

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2012
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NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Facility Number: 000104 Provider Number: 155197 AIM Number: 100266590</p> <p>Surveyor: W. Chris Greeney , Life Safety Code Specialist.</p> <p>At this Quality Assurance Walk-thru survey, Sanctuary at St. Pauls was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This three story facility was determined to be of Type II (222) construction and was fully sprinklered except for two medication rooms, an attached canopy over an entrance and an attached awning over a patio. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in resident sleeping rooms. The facility has a capacity of 78 and had a census of 76 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage, but in compliance with regard</p>	K0000	<p>This Plan of Correction consitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a defeciency exists or that one was cited correctly. This Plan of Correction is submitted the meet requirements established by state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiencystatement ending with an asterisk (\*) denotes a defecency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	<p>to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered, except an attached canopy over an entrance and an attached awning over a patio. All areas providing facility services were sprinklered, except two medication rooms. There were no detached buildings that provided facility services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure all areas of the facility were sprinklered. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>1. Based on observation with the</p>	K9999	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient;A1. No resident was affected.Q2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;A2. No resident was affected.Q3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;A3. A sprinkler head will be installed in each medication room on 2nd and 3rd floor, the sprinkler system will be extended outside into the canopy adding 3 sprinkler heads; a sprinkler system will be placed outside underneath the awning.Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e., what quality assurance program will be put in place;A4. Will be monitored with sprinkler system preventive maintenance.Q5. By what date the systemic changes will be completed.A5. November 15, 2012</p>	11/15/2012	

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	<p>Environmental Services Director (ESD) during a facility tour from 1:00 p.m. to 2:15 p.m. on 09/17/12, the medication room at the second floor nurses' station was not sprinklered. Additionally, the medication room at the third floor nurses' station was also not sprinklered. Based on interview interview with the ESD during the tour, he was not aware, and did not know why, the two medication rooms were not sprinklered.</p> <p>2. Based on observation with the Environmental Services Director (ESD) during a facility tour from 1:00 p.m. to 2:15 p.m. on 09/17/12, a canopy which extended over the health care entrance measured at 4 feet 7 inches was not sprinklered. The ESD interviewed during the tour, indicated the canopy was made of combustible material. The underside of the overhang appeared to be made of wood frame material.</p> <p>3. Based on observation with the Environmental Services Director (ESD) during a facility tour from 1:00 p.m. to 2:15 p.m. on 09/17/12, an awning made of fabric material was attached to the side of the building and extended over an outdoor patio area. The attached awning was not sprinklered. Based on interview with the ESD during the tour on 9/17/12, they had contacted the vendor of the awning during the survey and were told the awning was made of combustible</p>			

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	<p>material.</p> <p>3.1-19(ff)</p> <p>3.1-19(b)</p>			