

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 11/15/2013
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/14/13 and 11/15/13</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 sprinkled. The facility has a fire alarm system with smoke detection in the</p>	K010000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>corridors, in 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 99 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled except an eighteen foot by sixteen foot wood framed detached storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 6 resident room corridor doors on the A Hall and B Hall which had a double door were provided with a means suitable for keeping the doors closed. This deficient practice could affect 2 residents who reside on the A Hall in resident room 114, and 4 residents who reside on the B Hall in resident rooms 214 and 215.</p> <p>Findings include:</p> <p>Based on observations on 11/14/13 during a tour of the facility from 9:00 a.m. to 12:55 p.m. with the administrator and assistant maintenance supervisor, resident rooms 114, 214 and 215 had a double corridor door consisting of the left side</p>	K010018	K-0018 It is the policy of this facility to provide doors that have a suitable means to keep the door closed. Corrective Action: The springs were adjusted on the locking mechanisms on the doors to rooms 114, 214, and 215. This adjustment provides the means for keeping the doors closed.	11/22/2013			

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	<p>door knob and latching hardware latching into the right side door frame, which was latched shut at the top of each door. Furthermore, the right side door leaf for each room failed to latch at the top of each door frame on three separate attempts to latch each door by the assistant maintenance supervisor. This was verified by the administrator and assistant maintenance supervisor at the time of observations and acknowledged by administrator at the exit conference on 11/15/13 at 12:00 p.m.</p> <p>3.1-19(b)</p>				

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 15 hazardous areas, such as combustibile storage room over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects 18 residents who reside on the A Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/14/13 at 10:45 a.m. with the administrator and assistant maintenance supervisor, the A Hall storage room, which measured one hundred twenty square feet and stored two cardboard boxes of paper supplies, two plastic containers of clothes, and four plastic mattresses, lacked a self closing device. This was verified by the</p>	K010029	K 029 It is the policy of this facility to ensure that all storage areas have a self closing device. Corrective Action: An automatic closure was added to the Autumn Court storage room door.	11/22/2013			

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	<p>administrator and assistant maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 11/15/13 at 12:00 p.m.</p> <p>3.1-19(b)</p>				

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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects 68 residents who use the main dining room, located in the Administration Hall.</p> <p>Findings include:</p> <p>Based on observation on 11/15/13 during a test of the fire alarm system at 11:45 a.m. with the assistant maintenance supervisor, the Administration Hall set of fire doors was released from the magnetically hold open device and the set of fire doors failed to close and latch in the door frame, leaving a two inch gap between the doors. This was verified by the assistant maintenance supervisor at the time of testing and observation and acknowledged by the administrator at the exit conference on 11/15/13 at 12:00 p.m.</p>	K010044	K 044 It is the policy of this facility that all fire doors close and latch when released from the magnet. Corrective Action: The closing mechanism on the identified fire doors was adjusted to ensure that the doors closed and latched with no gaps.	11/22/2013			

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K010046 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the lighting in 2 of 13 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the areas in darkness. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice does not affect any residents since the 2 Service Hall exits are used by staff only.</p> <p>Findings include:</p> <p>Based on observations during a tour of the Service Hall on 11/14/13 from 11:30 a.m. to 12:30 p.m. with the administrator and assistant maintenance supervisor, the two Service Hall exits were provided with a single light fixture on emergency power outside each exit door. This was verified by the administrator and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/14/13 at 12:00 p.m.</p> <p>3.1-19(b)</p>	K010046	K 046 It is the policy of this facility that exit means of egress have dual lamp fixtures to ensure that if one bulb fails that there is adequate lighting and the area would not be left in darkness. Corrective Action: The light fixtures at these exits were changed so that there are two bulbs in each fixture.	11/22/2013			

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K010067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on interview and record review, the facility failed to ensure 2 of 2 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 46 residents who reside on the B Hall and C Hall.</p> <p>Findings include:</p> <p>Based on an interview with the administrator on 11/14/13 during record review from 9:00 a.m. to 10:45 a.m., when asked if the facility had any fire dampers and inspection records, the</p>	K010067	K 067 It is the policy of this facility to inspect fire dampers every four years. Corrective Action: Our heating and air conditioning provider will complete an inspection of the fire dampers and will provide documentation of the inspection. This will be scheduled to be completed every four years.	12/06/2013			

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	<p>administrator indicated there are two fire dampers located in the fire walls on the B Hall and C Hall. Furthermore, it was stated the two fire dampers are inspected every four years by the fire alarm system inspection company. Based on a review of the Compugage Fire Alarm System Inspection records dating from 10/19/12 to 11/2/13, there was no record the two fire dampers were inspected. Based on a telephone conversation between Compugage and the administrator on 11/14/13 at 10:30 a.m., the administrator indicated Compugage had no records the two fire dampers were inspected over the past four years. The lack of a four year fire damper inspection was verified by the administrator at the time of interview and record review and acknowledged by the administrator at the exit conference on 11/15/13 at 12:00 p.m.</p> <p>3.1-19(b)</p>			

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K040000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/14/13 and 11/15/13</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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery</p>			K040000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.		

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	<p>operated smoke detectors in all resident rooms. The facility has a capacity of 109 and had a census of 99 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled except an eighteen by sixty six foot wood framed detached storage building.</p>			