentation, annual "Fire/Smoke Door Inspection" documentation dated 06/21/22 and monthly "Fire Door Check Form" documentation with the Executive Director and the Maintenance Director during record review from 9:45 a.m. to 2:20 p.m. on 08/24/22, annual inspection documentation of fire door assemblies in the facility did not include all fire-rated assemblies in Forest Path (Building 05). The "Fire/Smoke Door Inspection" documentation dated 06/21/22 only included the fire door set at the B Wing exit to Assisted Living in Building 01 (Main Building). The "Fire Door Check Form" documentation is a monthly check of fire doors in the facility but it did not include the corridor door to the soiled utility room in Forest Path and did not verify the inspection documentation included all items under NFPA 80, Section 5.2.4.2. Based on interview at the time of record review, the Executive Director and the Maintenance Director agreed the corridor door to the soiled utility room was listed as a fire door on blueprint documentation and agreed the corridor door to the soiled utility room in Forest Path was not included in annual fire door inspection documentation. Based on observations with the Executive Director and the Maintenance Director during a tour of the Forest Path from 12:50 p.m. to 1:20 p.m. on 08/25/22, the single leaf corridor door to the soiled utility room in Forest Path was equipped with a 45 minute fire resistance rating label affixed to the hinge side of the door.</p> <p>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>			