DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING -- B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/27/2021 Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 At this Emergency Preparedness survey, Healthcare Center at Wittenberg Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 155 certified beds. At the time of the survey, the census was 107. Quality Review completed on 05/05/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/27/2021 Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 At this Life Safety Code survey, Healthcare	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Center at Wittenberg Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 addition to the facility. The facility is surveyed as two buildings due to different construction types. The building is partially protected by a 150 kW diesel powered emergency generator. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 107 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. Quality Review completed on 05/05/21			
K 0222 SS=D Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the			

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	egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire			

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	detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on record review, observation and interview; the facility failed to ensure 1 of 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect up to 5 residents, staff and visitors if needing to exit the facility using the North Exit Door of the current COVID-19 visitation area. Findings include: During a facility tour with the Executive Director, Acting Director of Maintenance, and Maintenance Tchnician #1, on 04/27/2021 at 1:15 p.m. it took excessive force to open the north exit door of the dining room, which is now limited in use to allow for COVID-19 visitation, due to rust that had formed at the base of the door, between the door and the door jamb. Based on interview at the time of testing, the Acting	K 0222	1.No Residents were affected by the alleged deficient practice. The North exit door of the dining room was immediately cleaned oiled and tested to ensure it was able to be opened without use of excessive force. 2.A rounding of all emergency exits that included testing to ensure easy opening was completed. No like circumstances were identified. 3.Education related to this requirement has been completed with the Maintenance Staff. Additionally, monthly testing of emergency exit door has been entered into the facility Preventative Maintenance program. 4.An audit has been created to	05/27/2021

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	Director of Maintenance agreed that the door took excessive force to open. This deficient practice was reviewed with the Executive Director at the time of exit. 3.1-19(b)		ensure emergency exit doors are able to be opened without excessive force. The audit will include 2 random emergency exit doors. It completed by the Director of Maintenance or designee weekly for 4 mos. The results of this audit will be reviewed by the QAPI Committee on a monthly basis for no less than 4 mos to ensure compliance.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1) Based on observation, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square	K 0232	1.No Residents were affected by the alleged deficient practice. The chair was removed upon surveyor identification of the chair not affixed to the floor or wall. The cited non-wheeled carts were replaced with carts with wheels. 2.A rounding of all corridors was completed to ensure no further furniture was present in the hallways that is not affixed to the floor and no further non-wheeled isolation carts were present in the corridors outside resident rooms. No like circumstances were identified. 3.Education related to this	05/27/2021

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	feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 15 residents, staff and visitors if needing to exit the facility. Findings include: During a tour of the facility with the Executive Director, Acting Director of Maintenance, and Maintenance Technician #1 on 04/27/2021 at 1:30 p.m. an unsecured chair was located in the corridor next to the south exit door of the Memory Care Unit. Based on interview at the time of the observations, the Acting Director of Maintenance acknowledged furniture in the aforementioned corridor were not affixed to the floor or to the wall. This deficient practice was reviewed with the Executive Director at the time of exit. 3.1-19(b) 2) Based on observation, the facility failed to protect 2 of 5 corridors in accordance with LSC		requirement has been completed with all staff. 4.An audit has been created to ensure corridors are free of furniture that is not affixed to the floor or wall and all isolation carts are on wheels. This audit will include all 7 corridors. It will be completed by the Director of Maintenance or designee weekly for 4 mos. The results of this audit will be reviewed by the QAPI Committee on a monthly basis for no less than 4 mos to ensure compliance.	

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	Section 19.2.3.4(4). LSC 19.2.3.4(4) states that projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect staff and up to 40 residents in the smoke compartments. Findings include: During a tour of the facility with the Executive Director, Acting Director of Maintenance, and Maintenance Technician #1, on 04/27/2021 at 12:59 p.m., a non-wheeled isolation cart was located in the corridor outside of Resident Room 701; at 1:37 p.m. non-wheeled isolcation carts were located in the corridor outside of Resident Rooms 303 and 309. At time time of each observation, the Acting Director of Maintenance and the Executive Director agreed that the isolation carts were not wheeled. This deficient practice was reviewed with the Executive Director at the time of exit. 3.1-19(b)			
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and			

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Bldg. 01	Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			
	Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Acting Director of Maintenance on 04/27/2021 at 10:40 a.m., the last fire alarm inspection report dated 03/09/2021 indicated the Fire Alarm Control Panel back-up batteries failed testing. Based on interview at the time of record review, the Acting Director of Maintenance agreed that the batteries failed testing and that they have not been replaced. Additionally, he stated that the facility is currently upgrading the entire fire alarm system, which will include a new control panel and batteries. This deficient finding was reviewed with the Executive Director at the time of exit.	K 0345	1.No residents were affected by the alleged deficient practice. Fire panel back up battery replacement is scheduled to occur on Friday, May 21, 2021. 2.The second battery back- up (located in the Health Care Center) was in working order and identified as such on the testing that occurred on March 9, 2021. 3.Education related to this requirement has been completed with all Maintenance Staff as well as Ryan Fire Protection. Specifically, the back- up batteries for the fire alarm panel are to be replaced immediately if they fail the testing process. 4.This directive is included in the TELS prompting for testing in the system. A report related to fire system testing and response will be completed by the Director of Maintenance to be reviewed by the QAPI Committee on a monthly basis for no less than 4 mos.	05/27/2021

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	3.1-19(b)			
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Therapy Gym (now COVID-19 Visitation area) in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 2 residents in the Therapy Gym. Findings include:	K 0351	1.No Residents were affected by the alleged deficient practice. The visualized missing sprinkler escutcheon was immediately replaced. 2.A visual inspection of all sprinkler heads was completed. No like circumstances were identified. 3.Education related to this requirement has been completed with all Maintenance staff. 4.An audit has been created to ensure all sprinkler head	05/27/2021

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	Based on observation with the Executive Director, Acting Director of Maintenance, and Maintenance Technician #1, on 04/27/2021 at 12:55 p.m. 1 of 4 sprinklers in the Therapy Gym was missing the escutcheon. Based on interview at the time of observation, the Acting Director of Maintenance agreed that the escutcheon was missing. This deficient finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		escutcheons are present. The audit will include all corridors and common areas. It will be completed by the Director of Maintenance or designee weekly for 4 mos. The results of this audit will be reviewed by the QAPI Committee on a monthly basis for no less than 4 mos to ensure compliance.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure 1 of 5 smoke barrier walls was maintained in accordance with LSC Section 19.3.7.5. Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. Section 8.5.2 states that smoke barriers shall be continuous from outside wall to outside wall and continuous	K 0372	1.No Residents were affected by the alleged deficient practice. The smoke barrier penetration was immediately sealed with the appropriate fire rated calk. 2.A visual inspection of all fire barriers took place. No like concerns were identified. 3.The maintenance department	05/27/2021

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	through all concealed spaces. This deficient practice could affect staff and at least 30 residents. Findings include: During a tour of the facility with the Executive Director, Acting Director of Maintenance, and Maintenance Technician #1 on 04/27/2021 at 12:57 p.m. the smoke barrier between the Administrative Corridor and the 700 Hall was not properly maintained. A 4 inch x 10 inch unsealed penetration was located around electrical wires. Based on interview at the time of observation, this was confirmed by the Acting Director of Maintenance. This deficient finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		has been educated on this requirement. 4.An audit has been created to ensure all sprinkler head escutcheons are present. The audit will be completed by the Director of Maintenance or designee weekly for 4 mos. The results of this audit will be reviewed by the QAPI Committee on a monthly basis for no less than 4 mos to ensure compliance.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on	K 0712	1.No Residents were affected by the alleged deficient practice. A fire drill was conducted on	05/27/2021

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	the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report Card" documentation with the Acting Director of Maintenance during record review at 10:25 a.m. on 04/27/2021, first shift (7:00 a.m. to 3:00 p.m.) fire drills conducted on 07/23/2020, 10/06/2020, and 04/07/2021 were conducted at 8:00 a.m. Based on interview at the time of record review, the Acting Director of Maintenance agreed that the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. This deficient finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		4/28/21 at 2:00 PM. 2.A review of the previous months' fire drills has been completed. For the 2 12 hour shifts that are in place fire drills have been completed at unexpected times under varying conditions. 3.A new Fire Drill Schedule/log has been put in place to ensure these drills are completed as required. The Maintenance Department has been educated on the requirement to hold a fire drill quarterly on each shift. 4.The Fire Drill log will be reviewed monthly by the Director of Maintenance. The results of the review will be submitted to the QAPI Committee on a monthly basis for no less than 4 mos.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 02 B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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
	in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 addition to the facility. The facility is surveyed as two buildings due to different construction types. The building is partially protected by a 150 kW diesel powered emergency generator. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 107 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. Quality Review completed on 05/05/21			