STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 01 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR 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
K 0000 Bldg. 01	A Post Survey Revisit to the Life Safety Code Recertification and State Licensure Survey conducted on 03/11/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/07/25 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this PSR Life Safety Code survey, Seymour Crossing 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), 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 98 and had a census of 69 at the time of this PSR visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/08/25	K 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiency 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Myers	HFA	05/23/2025

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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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 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. 19.2.2.2.1 states that doors complying with Section 7.2.1 shall be permitted. Section 7.2.1.5.10 states that 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. Section 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. Section 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. Additionally, Section 19.3.6.3.5 states that doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction. The authority having jurisdiction, The Centers of Medicare/Medicaid Services (CMS) requires corridor doors to be self-latching and provided with positive latching hardware. This deficient practice could affect 6 occupants in the therapy area. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Supervisor (MS) on 05/07/25 at 1:10p.m. the exit door in the Therapy Area which had previously been equipped with two latching devices, a regular door handle with a latching mechanism and a separate keyed dead bolt locking latch, had the latching hardware removed and now only had the dead bolt tyle hardware installed. 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 affected by deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Positive latching hardware has been added to door, allowing door to latch on its own **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 weekly ensuring proper latching mechanisms are in place. Reporting to ED immediately any doors not meeting compliance for immediate repair, ED to report monthly for six months any issues with	05/22/2025

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	remaining hardware was not positive latching as it did not allow the door to self-latch on its own. The MS agreed that the new configuration does not permit the door to latch on its own and he would need to purchase a latching mechanism with a key. This finding was acknowledged by the MS at the time of observation and again at the Exit Conference with the MS and Administrator present. This deficiency was cited on 03/11/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		compliance	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits	K 0271	Waiver in place until 6/30/2025	06/30/2025
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc	K 0921	Waiver in place until 6/30/2025	06/30/2025