

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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K 000 Bldg. 01	<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: 04/22/15</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>At this Life Safety Code survey, Wittenberg Lutheran Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>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 Chapel/Fellowship Hall identified as building 02 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two</p>	K 000	Please accept this plan of correction as our allegation of compliance. This plan of correction is being submitted for the purpose of complying with regulatory requirements and in no way should be deemed as an admission of any of allegations contained within the survey findings	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 038 SS=E Bldg. 01	<p>buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 113 at the time of this survey.</p> <p>All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 locked exit doors in the main dining room unlocked upon entry of a code into the keypad adjacent to the door. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to be carried by staff at all times, or other such reliable means available to the staff at all times. This deficient practice affects</p>	K 038	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Residents who eat in the main dining area have the potential to be affected be the alleged deficient practice. b. Door was evaluated and replacement door ordered on 04/30/2015. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	05/22/2015	

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K 130 SS=E	<p>staff, visitors, and 30 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/22/15 at 10:45 a.m., three exit doors from the main dining room were each equipped a magnetic door lock designed to release upon activation of the fire alarm, a power outage and a code entered into the keypad adjacent to the exit door. The maintenance director twice attempted to open the southwest and north doors using the code. The doors did not open. The north door could be opened upon activation of the fire alarm when demonstrated by the Maintenance Director on 04/22/15 at 10:50 a.m. However, the southwest door remained closed and locked despite repeated efforts by the Maintenance Director to open the door. The Maintenance Director agreed at the time of observations, the locking mechanism and keypad override was malfunctioning.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS</p>		<p>action(s) will be taken a. Residents who dine in the main dining area have the potential to be affected by the alleged deficient practice b. All doors were checked in this area on 04/22/2015 to ensure all were working properly. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. a. Monthly Environmental Audit was updated to include door assessment/review to ensure that the alleged deficient practice does not recur. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. a. The Quality Improvement Committee will review the Environmental Audits quarterly for compliance until such time the audits are satisfactory for one complete quarter. b. Executive Director will oversee for satisfactory compliance. Completion Date 05/22/2015</p>		

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Bldg. 01	<p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of non-flammable gas was secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage. NFPA 99, 8-5.2.1 requires the construction for nonpatient gas cylinder carts and hand trucks shall be constructed for the intended purpose and shall be self-supporting. They shall be provided with appropriate chains or stays to retain cylinders in place. This deficient practice affects visitors, residents and staff in the kitchen and adjacent main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/22/15 at 11:00 a.m., a carbon dioxide gas cylinder was free standing in the kitchen with a chain on the floor beside it. The Maintenance Director agreed, at the time of observation, the tank should have been secured.</p> <p>3.1-19(b)</p>	K 130	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. No residents have the potential to be affected by the alleged deficient practice due to the cylinder storage being in a nonresident area restricted to staff only.</p> <p>b. A safety chain was placed on said cylinder immediately and secured to the wall.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. No residents have the potential to be affected by the alleged deficient practice due to the cylinder storage being in a nonresident area restricted to staff only.</p> <p>b. The carbon dioxide gas cylinder for beverages has been added to the Culinary QA Audit to ensure it is being secure at all times.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>a. Daily inspections to occur for 90 days by Culinary Manager or</p>	05/22/2015	

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K 147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure flexible cords including extension cords and powerstrips in 3 of 6 smoke compartments were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall	K 147	designee to ensure compliance in the alleged deficient practice does not recur. b. Culinary QA Audit updated to include carbon dioxide cylinder is secured to wall at all times. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. a. The Quality Improvement Committee will review and monitor the Culinary Audits for one quarter for satisfactory compliance. b. Executive Director to oversee for satisfactory compliance. Completion Date 05/22/2015 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. Staff, visitors, and residents near the main dining area , also on 300, and 400 hallways have the potential to be affected by the alleged deficient practice of using	05/22/2015

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	<p>not be used as a substitute for fixed wiring of a structure or where run through holes in walls. This deficient practice could affect visitors, staff and 30 or more residents in the 300 and 400 halls and the main dining room access corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Man on 04/22/15, the following was noted:</p> <p>A) At 11:20 a.m., the power cord for a commercial ice machine was run through the wall between the exit corridor and the utility room near the main dining room where the cord was plugged into a utility room electrical outlet. The Maintenance Director acknowledged at the time of observation, the power cord was run through a wall.</p> <p>B) At 12:15 p.m., a power strip was used to supply power to a refrigerator in the nursing supply room;</p> <p>C) Between 12:30 p.m. and 1:30 p.m., power strips located under resident beds in room 313 and 409 were used to supply power to equipment in the rooms.</p> <p>3.1-19(b)</p>		<p>power strips in patient care areas.</p> <p>b. The ice machine was removed on 05/11/2015</p> <p>c. Power strip was removed from nursing supply room and refrigerator was moved closer to receptacle.</p> <p>d. Power strips identified in resident rooms 313 and 409 were removed on 04/22/2015.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. No residents have the potential to be affected by the alleged deficient practice due to said items have been removed or corrected.</p> <p>b. House check of resident rooms occurred to ensure no other power strips are in use on unauthorized equipment/devices.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the</p>	

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K 211 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other		<p>deficient practice does not recur.</p> <p>a. The Environmental Audit which will be processed monthly was updated to include doors to ensure that the alleged deficient practice does not recur.</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>a. The Quality Improvement Committee will review the Environmental Audits quarterly for satisfactory compliance.</p> <p>b. Executive Director to oversee for satisfactory compliance.</p> <p>Completion Date 05/22/2015</p>	

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	<p>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</p> <p>o Dispensers are not installed over or adjacent to an ignition source.</p> <p>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand sanitizers on the 100 hall was not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect visitors, staff and 10 or more residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/22/15 at 11:50 a.m., an alcohol based hand sanitizer was located just above an electrical outlet on the 100 hall. The Maintenance Director confirmed at the time of observation, the hand sanitizer was alcohol based.</p> <p>3.1-19(b)</p>	K 211	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. Staff, visitors, and residents on the 100 hallway have the potential to be affected by the alleged deficient practice.</p> <p>b. Dispenser relocated to an area that is in compliance</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>a. Entire facility was reviewed by Maintenance Director who failed any similar violations. Review occurred on 04/22/2015.</p> <p>b. No residents have the potential to be affected by the alleged deficient practice due to all other sanitizers</p>	05/22/2015

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K 000			<p>being properly placed away from electrical outlets.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>a. Policy to ensure appropriate location of sanitizer dispensers was created and maintenance staff were educated on 05/15/2015.</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>a. A yearly audit to be conducted to ensure proper placement of sanitizer dispensers.</p> <p>b. Executive Director to oversee for satisfactory compliance.</p> <p>Completion Date 05/22/2015</p>	

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	<p>types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 113 at the time of this survey.</p> <p>All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p>				