

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2016
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/28-29/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/15/16</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>At this PSR survey, Wittenberg Lutheran Village was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 original one story building with a partial basement identified as building 01 was determined to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000)</p>	K 0000	Please accept this plan of correction as our allegation of compliance. This plan of correction is being submitted for the purpose of complying with regulatory requirements and in no way should be deemed as an admission of any of allegations contained within the survey findings.	
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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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K 0054 SS=C Bldg. 01	<p>construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 127 at the time of this survey.</p> <p>All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist on 06/16/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 facility fire alarm system was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the</p>	K 0054	- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The every other year required sensitivity test on all smoke detectors was performed on May 11, 2016; however, a clerical error on the part of the inspector for 1 of 67 detectors caused an	06/30/2016

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	<p>second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity</p>		<p>erroneous entry to be documented. Vendor will be contacted to re-test the detector in question. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All other residents have the potential to be affected. Future Sensitivity smoke detector testing will be done timely and accurately.</p> <p>- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The director of Plant operations had the detector in question retested, and the findings are included in this P.O.C. Again, as noted in the previous POC submitted by Wittenberg Village, The Director of Maintenance will ensure the vendor performs said test timely. - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Director of Maintenance will be required to present to the QA committee, the fire system preventive maintenance calendar at the June QA meeting. Additionally, this corrective action will be monitored by the Director of Maintenance performing his annual LSC comprehensive</p>	

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K 0130 SS=C Bldg. 01	<p>range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Plant Operations Manager on 06/15/16 at 12:49 p.m., the facility was written up for an expired sensitivity test on 04/28/16. The facility completed a sensitivity test on 05/11/16. On the report, the smoke detector labeled as "Hall @ 709" had a sensitivity range from 0.6-1.8 and a value at 0.08. Based on an interview at the time of record review, the Plant Operations Manager acknowledged the aforementioned condition and confirmed the value was out of the sensitivity range.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to maintain 97 of 97 single station smoke detectors per manufacturer's recommendation. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review with the Plant</p>	K 0130	<p>audit in January of each year.</p> <p>- By what date the systemic changes will be completed. The date certain is June 30, 2016</p> <p>- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The smoke detectors will be cleaned on a weekly basis as recommended by the manufacture. Batteries will be replaced as recommended by the manufacturer. - How other residents having the potential to be affected by the same deficient</p>	06/30/2016	

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K 0000 Bldg. 02	<p>Operations Manager on 06/15/16 at 12:51 p.m., the facility was cited on 04/29/16 for not testing the battery operated smoke detectors weekly. No weekly testing was available for review. Based on interview at the time of record review, the Plant Operations Manager acknowledged the aforementioned condition and confirmed that no paperwork was available for review since 04/29/16.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 04/29/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State</p>	K 0000	<p>practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected.</p> <p>- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The smoke detector inspections will change from monthly to weekly to insure that the deficient practice does no recur. A copy of the recently completed testing is included. The Director of Maintenance will "sign off" of weekly testing of detectors for 90 days to Ensure this process becomes routine and systematic.</p> <p>- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The corrective action will be monitored on the check off sheets that are currently used to insure the deficient practice will not recur. These check off sheets will be turned in and monitored by the Director of Maintenance.</p> <p>- By what date the systemic changes will be completed. The date certain will be June 30, 2016.</p> <p>Please accept this plan of correction as our allegation of</p>		

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