

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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The A Wing, B Wing, C Wing, D Wing, Front Entrance/Main Dining Room Wing, and Service Hall Wing were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm</p>	K0000	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 corrections is prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as out credible allegation of compliance.	

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.

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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The A Wing, B Wing, C Wing, D Wing, Front Entrance/Main Dining Room Wing, and Service Hall Wing were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The A Wing, B Wing, C Wing, D Wing, Front Entrance/Main Dining Room Wing, and Service Hall Wing were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The A Wing, B Wing, C Wing, D Wing, Front Entrance/Main Dining Room Wing, and Service Hall Wing were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type II (222) construction and fully</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0017 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically</p>	K0017	K 0017 NFPA 101 Life Safety Code Standard It is the policy of this facility that corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. A hard wired automatic smoke detection smoke detector was installed in the Service Hall south employee lounge on 8-18-2012.	08/18/2012

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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects staff who use the Service Hall employee lounge.</p> <p>Findings include:</p> <p>Based on observation on 08/03/12 at 1:45 p.m. with the maintenance supervisor, the Service Hall south employee lounge was open to the corridor. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the maintenance supervisor at the time of observation and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0025 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 observations and interview, the facility failed to ensure 2 of 8 smoke barrier walls above smoke barrier doors were constructed to provide at least a one half hour fire resistance rating. This deficient practice could affect any of the 95 residents who reside on the existing C Wing, A Wing, B Wing and D Wing.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 08/03/12 during a tour of the facility from 12:00 p.m. to 3:40 p.m., the following smoke barrier walls above smoke barrier doors had missing drywall or penetrations which were not fire stopped:</p> <p>a. The C Wing smoke barrier wall at the D Wing entrance smoke barrier doors had two, two inch gaps around two, two inch circular electrical conduit pipes which were not firestopped and the two electrical conduit pipes were open on both ends.</p> <p>b. The B Wing smoke barrier wall above the</p>	K0025	K 0025 NFPA 101 Life Safety Code Standard It is the policy of this facility that smoke barriers are constructed to provide at least a one half hour fire resistance rating. The two, two inch gaps in the C wing smoke barrier wall at the D wing entrance smoke barrier doors were repaired on 8-6-2012. Contact was made with InterDesign to verify that the appropriate construction of the fire wall is in place between B wing and Evergreen Way assisted living. That documentation is attached to prove that the appropriate barrier is in place. This documentation is dated 8-10-2012. See attached documentation from InterDesign.	08/10/2012			

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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>smoke barrier doors at the assisted living entrance had a two foot by ten foot area of drywall missing. The C Wing smoke barrier penetrations not being firestopped and B Wing smoke barrier missing drywall was verified by the maintenance supervisor at the time of observations and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0029 SS=D	<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 the corridor doors to 2 of 15 hazardous areas, such as combustible storage rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice affects staff who use the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 08/03/12 during a tour of the facility from 12:00 p.m. to 3:40 p.m. with the maintenance supervisor, the door to the Service Hall food storage room which measured seven hundred twenty square feet and stored ninety seven shelves of combustible paper and cardboard lacked a self closing device. Furthermore, the two hundred square foot housekeeping storage room</p>	K0029	K 0029 NFPA 101 Life Safety Code Standard It is the policy of this facility that one hour rated construction with 3/4 hour fire-rated doors or an approved fire extinguishing system is in place to protect hazardous areas. A self closing device was installed on the service hall food storage door on 8-6-2012. The self closing device on the housekeeping storage room door was repaired on 8-7-2012 to close the identified one inch gap.	08/07/2012			

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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>door had a one inch gap where the self closing device failed to close the door along the entire latching side of the door frame. This was verified by the maintenance supervisor at the time of observations and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on the third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at</p>	K0050	K 0050 NFPA 101 Life Safety Code Standard It is the policy of this facility that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The Maintenance Department Staff members were educated on the fire drill policy of the facility on 8-17-2012 that 11-7 drills should take place at varying times throughout the shift as well as on the other two shifts. Please see attached policy and Maintenance staff sign off. Documentation is titled Drills.	08/17/2012			

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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on the third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on the third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>during the past year. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on the third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 smoke compartments converted to quick response sprinklers were equipped throughout the smoke compartment with quick response sprinklers. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, Table 3-2.5.1 states sprinklers with temperature ratings of 135 to 170 degrees F are Ordinary sprinkler's and sprinklers rated from 175 to 225 degrees F are intermediate rated sprinklers. 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all</p>	K0056	K056 NFPA 101 Life Safety Code Standard It is the policy of this facility that our automatic sprinkler system is installed in accordance with NFPA 13 to provide complete coverage for all portions of the building. Quick response sprinklers were installed in the identified C wing location as well as the front entrance location on 8-13-2012.	08/13/2012			

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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>sprinklers in a compartmented space shall be changed. This deficient practice could affect any of the 12 residents who reside on the C Wing and 83 residents on the A Wing, B Wing, and D Wing who use Main Dining room/Front Entrance Hall.</p> <p>Findings include:</p> <p>Based on observations on 08/03/12 between 12:00 p.m. and 3:40 p.m. during a tour of the facility with the maintenance supervisor, the C Wing in the existing portion of the building had two red liquid filled quick response sprinklers (155 degrees F) in the recessed ceiling near the C Wing new addition and seventeen metal standard sprinklers (212 degree F) throughout the remaining portion of the corridor. Furthermore, the Front Entrance/Main Dining room Wing had thirty six red liquid filled quick response sprinklers (155 degree F) in use throughout the smoke compartment and six standard sprinklers (212 degree F) in the Front Entrance Wing receptionist recessed ceiling. This</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was verified by the maintenance supervisor at the time of observation and verified by observing spare sprinklers in the spare sprinkler cabinet located in the maintenance office. The lack of quick response sprinklers throughout the C Wing existing Hall and the Front Entrance Hall was acknowledged by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0144 SS=F	<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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K0144	<p>K 0144 NFPA 101 Life Safety Code Standard It is the policy of this facility that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The generator weekly and monthly inspections were updated to include documentation that it was exercised under load monthly for 30 minutes and also that the batteries were inspected weekly. The generator logs were updated and an updated copy is attached. A test under load was completed on 8-14-2012. All work was completed on 8-17-2012. See attached documents titled Generator Logs.</p>	08/17/2012

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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. Chapter 3-4.4.1.3 of NFPA 99 requires storage</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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 manufacturer's 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> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions</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  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance</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  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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> <p>Findings include:</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  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2010 C Wing addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 addition to the one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K0000	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 corrections is prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as out credible allegation of compliance.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>open to the corridors, and battery operated smoke detectors in all resident rooms.</p> <p>The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lutheran Community Home was found not in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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) and 410 IAC 16.2. The 2010 C Wing addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 addition to the one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2010 C Wing addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 addition to the one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/12</p> <p>Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 483.70(a), Life Safety from Fire and the 2000 edition of the National</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2010 C Wing addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 addition to the one story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 109 and had a census of 101 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in C Wing.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the</p>	K0050	K 0050 NFPA 101 Life Safety Code Standard It is the policy of this facility that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The Maintenance Department Staff members were educated on the fire drill policy of the facility on 8-17-2012 that 11-7 drills should take place at varying times throughout the shift as well as on the other two shifts. Please see attached policy and Maintenance staff sign off. Documentation is titled Drills.	08/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in C Wing.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in C Wing.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility failed to ensure fire drills were held at unexpected times, at least quarterly on each shift for 1 of 3 shifts during the past year. This deficient practice affects all resident in C Wing.</p> <p>Findings include:</p> <p>Based on review of the Record of Drills-Alarms with the maintenance supervisor on 08/03/12 at 11:15 a.m., fire drills conducted on third shift from the year 2011 to 2012 were held at the following dates and times: 03/16/12 at 5:00 a.m., 06/22/12 at 5:05 a.m., 09/02/11 at 5:45 a.m., and 12/14/11 at 5:15 a.m. Based on an interview with the maintenance supervisor on 08/03/12 at 11:25 a.m., the third shift time runs from 11:00 p.m. to 7:00 a.m. The third shift fire drills being held at similar times was verified by the maintenance supervisor at the time of record review and confirmed by the assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K0144 SS=F	<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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all C Wing</p>	K0144	K 0144 NFPA 101 Life Safety Code Standard It is the policy of this facility that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The generator weekly and monthly inspections were updated to include documentation that it was exercised under load monthly for 30 minutes and also that the batteries were inspected weekly. The generator logs were updated and an updated copy is attached. A test under load was completed on 8-14-2012. All work was completed on 8-17-2012. See attached documents titled Generator Logs.	08/17/2012
---------------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. Chapter 3-4.4.1.3 of NFPA 99 requires storage</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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 manufacturer's 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 C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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 C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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 C Wing residents, staff and visitors.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 08/03/12 at 11:00 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output and voltage output during each load test conducted, with no indication of a thirty percent nameplate rated test or whether the generator set was run under operating temperature conditions. Based on an interview with the maintenance supervisor on 08/03/12 at 11:15 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output and voltage output is listed because the emergency generator contractor who performs annual testing suggested listing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>amperage output and voltage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test or documenting the generator load tests were performed under operating temperature conditions was confirmed by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generators was maintained. 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 manufacturer's 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715		X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2012	
NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>available by the authority having jurisdiction. This deficient practice could affect all C Wing residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 08/03/12 at 11:00 a.m., there was no record of weekly storage battery inspections for the generator set over the past year. Additionally, based on an interview during the record review, the maintenance supervisor stated there was no other documentation available for review to verify weekly generator storage battery inspections were conducted. This was verified by the maintenance supervisor and assistant director of nursing at the 3:40 p.m. exit conference on 08/03/12.</p> <p>3.1-19(b)</p>						