

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2013
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NAME OF PROVIDER OR SUPPLIER  SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/16/13</p> <p>Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Seymour Crossing was found not in 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>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>K 000. INITIAL COMMENTS: The creation and submission of this plan of correction does not constitutes an admission by this provider of any conclusion set for set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and that facility be approve for Paper Compliance.</p>	
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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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	<p>has a capacity of 115 and had a census of 82 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two detached wooden storage sheds and a detached thirteen hundred square foot residential home used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 135 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 32 residents who reside on the B Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/16/13 during a tour of the facility from 10:45 a.m. to 1:55 p.m., the following wall and ceiling smoke barriers were not fire stopped;</p> <p>a. The service corridor boiler room ceiling had a two inch circular area of drywall missing above the electric panels.</p> <p>b. The laundry room south wall next to</p>	K010025	<p>K 25. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Fire rated caulk was installed to all areas of concern by the Maintenance Director on Sept 17, 2013. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. Fire rated caulk was installed to all areas of concern by the Maintenance Director on Sept 17, 2013 and now we have no gapping issues. Other areas were inspected and no other areas were identified as having gapping issues. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the</p>	09/17/2013			

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	<p>the dryers had a twelve inch by twelve inch square area with no drywall where natural gas piping penetrated the south wall and the adjoining boiler room.</p> <p>c. The service corridor storage room ceiling had a one half inch gap around a low point sprinkler pipe drain line with no fire stopping material used to seal the gap.</p> <p>d. The B Hall lounge closet ceiling had a one half inch gap around a low point sprinkler pipe drain line with no fire stopping material used to seal the gap.</p> <p>The service corridor boiler room ceiling, laundry room south wall, service corridor storage room and B Hall lounge closet having missing drywall and ceiling penetrations which were not firestopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>		<p>Maintenance Director or/designee to ensure that all areas having gaps that needs Fire Rated Caulk are corrected. 4) 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 in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that all gaps are corrected. Any issues identified during the quarterly inspections or monthly Environment CQI will be addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be address.</p>				

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 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 20 residents who reside on the C Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/16/13 at 1:50 p.m. during a test of the fire alarm system with the maintenance supervisor, the C Hall set of smoke barrier doors did not close completely, leaving a three inch gap where the doors came together. This was</p>	K010027	<p>K27.1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The smoke barrier doors at the C Hall entrance were adjusted to ensure no gaps for smoke to penetrate. The adjustment was accomplished by the Maintenance Director on Sept 17, 2013. 2) 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 residents have the potential to be affected by the alleged deficient practice. The smoke barrier doors at the C Hall entrance were adjusted to ensure not gaps for smoke to penetrate and now we have no gapping issues at this location. Other areas were inspected and no other areas were identified as having gapping issues. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does</p>	09/17/2013			

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	verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.  3.1-19(b)		not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all areas having gaps that need adjustment in the smoke barrier doors does not recur. 4) 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 in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that all gaps are corrected. Any issues identified during the quarterly inspections or monthly CQI will be addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be address.		

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the laundry room, a hazardous area over 100 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 32 residents who reside on the B Hall, located adjacent to the service corridor where the laundry room is located.</p> <p>Findings include:</p> <p>Based on observation on 09/16/13 at 11:25 a.m. with the maintenance supervisor, the north laundry room door self closing device failed to completely close and latch the door, leaving a two inch gap where the door was hitting the top of the door frame. This was verified by the maintenance supervisor at the time</p>	K010029	<p>K29. 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The north laundry door was adjusted and repaired to ensure door closes and latches into frame without assistance. Door was repaired on Sept 18, 2013 by the Maintenance Dept. 2) 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 residents have the potential to be affected by the alleged deficient practice. The north laundry door was adjusted and repaired to ensure door closes and latches into frame without assistance. Door was repaired on Sept 18, 2013 by the Maintenance Dept. The other doors in the same area were inspected, and no others areas were identified as being affected. 3) What measures will</p>	09/18/2013			

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	of observation and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.  3.1-19(b)		be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all doors closes and latches into frame without assistance. 4) 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 in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that all doors closes and latches into frame without assistance. Any issues identified during the quarterly inspections or monthly Environment CQI will be addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any areas that needs to be address.		

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 3 of 4 third shift fire drills over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 09/16/13 at 10:00 a.m., the fire drills conducted on 06/28/13 at 1:00 a.m., 03/30/13 at 11:00 p.m., and 12/28/12 at 6:30 a.m. each indicated the fire drill was a simulated alarm drill written in the remarks section of each report. Based on an interview with the maintenance supervisor on 09/16/13 at 10:15 a.m., the simulated alarm written on each Monthly Fire Drill Report indicates the fire alarm system was not tested during these fire</p>	K010052	K52. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director was in-serviced and a new protocol will be follow after every simulated fire drill. On the same day of the simulated fire drill, follow up action will be conducted to test the fire alarm system. This will be documented and file for inspection. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director was in-serviced and a new protocol will be follow after every simulated fire drill. On the same day of the simulated fire drill, follow up action will be conducted to test the fire alarm system. This will be documented and file for inspection. Systems Event Report for the month of December 2012 and June 2013 were inspected and follow up action was conducted to test the	09/18/2013			

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	drills and there was no follow up action after each drill was conducted to test the fire alarm system. The lack of fire alarm system transmission documentation during the above listed Monthly Fire Drill Reports was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.  3.1-19(b)		fire alarm system. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director will conduct and test the fire alarm system after every simulated fire drill. This will be documented and file for inspection. 4) How the corrective action(s) will be monitored to ensure that deficient practice will not recur. i.e., what quality assurance program will be put in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that on the same day of the simulated fire drill, follow up action was conducted to test the fire alarm system. This will reviewed by the Quality Assurance Committee and action plans developed for any areas that needs to be address.		

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K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 5 of over 300 sprinklers covered with white paint or green corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 residents who reside on the A Hall and 47 resident who use the main dining room, located across the corridor from the receptionist desk.</p> <p>Findings include:</p> <p>Based on observations on 09/16/13 during a tour of the facility from 10:45 a.m. to 1:55 p.m. with the maintenance supervisor, the sprinkler in the service corridor by the food storage room, the sprinkler in the service corridor by the maintenance office, and the sprinkler in the main entrance corridor above the</p>	K010062	<p>K62. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All affected sprinklers heads will be replaced by P.I.P.E., Inc on november 15, 2013. 2) 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 residents have the potential to be affected by the alleged deficient practice. All affected sprinklers heads will be replaced by P.I.P.E., Inc on November 15, 2013 and no paint or corrosion will be in the sprinklers heads identified. 3) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all sprinklers have no paint or corrosion on the sprinkler heads. Those sprinklers heads affected by paint or correction will be replace in Accordance with NFPA 25, 1998 editon, 2-2.1.1. 4) How the corrective action(s) will be monitored to ensure the deficient</p>	11/15/2013			

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	<p>receptionist desk were covered with white paint. Furthermore, the sprinkler located at the ambulance entrance outside porch overhang and the sprinkler in the A Hall spa closet were covered with green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>		<p>practice will not recur. i.e., what quality assurance program will be put in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that sprinklers affected are corrected. Any issues identified during the quarterly inspections or monthly Environmental CQI will be addressed timely by the Maintenance Director or/designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be address.</p>	

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K010144 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to maintain a written record of weekly battery inspections for 4 of 52 weeks over the past year and a written record for 2 of 12 monthly load tests over the past year were available for review. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p>	K010144	<p>K144. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Effective 09/30/2013 2 sets of documents will be kept on file on battery inspections and written records of load tests to be available for inspections. Original will be kept in the Maintenance Director office and a copy will be kept in the Administrator Office. 2) 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 residents have the potential to be affected by the alleged deficient practice. The Maintenance Director will ensure that 2 sets of documents are kept on file on battery inspections and written records of load tests to be available for inspections. Original will be kept in the Maintenance Director office and a copy will be kept in the Administrator Office. 3) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Routine inspections will be conducted by the Administrator or/designee to ensure that weekly battery</p>	09/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2013
NAME OF PROVIDER OR SUPPLIER  SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274		
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	<p>Findings include:</p> <p>Based on review of the Emergency Generator Weekly Exercise Log and Monthly Load Test Log with the maintenance supervisor on 09/16/13 at 10:00 a.m., there was no record of weekly inspections including storage battery tests for the generator set for the month of September 2012. Additionally, there were no monthly load test records available for review for the months of July and August 2013. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/16/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>		<p>inspections and monthly load tests are being conducted and that 2 sets of documents are kept on file, one in the Maintenance Director office and a copy is kept in the Administrator office. Any deficient practice will be corrected immediately. 4) How the corrective action(s) will be monitored to ensure the deficient practice will recur. i.e., what quality assurance program will be put in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that weekly battery inspections and monthly load tests are being conducted and documents are kept in the Maintenance Director office and a copy in the Administrator office. Any issues identified during the quarterly inspections or monthly Environmental CQI will be address timely by the Maintenance Director or/designee. This will be review by the Quality Assurance Committee and action plans developed for any areas that needs to be address.</p>		