

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2012
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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey with an Environmental Preoccupancy Survey for the relocation of beds for Room 102 from 0 beds to 1 bed, Room 117 from 0 beds to 1 bed, Room 819 from 1 bed to 2 beds, Room 820 from 1 bed to 2 beds, Room 823 from 1 bed to 2 beds, and Room 825 from 1 bed to 2 beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/31/12</p> <p>Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code and Environmental Preoccupancy survey, Seymour Crossing 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 16.2-3.1-19, Environment and</p>	K0000		
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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>Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 73 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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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 1 of 8 attic smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice could affect all residents who reside on the D Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 05/31/12 at 12:10 p.m., the D Hall attic smoke barrier wall had a six inch by six inch area in the center and at the bottom of the attic smoke barrier wall with no fire stopping material between the D Hall attic and the Rehabilitation Hall attic. This was verified by the maintenance director at the time of observations and confirmed by the administrator at the 12:30 p.m. exit conference on 05/31/12.</p>	K0025	<p>K-025</p> <p>A. ACTIONS TAKEN:</p> <p>1. The D hall attic smoke barrier wall has been repaired with fire stopping material.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 100% audit of facility smoke barriers to ensure that there are no further areas requiring. No others were identified.</p> <p>C. MEASURES TAKEN:</p>	06/20/2012			

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	3.1-19(b)		<p>1. Maintenance staff in serviced on need to promptly repair smoke barrier by ED by 6/24/12.</p> <p>D. HOW MONITORED:</p> <p>1. The Maintenance Supervisor/Designee will audit overall facility smoke barrier for integrity quarterly for any needed/required repairs. This will be an on-going QA program.</p> <p>2. The ED/Designee will monitor for compliance of these repairs in daily QA stand-up meeting.</p> <p>3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:</p> <p>6/20/12.</p>		

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K0067 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 observation and interview, the facility failed to ensure 1 of 8 egress corridors was not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply, return or exhaust air system serving adjoining areas. This deficient practice affects all resident who reside on the D Hall.</p> <p>Findings include:</p> <p>Based on observations on 05/31/12 during a tour of the D Hall from 8:35 a.m. to 9:40 a.m. with the administrator, the fourteen D Hall resident rooms used the egress corridor as a return air system. This was verified by the administrator and maintenance supervisor at the time of observations and confirmed by the Administrator at the 12:30 p.m. exit conference on 05/31/12.</p> <p>3.1-19(b)</p>	K0067	<p>K-067 A. ACTIONS TAKEN: 1. The D hall HVAC has been repaired to shut down in the event of the Fire system going into alarm. B. OTHERS IDENTIFIED: 1. 100% audit of facility HVAC systems to ensure that there are no further areas requiring repair. No others were identified. C. MEASURES TAKEN: 1. Maintenance staff in serviced on need of HVAC shut down when fire system in alarm to separate return air from reaching adjoining areas by the ED by 6/20/12. 2. A waiver request to be completed to continue to allow current configuration with system shut down with fire alarm until the system can be reconfigured. D. HOW MONITORED: 1. The Maintenance Supervisor/Designee will audit appropriate operation of HVAC system during Fire system alarm quarterly for any needed/required repairs. This will be an on-going QA program. 2. The ED/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly</p>	06/20/2012			

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