STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155715	A. BUILDING -- B. WING	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/24/24 Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440 At this Emergency Preparedness survey, Lutheran Community Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 95 certified beds. At the time of the survey, the census was 78. Quality Review completed on 09/27/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/24/24 Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440 At this Life Safety Code survey, Lutheran Community Home was found not in compliance	K 0000	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.	

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

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	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) and 410 IAC 16.2. The facility consisted of two, one story buildings. The original building was determined to be Type II (222) construction and fully sprinkled. The Forest Path building was determined to be Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, with battery operated smoke alarms in all resident sleeping rooms in the original building and hard wired smoke detectors in the resident sleeping rooms in the Forest Path building. The original building has a capacity of 85 and had a census of 71 at the time of this survey. The Forest Path building has a capacity of 10 and had a census of 7 at the time of this survey. The facility has a total capacity of 95 and had a census of 78 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached storage building which was not sprinkled. Quality Review completed on 09/27/24		Lutheran Community Home respectfully requests desk review or paper compliance in lieu of a post survey revisit. Supporting documentation will be provided demonstrating the correction of deficiencies and the steps to prevent reoccurrence.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other 1. Based on record review, observation, and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was available for 5 of 12 months. NFPA	K 0300	K 0300 It is the policy of this facility to ensure that the inspection of battery-operated smoke detectors is completed and documented monthly. It is also	10/08/2024

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	101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 09/24/24 between 10:00 a.m. and 2:15 p.m. with the Executive Director and Maintenance Supervisor present, the facility was able to provide a preventative maintenance report that all resident room battery powered smoke alarms were tested on a monthly basis, however, there were no tests performed since March 2024. This was confirmed by the Maintenance Supervisor at the time of record review. During a tour of the facility with the Executive Director and Maintenance Supervisor between 2:15 p.m. and 4:30 p.m., all resident sleeping rooms were equipped with battery powered smoke alarms. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated		the policy of this facility to change the batteries in the battery-operated smoke detectors annually. Corrective Action: All smoke detectors had been inspected monthly but the documentation of the inspection was not completed. All Maintenance Staff were educated the week of October 4, 2024 on the need to document the test/inspection monthly. They were also educated on the need to change the batteries in the battery-operated smoke detectors annually. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). Documentation of the October inspection/test was completed on October 7, 2024. This documentation will be ongoing monthly. (Attachment titled Monthly Battery-Operated Smoke Detector Inspection). The batteries were replaced at the time of the test/inspection and this task is scheduled every October. Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review the K tags and the corrections monthly for six months.	

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	smoke alarms in all resident sleeping rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 09/24/24 between 10:00 a.m. and 2:15 p.m. with the Executive Director and Maintenance Supervisor present, the battery operated smoke alarm maintenance documentation failed to indicate battery replacement. Based on interview at the time of record review, the Maintenance Supervisor said he replaces the batteries in the resident room smoke alarms only as needed. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having	K 0345	K 0345 It is the policy of this facility to maintain the fire alarm system in accordance with NFPA 72. Corrective Action: All Maintenance Staff were educated on the need for a	10/08/2024

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	jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include: Based on record review on 09/23/24 between 10:00 a.m. and 2:15 p.m. with the Executive Director and Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 10/03/23 by the facility's fire alarm inspection vendor, however, there was no semi-annual visual inspection documentation provided six months after the annual inspection by either the vendor or in-house maintenance staff. Based on interview at the time of record review, the Maintenance Supervisor said a semi-annual visual inspection of the fire alarm system's devices was not performed six months after the annual fire alarm inspection on 10/03/24. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		semi-annual visual inspection of the fire alarm system. (Attachment title Mandatory Maintenance Staff Education Plan of Correction 2024). This should occur six months after the annual fire alarm inspection. Koorsen completed the annual inspection on October 3, 2024. The semi-annual visual inspection is scheduled for April, 2025 and will be documented on the attached form. (Attachment titled Semi-Annual Visual Inspection of Fire System). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review the K tags and the corrections monthly for six months.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 8	K 0353	K 0353 It is the policy of this facility to	10/08/2024

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	smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff and at least 30 resident, as well as staff and visitors while in the adjacent dining room. Findings include: Based on observations on 09/24/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Executive Director and Maintenance Supervisor, there were two sprinkler heads in the dishing washing area of the kitchen covered with corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the two sprinkler heads in the dishing washing room of the kitchen were covered with corrosion. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges on the sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing,		replace corroded sprinkler heads. Corrective Action: The two sprinkler heads in the dish room were replaced on October 2, 2024. (Attachment titled Sprinkler Head Replacements). It is also the policy of this facility to replace sprinkler gauges every five years. The three sprinkler gauges were replaced on October 2, 2024. (Attachment titled Sprinkler Gauge Replacements). The Maintenance Staff were educated the week of October 4, 2024 on the need to report corroded sprinkler heads and any outdated gauges to the Maintenance Supervisor. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review K tags and the corrections monthly for six months.	

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	and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 09/24/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Executive Director and Maintenance Supervisor, three of three sprinkler gauges on the sprinkler system riser each had a date of 2017 which was over two years past due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. Based on interview at the time of the observation, the Maintenance Supervisor confirmed the sprinkler system gauge had not been recalibrated within the most recent five year period and would have the gauge replaced as soon as possible. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault	K 0511	K 0511 It is the policy of this facility to comply with code with all electrical wiring.	10/08/2024

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	Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without		Corrective Action: The electrical receptacle in the D Wing Clean utility Room was changed to a GFCI receptacle on September 25, 2024. (Attachment titled GFCI Receptacle Replacement). Maintenance Staff were educated to observe and report any outlets that require changing to the Maintenance Supervisor. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). All outlets within 3 feet of a sink were reviewed and no other issues were noted. Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review the K tags and the corrections monthly for six months.	

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	GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one staff while in the D Wing Clean Utility Room. Findings include: Based on observations on 09/24/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Executive Director and Maintenance Supervisor, the electric receptacle within three feet of the sink in the D Wing Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Executive Director agreed the receptacle near the sink in the D Wing Clean Utility Room was not properly GFCI protected. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference.			

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	3.1-19(b)			
K 0000 Bldg. 05	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/24/24 Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440 At this Life Safety Code survey, Lutheran Community Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The facility consisted of two, one story buildings. The original building was determined to be Type II (222) construction and fully sprinkled. The Forest Path building was determined to be Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, with battery operated smoke alarms in all resident sleeping rooms in the original building and hard wired smoke detectors in the resident sleeping rooms in the Forest Path building. The original building has a capacity of 85 and had a census of 71 at the time of this survey. The Forest Path building has a capacity of 10 and had a census of 7 at the time of this survey. The facility has a total capacity of 95 and had a census	K 0000		

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	of 78 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached storage building which was not sprinkled. Quality Review completed on 09/27/24			
K 0345 SS=F Bldg. 05	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants. Findings include: Based on record review on 09/23/24 between 10:00 a.m. and 2:15 p.m. with the Executive Director and Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 10/03/23 by the facility's fire alarm inspection vendor, however,	K 0345	K 0345 It is the policy of this facility to maintain the fire alarm system in accordance with NFPA 72. Corrective Action: All Maintenance Staff were educated on the need for a semi-annual visual inspection of the fire alarm system. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). This should occur six months after the annual fire alarm inspection. Koorsen completed the annual inspection on October 3, 2024. The semi-annual visual inspection is scheduled for April, 2025 and will be documented on the attached form. (Attachment titled Semi-Annual Visual Inspection of Fire System). Monitoring of Corrective Action: The Quality Assurance Performance Improvement	10/08/2024

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	there was no semi-annual visual inspection documentation provided six months after the annual inspection by either the vendor or in-house maintenance staff. Based on interview at the time of record review, the Maintenance Supervisor said a semi-annual visual inspection of the fire alarm system's devices was not performed six months after the annual fire alarm inspection on 10/03/24. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		Committee will review the K tags and the corrections monthly for six months.	
K 0353 SS=F Bldg. 05	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler system gauges on the sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 09/24/24 between 2:15 p.m. and 4:30 p.m. during a tour of the facility with the Executive Director and Maintenance Supervisor, three of three sprinkler gauges on the	K 0353	It is the policy of this facility to replace sprinkler gauges every five years. Corrective Action: The three sprinkler gauges were replaced on October 2, 2024. (Attachment titled Sprinkler Gauge Replacements). The Maintenance Staff were educated the week of October 4, 2024 on the need to report corroded sprinkler heads and any outdated gauges to the Maintenance Supervisor. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). Monitoring of Corrective Action: The Quality Assurance Performance Improvement	10/08/2024

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LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	sprinkler system riser had dates of 2015, 2016, and 2017 which were all due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. Based on interview at the time of the observation, the Maintenance Supervisor confirmed the sprinkler system gauge had not been recalibrated within the most recent five year period and would have the gauge replaced as soon as possible. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		Committee will review K tags and the corrections monthly for six months.	