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

PRINTED: 11/07/2024 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05		(X3) DATE SURVEY COMPLETED		
		155715	B. WING			R 11/04/2024		
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME				STREET ADDRESS, CITY, 111 W CHURCH AVE SEYMOUR, IN 47274	STATE, ZIP CODE	1110112021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{K 000}	INITIAL COMMENT:	S	{K 0	00}				
	Code Recertification conducted on 09/24/ Indiana Department 42 CFR 483.90(a). Survey Date: 11/04/ Facility Number: 00 Provider Number: 1 AIM Number: 10027/ At this PSR to the Li Lutheran Community compliance with Red Medicare/Medicaid, Life Safety from Fire National Fire Protect Life Safety Code (LSThe facility consisted The original building (222) construction and Fath building was deconstruction and full has a fire alarm syst the corridors, spaces battery operated sm sleeping rooms in the wired smoke detector rooms in the Forest building has a capacity of the corridors of this building has a capacity of the corridors of this building has a capacity of the corridors of this building has a capacity of the corridors of this building has a capacity of the capacity of the corridors of the corrido	0347 55715						
LABORATORY	time of this visit.	and had a census of 79 at the /SUPPLIER REPRESENTATIVE'S SIGNATU	IDE	TITL	-	(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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 05		(X3) DATE SURVEY COMPLETED	
		455745				R	
NAME OF DE	DOVIDED OD SLIDDI IED	155715	B. WING	et.	REET ADDRESS, CITY, STATE, ZIP CODE	11/	04/2024
NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME				11	1 W CHURCH AVE EYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
{K 000}	Continued From page 1		{K 000}				
	access were sprinkled	esidents have customary d and all areas providing sprinkled. The facility has a lding which was not					
{K 000}	Quality Review completed on 11/06/24 INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/24/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).		{K 0	000}			
	Survey Date: 11/04/2	24					
	Facility Number: 000 Provider Number: 15 AIM Number: 100275	5715					
	Lutheran Community compliance with Requ Medicare/Medicaid, 4 Life Safety from Fire a	uirements for Participation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101,					
	The original building v (222) construction an Path building was det construction and fully has a fire alarm syste the corridors, spaces	of two, one story buildings. was determined to be Type II d fully sprinkled. The Forest termined to be Type V (111) sprinkled. Each building m with smoke detection in open to the corridors, with ke alarms in all resident					

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		155715	B. WING			R 11/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	1331.13		8	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	04/2024
				1	11 W CHURCH AVE		
LUTHERA	N COMMUNITY HOME		SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{K 000}	wired smoke detector rooms in the Forest P building has a capacit 72 at the time of this suilding has a capacit 7 at the time of this su total capacity of 95 ar time of this visit. All areas where the reaccess were sprinkled	original building and hard is in the resident sleeping that building. The original by of 85 and had a census of survey. The Forest Path by of 10 and had a census of survey. The facility has a had had a census of 79 at the desidents have customary did and all areas providing sprinkled. The facility has a liding which was not	{K 0	000}			