

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 11/14/2011
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN46307
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K0000	<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: 11/14/11</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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>This one story facility was determined to be of Type II (222) construction and was partially</p>	K0000		

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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K0029 SS=E	<p>sprinklered. The Chapel and Fellowship Hall occupy one wing of the facility and are not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 155 and had a census of 149 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/16/11.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>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</p>	K0029	1. What corrective action(s) will be accomplished for those residents found to have been	12/14/2011	

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	<p>ensure 1 of 12 doors to hazardous areas such as the kitchen was equipped with a positive latch. Self closing doors to sprinklered hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects occupants of the main dining room with a capacity for more than 20 residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/14/11 at 2:15 p.m., the self closing door separating the kitchen from the main dining room was equipped with a deadbolt latch which did not hold the door in the door frame each time the door closed. The maintenance director acknowledged at the time of observation, the deadbolt latch on the door had to be manually latched each time it self closed to keep it tightly closed. The door was actually latched only when the kitchen was closed and unoccupied.</p> <p>3.1-19(b)</p>		<p>affected by alleged deficient practice? 1. No residents, staff and visitors were affected by the alleged deficient practice. Resident's staff and visitors who use main dining room have the potential to be affected by the alleged deficient practice. 2. A lever lockset was installed allowing for positive latching. Installed 11/15/2011 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. Residents staff and visitors who use main dining room have the potential to be affected by the alleged deficient practice 2. A lever lockset was installed allowing for positive latching. Installed 11/15/2011 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practices do not recur? 1. Weekly preventative maintenance checks will be completed on operation of fire doors and positive latching for doors to hazardous areas. See attachment A 2. In service for maintenance staff for weekly Preventative maintenance check will be complete by 12/14/2011 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur, i.e. what quality assurance program will be put into place? A weekly Preventative maintenance check will be</p>		

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K0048 SS=C	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately</p>	K0048	<p>completed weekly and ongoing throughout the year. Monitor by safety committee for compliance monthly The Administrator will oversee quality assurance compliance. Completion Date: December 14, 2011</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by alleged deficient practice? 1. No residents, staff and visitors were affected by the alleged deficient practice. All Resident's staff and visitors in the Healthcare pavilion have the potential to be affected by the alleged deficient practice. 2. Revision of the existing code red policy was completed to include the identification of different types of fire extinguishers and their areas of use Completed 11/21/2011. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. Residents staff and visitors who are in the Healthcare pavilion have the potential to be affected by the alleged deficient practice 2. Revision of the existing code red policy was completed to include the identification of different types of fire extinguishers and their areas of use. 11/21/2011 completed 3. What measures will be put into place or what systemic</p>	12/14/2011

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	<p>available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 11/14/11 at 12:10 p.m., required elements of the policy and procedure for the written Fire Plan were missing and/or found in different and separate places. The Code Red Policy did not include identification of the different types of fire extinguishers located in the facility and their use. Use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system was identified on a placard located above the extinguishers in the kitchen but it was not included in the Code Red Policy. The maintenance director acknowledged at the time of record review, the identification of fire extinguishers and their uses had been omitted in the written fire plan. The maintenance director said an annual inservice was provided for staff with hands on training with the portable fire extinguishers but he provided only</p>		<p>changes will be made to ensure that the alleged deficient practices do not recur? 1. In service for all staff for revised code red policy will be complete by 12/14/2011 2. Revision of the existing code red policy was completed to include the identification of different types of fire extinguishers and their areas of use. (See attachment B Code red policy) 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur, i.e. what quality assurance program will be put into place? 1. Safety committee will monitor monthly. 2. The Administrator will oversee quality assurance compliance. Completion Date: December 14, 2011</p>		

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K0069 SS=D	<p>staff signature sheets which didn't include the training information.</p> <p>3.1-19(b)</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to provide the minimum protection between 2 of 2 commercial cooking appliances in the kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, at 9-1.2.3 requires deep fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment except where a steel or tempered glass baffle plate is installed at a minimum of eight inches in height between the adjacent appliances. This deficient practice could affect 4 kitchen staff.</p>	K0069	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by alleged deficient practice? 1. No residents, staff and visitors were affected by the alleged deficient practice. All Residents, staff and visitors that use main dining kitchen area have the potential to be affected by the alleged deficient practice. 2. A stainless steel splash guard was installed vertically per code between deep fryer and stove. Installed 11/15/2011. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. All Residents, staff and visitors who use main dining kitchen area have the potential to be affected by the alleged deficient practice. 2. A stainless steel splash guard</p>	12/14/2011

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K0144 SS=F	<p>Findings include:</p> <p>Based on observation of the commercial cooking appliances in the kitchen with the maintenance director on 11/14/11 at 1:45 p.m., the minimum separation of 16 inches, or separation by a steel or tempered glass baffle plate, was not provided between the gas range and fryer. The maintenance director said at the time of observation, the gas range had been recently replaced and the separation plate had been omitted in the installation.</p> <p>3.1-19(b)</p> <p>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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a</p>	K0144	<p>was installed vertically per code between deep fryer and stove. Installed 11/15/2011. 3. Revised quarterly preventive maintenance checks 11/21/2011 (See attachment C) 4. Maintenance staff to be in serviced by December 14, 2011 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practices do not recur?</p> <p>1. Splash guard has been permanently installed, 11/15/11 2. This will be monitored quarterly on the preventative maintenance rounds. 3. Revised quarterly preventive maintenance checks 11/21/2011(See attachment C) 4. Maintenance staff to be in serviced by December 14, 2011 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur, i.e. what quality assurance program will be put into place? 1. Safety committee to monitor compliance quarterly 2. The Administrator will oversee quality assurance compliance. Completion Date: December 14</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by alleged deficient practice? 1. No residents, staff and visitors were affected by the</p>	12/14/2011	

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	<p>remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on interview on 11/14/11 at 11:20 a.m. with the maintenance director, the upgraded emergency generator was installed after 2003. The</p>		<p>alleged deficient practice. All residents, staff and visitors have the potential to be affected by the alleged deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. All residents, staff and visitors have the potential to be affected by the alleged deficient practice 2. Emergency shut off switch to be installed and certified by Lionheart Engineering by December 14, 2011. 3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practices do not recur? 1. Emergency shut off switch to be installed and certified by Lionheart Engineering by December 14, 2011. 2. Preventative maintenance sheet revised to add check on remote shut off installed annually, (See attachment D) 3. In service for maintenance staff for annual Preventative maintenance check will be complete by December 14, 2011 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice does not recur, i.e. what quality assurance program will be put into place? 1. Monitor by safety committee for compliance monthly 2. The Administrator will oversee quality assurance compliance. Completion Date: December 14, 2011</p>	

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	<p>maintenance director also said during the interview, there was a remote emergency shut off for the emergency generator on the generator itself. No other remote emergency shut off for the generator was observed during a tour of the facility on 11/14/11 between 1:10 p.m. and 3:45 p.m.</p> <p>3.1-19(b)</p>				