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	03/07/2023

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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/09/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/07/23 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710 At this PSR survey to the 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 65. Quality Review completed on 03/07/23	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 review the attachments provided with this plan of correction, which include pictures of repairs that were made.] 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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/09/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/07/23 Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Myers		03/17/2023

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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	At this PSR survey, Seymour Crossing was found not in compliance with Requirements for Participation 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 corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has three detached storage sheds which were not sprinklered. Quality Review completed on 03/07/23		accept this plan as our facility's compliance. [Please review the attachments provided with this plan of correction, which include pictures of repairs that were made.] 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 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke 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			

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	to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on record review, observation, and interview; the facility failed to ensure openings through 1 of 1 ceiling smoke barriers would resist the passage of smoke. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility by the D Wing. Findings include: Based on observations with the Maintenance Director at 9:50 a.m. on 03/07/23, HVAC ductwork had been removed from two former ceiling mounted air supply or air return grills in the corridor by Room 102 and by Room 105 in the D Wing which exposed the attic above. Each of the two openings in the ceiling had a fire damper installed in the opening. The Maintenance Director provided "Fire Damper Inspection Checklist" documentation at 9:45 a.m. on 03/07/23 which indicated a contractor had inspected and tested D Wing fire dampers on 02/15/23. All fire dampers passed inspection and testing. Based on interview at the time of the observations, the Maintenance Director agreed the holes in the	K 0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The holes in ceiling by room 102 and 105 were closed. The air supply return grills have been removed and covered with material capable of resisting the transfer of smoke. **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 potential to be affected. All ceiling areas were inspected to ensure there were no opening through ceiling smoke barrier by the maintenance director. The facility will ensure ceiling penetrations are smoke resistant. **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 ceiling penetrations monthly repairing immediately those found not in compliance and reporting to the Quality Assurance Committee the results of findings.	03/16/2023

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	ceiling caused by the removal of HVAC ductwork did not ensure the D Wing ceiling smoke barrier would resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. This deficiency was cited on 01/09/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		Maintenance director to inspect ceiling penetrations after contractor/construction immediately after work is completed. **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 months. Executive Director to complete random checks of penetrations and audit reports, reporting findings to QA meeting for a period of not less than six months.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches			

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	for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure doors in 1 of 1 attic smoke barrier walls in the D Wing would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility by the D Wing. Findings include: Based on observations with the Maintenance Director at 9:57 a.m. on 03/07/23, the smoke barrier door in the attic above the corridor door set by Room 102 in the D Wing was self-closing but the door would not fully self-close and left a two inch opening in between the door and the attic wall on the side of the door that did not have hinges. Based on interview at the time of the observations, the Maintenance Director agreed the gap in between the smoke barrier door and the wall in the attic above the corridor door set by Room 102 in the D Wing would not ensure the door would restrict the movement of smoke. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. This deficiency was cited on 01/09/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0374	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The gap in the smoke barrier door has been repaired ensuring there are no gaps when closed. **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 potential to be affected. Maintenance director inspected all ceiling areas to ensure all smoke barrier doors to the attic closed properly. **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. Maintenance Director will inspect smoke barriers door after construction to ensure doors close properly. **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**	03/16/2023

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	3.1-19(b)		**into place?** 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.	