CENTERS FOR	R MEDICARE & MEDIC	•			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155715	B. WING		09/24/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000						
Bldg		1/24 00347 155715	E 0000			
	Community Home of Emergency Prepare Medicare and Medicare and Suppliers, 42 Community The facility has 95 of the survey, the cens	certified beds. At the time of				
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 09/24 Facility Number: 0 Provider Number: AIM Number: 1000 At this Life Safety 0	00347 155715 275440 Code survey, Lutheran	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept the plan of correction as our creditallegation of compliance.	is	
	Community Home	was found not in compliance				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155715	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/24/2024
	ROVIDER OR SUPPLIER		111 W	ADDRESS, CITY, STATE, ZIP COD CHURCH AVE DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L. The facility consisted The original building (1122) construction Forest Path building (111) construction a building has a fire a detection in the correction corridors, with batter all resident sleeping and hard wired smoot sleeping rooms in the original building has census of 71 at the transparent Path building a census of 7 at the facility has a total coof 78 at the time of All areas where the access were sprinkled facility services were detached storage but sprinkled. Quality Review con	the and the 2012 edition of the etion Association (NFPA) 101, and 410 IAC 16.2. The and fully sprinkled of two, one story buildings and was determined to be Type of an and fully sprinkled. The gray was determined to be Type V and fully sprinkled. Each larm system with smoke etidors, spaces open to the erry operated smoke alarms in grooms in the original building the detectors in the resident are Forest Path building. The sa capacity of 85 and had a time of this survey. The ghas a capacity of 10 and had time of this survey. The apacity of 95 and had a census this visit. The apacity of 95 and had a census this visit. The apacity of 10 and had a census this visit.		Lutheran Community Home respectfully requests desk revor paper compliance in lieu of post survey revisit. Supportin documentation will be provide demonstrating the correction deficiencies and the steps to prevent reoccurrence.	a g d
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other				
	interview; the facility documentation for to of all battery operate	review, observation, and ty failed to ensure he preventative maintenance ed smoke alarms in resident e 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 documented monthly. It is also	and

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/24/2024	
	PROVIDER OR SUPPLIER		STREET 111 W SEYMO	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
TAG	101 in 4.6.12.3 state obvious to the publishall be maintained. and Signaling Code Maintenance and To equipment shall be accordance with the instructions and per 14. NFPA 72, 14.2 maintenance progra requirements of this equipment manufactory and visitors. Findings include: Based on record revalum and 2:15 p.m. Maintenance Superable to provide a prothat all resident roomalarms were tested of there were no tests of This was confirmed Supervisor at the tirtour of the facility of Maintenance Superation of the facility of Maintenance Superation of the facility failed to ensure the public of the facility of the facility failed to ensure the public of the facility of the facility failed to ensure the public of the public	riew on 09/24/24 between 10:00 with the Executive Director and visor present, the facility was eventative maintenance report in battery powered smoke on a monthly basis, however, performed since March 2024. by the Maintenance me of record review. During a with the Executive Director and visor between 2:15 p.m. and ant sleeping rooms were ry powered smoke alarms.	TAG	the policy of this facility to char the batteries in the battery-operated smoke deternanually. Corrective Action: All smoke detectors had been inspected monthly but the documentation of the inspective was not completed. All Maintenance Staff were educed the week of October 4, 2024 the need to document the test/inspection monthly. They were also educated on the need thange the batteries in the battery-operated smoke deternanually. (Attachment titled For Correction Maintenance St. Education 10-2024). Documentation of the Octobe inspection/test was completed October 7, 2024. This documentation will be ongoin monthly. (Attachment titled Monthly Battery-Operated Sm. Detector Inspection). The batteries were replaced at the of the test/inspection and this is scheduled every October. Monitoring of Corrective Action The Quality Assurance Performance Improvement Committee will review the K to and the corrections monthly for months.	ctors n fon ated on y eed to ctors Plan aff or d on g noke e time task on:
	preventative mainte	nance of battery operated	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/24/2024	
	PROVIDER OR SUPPLIEI		111 W	ADDRESS, CITY, STATE, ZIP COD CHURCH AVE DUR, IN 47274	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	complete. NFPA 7 operations integrity inspection, testing, NFPA 72 29.10 states the maintained and manufacturer's pub requirements of Chaptractice could affect visitors. Findings include: Based on record real.m. and 2:15 p.m. Maintenance Super operated smoke ala failed to indicate be interview at the time Maintenance Super batteries in the residual needed. This finding was residuant in the state of the	resident sleeping rooms was 2 14.2.1.1.1 states to ensure 4, the system shall have an and maintenance program. The fire-warning equipment shall tested in accordance with lished instructions and per the apter 14. This deficient at all residents, staff and the executive Director and visor present, the battery run maintenance documentation attery replacement. Based on the of record review, the visor said he replaces the dent room smoke alarms only viewed with the Executive enance Supervisor during the			
K 0345 SS=F Bldg. 01	failed to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual inspe	or - Testing and view and interview, the facility of 1 fire alarm system in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ctions shall be performed in the schedules in Table 14.3.1, or	K 0345	K 0345 It is the policy of this facility to maintain the fire alarm system accordance with NFPA 72. Corrective Action: All Maintenance Staff were	10/08/2024 in

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more often if required by the authority having

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educated on the need for a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K 0353	jurisdiction. Table must be visually instance and a. Control unit troul b. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient pract. Findings include: Based on record revalum. and 2:15 p.m.: Maintenance Super documentation provalarm system inspectacility's fire alarm there was no semi-adocumentation provannual inspection be in-house maintenant the time of record resupervisor said a set the fire alarm system is the fire alarm system is the fire alarm system is unon the time of record resupervisor said a set the fire alarm system is unon the stance of 10/03/24. This finding was re	14.3.1 states that the following spected semi-annually: ble signals stors (e.g. duct detectors, manual stat detectors, smoke detectors,		IAU	semi-annual visual inspection the fire alarm system. (Attachment title Mandatory Maintenance Staff Education For Correction 2024). This show occur six months after the annufire alarm inspection. Koorsen completed the annual inspection October 3, 2024. The semi-annual visual inspection scheduled for April, 2025 and to be documented on the attache form. (Attachment titled Semi-Annual Visual Inspection Fire System). Monitoring of Corrective Action The Quality Assurance Performance Improvement Committee will review the K ta and the corrections monthly for months.	Plan uld ual on is will d of	DATE
SS=F Bldg. 01	Sprinkler System 1. Based on observ	- Maintenance and Testing ation and interview, the	K 0:	353	K 0353		10/08/2024
	facility failed to ens	sure sprinkler heads in 1 of 8			It is the policy of this facility to		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		A. BUILDING B. WING	<u>01</u>	COMPLETED 09/24/2024			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE				
LUTHER	AN COMMUNITY H	OME		OUR, IN 47274			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG		ts covered with corrosion were	IAG	replace corroded sprinkler he			
	-	, 2011 edition, at 5.2.1.1.1					
	•	show signs of leakage; shall , foreign materials, paint, and		Corrective Action:			
		nd shall be installed in the		The two sprinkler heads in the dish room were replaced on	;		
		e.g., up-right, pendent, or		October 2, 2024. (Attachmen	<u>, </u>		
	· ·	ore, at 5.2.1.1.2 any sprinkler		titled Sprinkler Head			
	· ·	any of the following shall be		Replacements). It is also the			
	~	ge (2) Corrosion (3) Physical		policy of this facility to replace			
	* ` '	fluid in the glass bulb heat		sprinkler gauges every five ye	I		
		(5) Loading (6) Painting		The three sprinkler gauges we	I		
	-	e sprinkler manufacturer.		replaced on October 2, 2024.			
	This deficient practice could affect kitchen staff			(Attachment titled Sprinkler G	auge		
	and at least 30 resid	ent, as well as staff and		Replacements). The Maintenance			
	visitors while in the	adjacent dining room.		Staff were educated the wee	k of		
				October 4, 2024 on the need	to		
	Findings include:			report corroded sprinkler head	I		
	D 1 1	00/04/041		and any outdated gauges to t	ne		
		ons on 09/24/24 between 2:15		Maintenance Supervisor.			
		during a tour of the facility with		(Attachment titled Plan of			
		tor and Maintenance		Correction Maintenance Staff			
	_	ere two sprinkler heads in the a of the kitchen covered with		Education 10-2024).			
		interview at the time of		Manitoring of Corrective Action	n.		
		intenance Supervisor agreed		Monitoring of Corrective Action The Quality Assurance	^{11.}		
		ads in the dishing washing		Performance Improvement			
	•	were covered with corrosion.		Committee will review K tags	and		
	130m of the kitchen	zovetea wim conodion.		the corrections monthly for six			
	This finding was rev	viewed with the Executive		months.	`		
		enance Supervisor during the					
	exit conference.	1					
	3.1-19(b)						
		ation and interview, the					
		ure 3 of 3 sprinkler system					
		der system riser were replaced					
		eumented as tested every 5					
		n with a calibrated gauge. for the Inspection, Testing,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/24/2024	
	ROVIDER OR SUPPLIER		STREET A 111 W (SEYMO		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Systems, 2011 Editingauges shall be replevery 5 years by congauge. Gauges not the full scale shall be This deficient pract staff, and visitors.	Water-Based Fire Protection ion, Section 5.3.2.1 states aced every 5 years or tested imparison with a calibrated accurate to within 3 percent of the recalibrated or replaced. ice could affect all residents,			
	p.m. and 4:30 p.m. the Executive Direct Supervisor, three of sprinkler system rist which was over two replacement or recainformation was aff gauge. Based on in observation, the Maconfirmed the sprin been recalibrated w	ons on 09/24/24 between 2:15 during a tour of the facility with tor and Maintenance Three sprinkler gauges on the er each had a date of 2017 o years past due for libration. No recalibration date fixed to the dry sprinkler system terview at the time of the intenance Supervisor kler system gauge had not ithin the most recent five year ave the gauge replaced as			
		viewed with the Executive enance Supervisor during the			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and	Electric			
	failed to ensure 1 of provided with groun (GFCI) protection a	on and interview, the facility fover 10 wet locations, was and fault circuit interrupter gainst electric shock. NFPA on 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2024		
	F PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	Circuit-Interrupter states, ground-fault personnel shall be circuit-interrupter personnel shall be circuit interrupter personnel shall be circuit-interrupter personnel shall be permitted to not readily accessible branch circuit dediction, or pipeline shall be permitted the with 426.28 or 427. Exception No. 2 to only, where the corsupervision ensure are involved, an asseconductor program shall be permitted the outlets used to supperceate a greater haz having a design that protection. (5) Sinks - where read to removal of power were accorded to power were acceptance acceptance to the personnel shall be permitted to the personnel shall be perm	e: See 215.9 for ground-fault rotection for personnel on relling Units. All 125-volt, and 20-ampere receptacles ations specified in 210.8(B)(1) are ground-fault protection for personnel. (3) and (4): Receptacles that are ple and are supplied by a cated to electric snow-melting, and vessel heating equipment to be installed in accordance		TAG	Corrective Action: The electrical receptacle in the Wing Clean utility Room was changed to a GFCI receptacle September 25, 2024. (Attachittled GFCI Receptacle Replacement). Maintenance 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 viewiewed and no other issues noted. Monitoring of Corrective Action The Quality Assurance Performance Improvement Committee will review the Kital and the corrections monthly formonths.	e on ment Staff I Lee were were	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155715		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/24/2024		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet locat (7) Locker rooms we facilities (8) Garages, service electrical diagnostic equipme NFPA 70, 517-20 Wereceptacles and fixe the wet location to be interrupter (GFCI) preduce the contact of electrical insulation. This deficient pract in the D Wing Clean Findings include: Based on observation p.m. and 4:30 p.m. the Executive Direct Supervisor, the electrical insulation of the sink in the D not provided with a tested with a GFCI did not break the eleinterview at the tim Director agreed the D Wing Clean Utili protected. This finding was re	th associated showering bays, and similar areas where nt, electrical hand tools. Vet Locations, requires all ad equipment within the area of have ground-fault circuit protection. Note: Moisture can esistance of the body, and is more subject to failure. ice could affect one staff while				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155715	B. WI	NG		09/24	/2024	
	ROVIDER OR SUPPLIER		<u> </u>	111 W (ADDRESS, CITY, STATE, ZIP COD CHURCH AVE DUR, IN 47274			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	•	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	3.1-19(b)							
	,							
K 0000								
Bldg. 05								
	_	Recertification and State	K 0	000				
	_	ere conducted by the Indiana						
	-	th in accordance with 42 CFR						
	483.90(a).							
	G D 00/24	1/24						
	Survey Date: 09/24	1/24						
	Facility Number: 000347 Provider Number: 155715 AIM Number: 100275440							
	711W Number: 1002	2/3440						
	At this Life Safety (Code survey, Lutheran						
	_	was found not in compliance						
	with Requirements	_						
	_	, 42 CFR Subpart 483.90(a),						
		re and the 2012 edition of the						
	National Fire Protec	ction Association (NFPA) 101,						
	Life Safety Code (L	SC) and 410 IAC 16.2.						
	-	ed of two, one story buildings.						
	_	ig was determined to be Type						
		n and fully sprinkled. The						
	_	g was determined to be Type V						
		and fully sprinkled. Each						
	_	larm system with smoke						
		ridors, spaces open to the						
		ery operated smoke alarms in						
		rooms in the original building						
		ke detectors in the resident						
		ne Forest Path building. The s a capacity of 85 and had a						
		time of this survey. The						
		g has a capacity of 10 and had						
	_	time of this survey. The						
		apacity of 95 and had a census						
	incinity mas a total Co	apacity of 75 and nad a consus					1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>05</u>		COMPLETED	
		155715	B. W	NG		09/24/	2024
	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
K 0345 SS=F Bldg. 05	of 78 at the time of All areas where the access were sprinkled facility services were detached storage but sprinkled. Quality Review cont NFPA 101 Fire Alarm System Maintenance Based on record reversed failed to maintain 1 accordance with NF Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual inspectance of the require jurisdiction. Table must be visually instance and the record reversed in the require jurisdiction. Table must be visually instance of the require jurisdiction and the record in the record of the record of the record of the record from the record reversed in the record reversed ocumentation provides where the record reversed record reversed the record reversed record record reversed record reversed record reversed record reversed record record reversed record record record reversed record recor	this visit. residents have customary ed and all areas providing re sprinkled. The facility has a ilding which was not repleted on 09/27/24 n - Testing and riew and interview, the facility of 1 fire alarm system in PA 72, as required by LSC 101 and 9.6. NFPA 72, Section less otherwise permitted by etions shall be performed in eschedules in Table 14.3.1, or ed by the authority having 14.3.1 states that the following pected semi-annually: ble signals tors (e.g. duct detectors, manual at detectors, smoke detectors,	K 0		K 0345 It is the policy of this facility to maintain the fire alarm system accordance with NFPA 72. Corrective Action: All Maintenance Staff were educated on the need for a semi-annual visual inspection the fire alarm system. (Attachment titled Plan of Correction Maintenance Staff Education 10-2024). This sho occur six months after the ann fire alarm inspection. Koorsen completed the annual inspection on October 3, 2024. The semi-annual visual inspection scheduled for April, 2025 and be documented on the attache form. (Attachment titled Semi-Annual Visual Inspection Fire System). Monitoring of Corrective Action The Quality Assurance	of uld ual on is will ed	10/08/2024
	facility's fire alarm	inspection vendor, however,			Performance Improvement		

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER A. BUILDING O. B. WING		ONSTRUCTION <u>05</u>	(X3) DATE SURVEY COMPLETED 09/24/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 111 W CHURCH AVE SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0353	documentation provannual inspection be in-house maintenanthe time of record resupervisor said a set the fire alarm system six months after the on 10/03/24. This finding was resulting the same and the same alarm system six months after the on 10/03/24.	annual visual inspection wided six months after the y either the vendor or ce staff. Based on interview at eview, the Maintenance emi-annual visual inspection of m's devices was not performed annual fire alarm inspection viewed with the Executive enance Supervisor during the			Committee will review the K ta and the corrections monthly for months.	Ŭ	
SS=F Bldg. 05	Based on observation failed to ensure 3 of the sprinkler system years or documente comparison with a comparison of the full scale shall be the comparison of	on and interview, the facility of 3 sprinkler system gauges on a riser were replaced every 5 d as tested every 5 years by calibrated gauge. NFPA 25, pection, Testing, and ter-Based Fire Protection ion, Section 5.3.2.1 states aced every 5 years or tested imparison with a calibrated accurate to within 3 percent of the recalibrated or replaced. ice could affect all residents, ons on 09/24/24 between 2:15 during a tour of the facility with tor and Maintenance	K 0	353	It is the policy of this facility to replace sprinkler gauges every years. Corrective Action: The three sprinkler gauges we replaced on October 2, 2024. (Attachment titled Sprinkler Garel Replacements). The Maintens Staff were educated the week October 4, 2024 on the need to report corroded sprinkler head 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	ere auge ance c of o ds	10/08/2024

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155715	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/24/2024	
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE CORRECTION CORR		TE	(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.			

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