STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155586	A. BUILDING -- B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(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: 12/14/22 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 At this Emergency Preparedness survey, Lutheran Life Villages was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 142 and had a census of 105 at the time of this survey. Quality Review completed on 12/19/22	E 0000		
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: 12/14/22 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 At this Life Safety Code survey, Lutheran Life Villages was found not in compliance with	K 0000	This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal law and not because Lutheran Life Village Anthony Boulevard agrees with the allegations and citations listed in this statement of deficiencies. Lutheran Life Villages maintains that the alleged deficiency does not jeopardize the health and safety of the residents, nor does it constitute substandard quality of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shauna Shafer	HFA	12/28/2022

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. The Health and Rehabilitation building is a one story sprinklered building of Type I (332) construction. The building has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and battery-operated smoke detector in the resident rooms. The facility has a capacity of 142 and had a census of 105 at the time of this survey. Quality Review completed on 12/19/22		care or limit our capability to render adequate care. Please accept this plan of correction as our credible allegation of compliance. Lutheran Life Village Anthony Boulevard is respectfully requesting paper compliance.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility	K 0353	1. Maintenance Director secured a	03/13/2023

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	failed to maintain 1 of 1 ceiling constructions in the boiler/generator room. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect maintenance staff in the boiler/generator room. Findings include: Based on observation with the Maintenance Director and the Administrator on 12/14/22 at 12:50 p.m., in the boiler/generator room there were numerous holes in the plaster ceiling from a one (1) inch to three (3) feet in size leaving a two (2) to three (3) foot gap between the sprinklers and the roof decking. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed holes in the ceiling and the plaster needs repaired. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		contractor to seal the identified holes in the plaster ceiling in the generator/boiler room the week of 12.19.2022. **2. Maintenance Director completed a review of the AB campus ceilings on 12/14/22 and did not identify any other holes in the plaster ceiling that required repairs.** **1. 3. Training: Maintenance staff educated on 12.22.2022, regarding deficient practice and ceiling maintenance in regards to sprinkler function.** **1. 4. Quality: Director of Maintenance/Designee will audit ceilings on a weekly basis for one month and then monthly for five months. The audit results will be shared by the Director of Maintenance with the QAA/QAPI committee on a monthly basis for 6 months. (See Audit Tool)** **Artifacts Submitted: Training Agenda, Education /Signature, and Audit Tool**	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

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	Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observations, records review, and interview, the facility failed to ensure 5 of 9 fire barrier walls used as smoke barriers were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice affects 5 of 6 smoke compartments but does affect all residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 12/14/22 between 1:40 p.m. and 2:00 p.m., above the ceiling tiles of the fire walls that were used as smoke barriers at the end of all 4 halls and to the dining room, contained pink foam	K 0372	**1. Fire Foam Finding: Director of Maintenance ordered fire foam rated at ASTME 814 the week of 12.19.2022 to be installed over all smoke barriers, removing existing foam in affected areas.** **2. Smoke Barriers/Fire Foam: Maintenance Director completed a review of the smoke barrier areas regarding the fire foam in question on 12/14/22; the areas identified will have existing foam removed and replaced with the fire rated foam at ASTME 814.** 3. **Training: Maintenance staff educated on 12.22.2022, regarding deficient practice and approved fire foam rating.** **4. Quality: Director of Maintenance/Designee will audit fire foam sustainability over smoke barriers monthly for 6 months. The audit results will be shared by the Director**	03/13/2023

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	and a little yellow foam. Based on records review with the Maintenance Director and the Administrator at 2:10 p.m., the can of fire foam provided had a listed rating of ASTM E 84 and not the required ASTM E 814. Based on interview at the time of observation, the Maintenance Director stated he was unsure of the rating of the foam in the walls because it was installed by previous Maintenance Director and agreed the foam in stock had a rating of ASTM 84 and not ASTM E 814. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**of Maintenance with the QAA/QAPI committee on a monthly basis for 6 months. (See Audit Tool)** **Artifacts: Training Agenda, Education / Signature, and Audit Tool**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 9 of 9 fire door assemblies were completed in accordance with LSC 19.1. and with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Maintenance Director on 12/14/22 at 10:19 a.m., the annual fire door inspections were past due. The annual fire door inspection documentation had an inspection date of 10/22/21. No other documentation was available to show the facility's fire doors were inspected within the last 12 months. Based on interview at the time of	K 0761	**1. Annual Fire Door Inspection Finding: Director of Maintenance secured contracted inspector to come week of January 16th to inspect all doors.** **2. Annual Fire Door Inspection Finding: This finding impacts all doors. Director of Maintenance secured contracted inspector to come week of January 16th to inspect all doors per the annual requirement.** 3. Training: **Maintenance staff educated on 12.22.2022, regarding deficient practice and fire door inspections.** **4. Quality: Director of**	03/13/2023

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	records review and observation, the Maintenance Director stated the annual fire door inspections were past due and are waiting for the contractor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**Maintenance will audit annual door inspection upon completion and report results to the monthly QAA/QAPI. The annual door inspection will be scheduled annually in the TELS preventative maintenance program.** **Artifacts: Training Agenda, Education / Signature**	