STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING -- B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/11/25 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this Emergency Preparedness survey, Seymour Crossing was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 115 certified beds. At the time of the survey, the census was 71. Quality Review completed on 03/13/25	E 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2416. Thank you for your consideration.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/11/25 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this Life Safety Code survey, Seymour Crossing was found not in compliance with	K 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please feel free to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Myers	HFA	03/31/2025

Any defiencystatement 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 disclo 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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	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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/13/25		contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2416. Thank you for your consideration.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure all therapy exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 6 occupants in the	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the ability to be effected by deficient practice **What measures will be put into**	03/25/2025

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	therapy area. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., the exit door in the Therapy Area was equipped with two latching devices, a regular door handle with a latching mechanism and a separate keyed dead bolt locking latch. The CMS and agreed that, when locked, to exit the Therapy area it would require two separate actions to open the door. 2. Based on observation and interview, the facility failed to ensure the means of egress from the therapy exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key or special knowledge from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25 occupants if needing to exit the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., the (1) exit door from the therapy area was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code posted did not release the		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** One of the latching mechanisms has been removed from therapy door, additionally therapy exit door has been inspected to ensure door opens when code is entered. The code on the front door has been updated so as to not require special knowledge of where to find the code. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will inspect all doors and code signage weekly bringing to bi- monthly QA meetings for review and recommendation for a period of not less than 12 months. Executive Director to review inspections weekly and complete random checks of doors and codes areas reporting findings to QA meeting for a period of not less than six months.	

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	mechanism and allow the door to open. Additionally, (2) the main entrance/exit door was magnetically locked and could be opened by entering a four-digit code but the code was posted in such a way that it was difficult to locate since the location of the posting was not in close proximity to the code pad. The posted code was embedded in a picture of a postman who was carrying a letter pouch, and the digits on the letter pouch reflected the code to release the magnetic locking mechanism, requiring special knowledge of where to look to find the code. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of over 4 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 12 residents and staff using the "D Hall" Exit. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., the exit discharge from the "D Hall", terminated in the grass near the road. The	K 0271	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by alleged deficient practice, unit currently has no residents on it. The sidewalk outside of the D wing exit to be expanded to comply with K271, temporary waiver has been requested **How will you identify other residents having the potential to be affected by the same deficient practice and what**	06/20/2025

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	sidewalk did not terminate either at a public sidewalk or a parking lot that the facility owned and maintained. Based on interview at the time of observation, the CMS acknowledged that the walkway was going to need to be addressed and redirected. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)		**corrective action will be taken?** All residents have potential to be affected by alleged deficient practice. The sidewalk outside of the D wing exit to be expanded to comply with K271. All other exit discharges were inspected by the maintenance director with no additional concerns identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to conduct weekly rounds of all discharge exits ensuring compliance and reporting to QA Committee reports of all findings for a period of no less than six months reporting to administration immediately any concerns **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Executive Director to review with QA Committee results of inspections monthly for a period of not less than six months noting any repairs or replacements that were made. Please note temporary waiver requested to complete project. Anticipated completion date is 6-30-2025	

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K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 alcove with a large quantity of combustible material open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect 5 staff in the "D Hall" area. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., in the "D Hall" area, near an exit, there was an alcove open to the corridor. The alcove was being used as hazardous storage of new beds in large boxes and other combustible furniture such as chairs and tables. Based on interview at the time of observation, the CMS stated that the area would need to be cleared out. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)	K 0361	**K361** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents affected by alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The alcove in The D Hall has been cleaned out and had all combustible materials removed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Director to inspect D wing alcove weekly removing any combustible materials that may have been placed in that area. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will bring results of audits to monthly QA meeting for review and recommendation monthly for a period of not less than 12	03/21/2025

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			months. Executive Director to complete random checks of D wing Alcove, reporting findings to QA meeting for a period of not less than six months.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., the corridor door to Room # 108 had a gap which penetrated completely through the door near the door handle mechanism. The MS agreed that the door would not resist the passage of smoke. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents affected by alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The gap in the smoke barrier door has been repaired ensuring there are no gaps. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Director will monitor smoke barrier doors ensuring functionality, reporting to executive director any issues immediately for replacement or repair. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	03/21/2025

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			Executive Director to review results of inspections monthly for a period of not less than six months noting any repairs or replacements that were made.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview the facility failed to ensure areas around the facility were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) and Cooperate Maintenance Support (CMS) on 03/11/25 between 1:35 p.m. and 4:45 p.m., in the grass near the Service Hall Entrance, close to a facility smoking area, there were over 60 cigarette butts disposed on the ground in the grass and leaves. Additionally, near the smoking area in the rear, and on the edge of the parking lot near the front of the building, large collections of cigarette butts (50 plus) were disposed of on the ground. The CMS stated that it was likely the result of staff given the locations of the aforementioned butts. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents affected by alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Metal or non-combustible containers with self-closing cover devices have been added to all smoking areas. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance director to inspect all smoking areas weekly to ensure compliance with using devices. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the	03/21/2025

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			Maintenance Director will bring results of Inspections to bi-monthly QA meetings for review and recommendation monthly for a period of not less than 12 months. Executive Director to review inspections weekly and complete random checks of smoking areas reporting findings to QA meeting for a period of not less than six months.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is	K 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents affected by alleged deficient practice, inspections for all designated PCREE will be completed upon acquisition of equipment or contracted service. Temporary waiver requested **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the ability to be affected by deficient practice, inspections for PCREE will be completed upon acquisition of equipment or contracted service **What measures will be put into place or what systemic changes you will make to**	06/30/2025

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	maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and facility tour with the Maintenance Supervisor (MS), Administrator (AD) and Cooperate Maintenance Support (CMS) on 03/11/25 between 10:40 a.m. and 4:45 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The AD stated that PCREE such as nebulizers, oxygen concentrators, hospital beds, and other electrical medical equipment was present and in use at the facility. The CMS stated that this had been an issue at some other facilities and they were working on a plan of correction. This finding was acknowledged by the MS and CMS at the time of observation and again at the Exit Conference with the MS, CMS and Administrator present. 3.1-19(b)		**ensure that the deficient practice does not recur?** Facility to complete and document and maintain documentation for all PCREE along with testing prior to putting back into use after any repair or modification, along with any new equipment **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the Maintenance Director will inspect PCREE per policy bringing to bi-monthly QA meetings for review and recommendation for a period of not less than 12 months. Executive Director to review inspection reports and complete checks reporting findings to QA meeting for a period of not less than six months. Facility respectfully requests temporary waiver to complete testing, anticipated completion date 6.30.2025 Please see attached waiver request.	