

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2015
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NAME OF PROVIDER OR SUPPLIER  SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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K 000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 2/26/15</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyors: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of the three story building and the main entrance/dining room was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>The nursing home is a fully sprinklered</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K 021 SS=E Bldg. 01	<p>three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story fully sprinklered building of type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms of the existing building. The facility has a capacity of 166 and had a census of 156 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/04/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close</p>			

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	<p>all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 47 residents on the first floor</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 1:00 p.m., there was a two hour fire wall separating the nursing home of Type II (222) construction, and the main</p>	K 021	<ol style="list-style-type: none"> <li>Door will be replaced with a new door from an outside contractor. A 90minute mineral core wood fire rated door has been ordered, and will be installed upon arrival by third party contractor.</li> <li>Maintenance Director or designee will perform an additional walkthrough of the building to check all other fire rated doors to ensure proper closure. Doors will be ordered and replaced as required.</li> <li>Fire Doors will be added to quarterly Preventive Maintenance program to ensure that all fire doors close properly and latch. Quarterly, a report will be sent to the QA committee.</li> <li>This report will be reviewed quarterly by the QA</li> </ol>	03/28/2015

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K 025 SS=E Bldg. 01	<p>entrance/dining room area of Type V (111) construction. The fire wall runs through resident room 124 making the restroom wall part of the two hour fire barrier. The fire door in the restroom fire wall was self closing but would not latch into the frame. Based on interview at the time of observation, the Maintenance Supervisor confirmed the restroom door was a fire door and was not latching into the frame due to laminate coming off of the door and blocking it from fully closing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice can</p>	K 025	<p>committee to ensure ongoing compliance.</p> <p>5. This will be completed on or before March 28, 2015.</p> <p>1. Sprinkler head penetrations outside room 326 have been sealed with caulk. Caulk was also installed around the ceiling penetration (wires) in the firstfloor nurse</p>	03/28/2015	

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K 033 SS=E Bldg. 01	<p>affect 47 residents on the first floor and 48 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Tech #1 on 02/26/15 between 10:25 a.m. and 12:20 p.m., the following penetrations were noted:</p> <p>a. Two unsealed penetrations through the ceiling measuring a half of an inch around the sprinkler heads of room 326, located on the third floor.</p> <p>b. Three unsealed penetrations through the ceiling measuring a half of an inch around wires and conduit of the nurses call CPU closet, located on the first floor.</p> <p>Based on interview at the time of observation, the Maintenance Tech #1 acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building.</p>		<p>call CPU closet.</p> <p>2. Maintenance Director or designee will perform an additional walkthrough of the building to identify any other ceiling penetrations. Any and all corrections will be made.</p> <p>3. Maintenance staff will be in-serviced on properly sealing ceiling penetrations. Ceiling penetration checks including but not limited to wire passage ways, sprinkler head escutcheons, missing/broken ceiling tiles, etc. will be added to the quarterly preventive maintenance program. Quarterly, a report will be sent to the QA committee.</p> <p>4. This report will be reviewed quarterly by the QA committee to ensure ongoing compliance.</p> <p>5. This will be completed on or before March 28, 2015.</p>				

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K 034 SS=E Bldg. 01	<p>8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 exit stairways in accordance with LSC 7.7.1 and LSC 7.7.2. LSC 7.7.1 requires exits to discharge to the public way or an exterior exit discharge. LSC 7.7.2 allow no more than 50 percent of exits to discharge into an area on the level of exit discharge. This deficient practice could affect any of the 44 residents on the second floor and any of the 45 residents on the third floor in the event of an emergency evacuation.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Tech #1 on 02/26/15 at 10:00 a.m. and then again at 10:30 a.m., the southwest stair and northeast stair discharged onto the first floor and not directly to the exterior of the building. Based on interview, this was confirmed by the Maintenance Tech #1 at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p>	K 033	<p>This is an ongoing issue with the design of the building. Saint Anne has historically retained RTM Consulting in order to perform the proper risk assessment. An on-site visit has been scheduled with RTM on March 17, 2015. We hope to have the Fire Safety Evaluation System (FSES) shortly thereafter. Saint Anne Home has also engaged MKM architecture to address this issue long-term as part of an overall campus expansion and improvement project.</p>	03/28/2015

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K 038 SS=F Bldg. 01	<p>Based on observations and interview, the facility failed to ensure items stored in 1 of 2 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This deficient practice affects any residents, visitors and staff using the southwest stairwell for evacuation.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Maintenance Tech #1, HR director, and the Maintenance Supervisor on 02/26/15 between 10:25 p.m. and 12:32 p.m., in the southwest stairwell there were 4 tables and 24 chairs stored under the stairs.</p> <p>Based on an interview at the time of observation, the Maintenance Supervisor acknowledged these items were being stored in the stairwell.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 034	<p>1. Items were removed immediately from the SW stairwell. 2. Maintenance Director or designee will perform an additional walk-thru of the building and determine if any other stairwells are being used as storage. Any additional stairwells that have items in them will be cleaned out. 3. Maintenance staff will be in-serviced on K034 regulation. In addition, monthly stairwell checks will be added to the preventive maintenance program. Quarterly, a report will be sent to the QA committee. 4. This report will be reviewed quarterly by the QA committee to ensure ongoing compliance. 5. This will be completed on or before March 28, 2015.</p>	03/28/2015	

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	<p>1) Based on observation and interview, the facility failed to ensure 1 of 2 chapel exit discharge paths were readily accessible at all times. This deficient practice could affect all residents using the chapel in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 1:50 p.m., the left chapel double exit door required excessive force to open and the right chapel double exit door would not open. Based on an interview at the time of observation, the Maintenance Supervisor stated the bottom of the door jamb was lifted from weather conditions.</p> <p>3.1-19(b)</p> <p>2) Based on observation and interview, the facility failed to ensure 4 of 8 exit access corridors were readily accessible and unobstructed at all times. This deficient practice could affect any of the 47 residents on the first floor, 48 residents on the fourth floor and any staff member in the basement.</p> <p>Findings include:</p>	K 038	<p>1. The wooden Chapel Emergency Exit Doors will be replaced by an outside contractor with brand new metal doors. The cluttered hallways will be cleaned out on 1st floor, 3rd floor, and basement. Also, the outside exit door near room 109 ("Door #5") will be reprogrammed to permit the delayed 15 second egress as well as reprogrammed to drop out/unlock during a fire alarm. An outside contractor will be used to also test all exterior magnetically locked doors. 2. Maintenance Director or designee will check all other outside exit doors to ensure proper functioning. Maintenance director will also inspect cluttered hallways and test 15 second egress on appropriate doors (i.e. chapel vestibule exit door (door #2) and door #5. 3. Staff will be in-serviced on K038 related to hallway obstructions. Additionally, maintenance staff will in-serviced on regulations for egress doors, to include all areas identified in the 2567. Quarterly checks for hallway obstructions and egress door function will be added to the preventive maintenance program. Quarterly, a report will be sent to the QA committee. 4. This report will be reviewed quarterly by the QA committee to ensure ongoing compliance. 5. This will be completed on or before March 28, 2015.</p>	03/28/2015	

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	<p>Based on an observation during the tour of the facility with the Maintenance Tech #1, HR director, and the Maintenance Supervisor on 02/26/15 between 10:25 a.m. and 12:32 p.m., the following items were being stored in the corridors:</p> <p>a. on the third floor corridor by room 308 there were five empty soiled linen containers, one clean linen cart, and one geriatric chair.</p> <p>b. on the first floor corridor by room 108 there were six empty soiled linen containers and one clean linen cart.</p> <p>c. in the basement by the elevator there were six chairs, one night stand, and one computer desk.</p> <p>Based on an interview at the time of observation, Maintenance Tech #1 and Maintenance Supervisor acknowledged these items were being stored in the corridor and are only supposed to be in the corridor when they are in use.</p> <p>3.1-19(b)</p> <p>3) Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks on the first floor by room 109 was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be</p>			

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	<p>installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 47 residents, staff and visitors on the first floor.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Tech #1 at 12:15 p.m. on 02/26/15, the exit door labeled as the trash door located on the first floor by Room 109 leading to the exterior of the building is marked as a facility exit, was equipped with a delayed</p>			

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	<p>egress lock, and was provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force four separate times. Based on interview at the time of observation, the Maintenance Tech #1 stated the aforementioned exit is a facility exit, was equipped with a delayed egress lock and the necessary signage, but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force four separate times.</p> <p>3.1-19(b)</p> <p>4) Based on observation and interview, the facility failed to ensure 1 of 1 first floor exit doors equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 7.2.1.6.1 (a) requires actuation of the fire alarm system shall unlock any doors equipped with approved, listed delayed egress locks in accordance with section 9.6. LSC 9.6.5.2(5) requires the unlocking of the doors with actuation of the fire alarm system. Doors should not relock when the audible alarms are silenced since the</p>			

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K 046 SS=F Bldg. 01	<p>rest of the system is still actuated. This deficient practice could affect 47 residents, staff and visitors on the first floor.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Maintenance Tech #1 on 2/26/15 at 2:30 p.m., the exit door labeled as the trash door located on the first floor by Room 109 leading to the exterior of the building was marked as a facility exit, and equipped with a magnetic locking system; failed to remain unlocked when the fire alarm system was activated. Based on interview, this was acknowledged by the Maintenance Tech #1 at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 18 of 18 emergency light fixtures were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires</p>	K 046	<p>1. Batteryoperated Emergency Lighting Equipment was tested to ensure functionality.</p> <p>2. Maintenance Director or designee will do anadditional walkthrough of the building to inspect all the battery</p>	03/28/2015

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K 062 SS=E Bldg. 01	<p>an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations and record review with the HR Director and the Maintenance Supervisor on 02/26/15 at 11:49 p.m., the Battery Operated Emergency Lights-Test Log for 2014 and 2015 did show a monthly 30 second test but did not show a 90 minute annual test. Based on an interview during the review, the Maintenance Supervisor confirmed there was no 90 minute test recorded.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview,</p>	K 062	<p>operated emergency lighting systems and to change out any faulty equipment.</p> <p>3. Maintenance Supervisor implemented annual PM test to ensure that the Emergency Lighting System works correctly for 90 minutes in accordance to regulation. Quarterly, a report will be sent to the QA committee.</p> <p>4. Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance.</p> <p>5. This will be completed by March 28th, 2015.</p> <p>1. All 11 missing escutcheons</p>	03/28/2015

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	<p>the facility failed to ensure 11 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 47 residents on the first floor, one resident on the second floor, and 48 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Tech #1 on 02/26/15 between 10:00 a.m. and 1:30 p.m., the following sprinkler heads were missing escutcheons:</p> <ul style="list-style-type: none"> <li>a. one sprinkler head in room 310 on the third floor</li> <li>b. one sprinkler head in the men's restroom on the third floor</li> <li>c. one sprinkler head in the women's restroom on the third floor</li> <li>d. one sprinkler head on the third floor hallway by the recreation room</li> <li>e. one sprinkler head in the public restroom on the second floor</li> <li>f. one sprinkler head in the public restroom on the first floor by room 103</li> <li>g. one sprinkler head in room 124 on the first floor</li> <li>h. two sprinkler heads in the first floor nurse's station</li> <li>i. one sprinkler head in the scheduling coordinator's room on the first floor</li> <li>j. one sprinkler head in the supply closet located in the front offices</li> </ul>		<p>have been installed. All ceiling fans (6) that are blocking sprinkler heads will be replaced with flush-mounted dome lights. The sprinkler head that was 'pushed up too high' was in room 214. An outside contractor will be hired to correct this. The IT and laundry storage areas have been cleaned out so that 18" of clearance exists between items &amp; the ceiling. The light in the phone room was moved away from the sprinkler head and is no longer supported by the sprinkler pipe. The 2 corroded sprinkler heads in the kitchen dish room area were replaced by an outside contractor.</p> <p>2. Maintenance Director will perform additional walk-thru of the building and determine if any other problems exist with sprinkler heads, escutcheons, storage too close to the ceiling, blocked heads, etc. Any problems observed by the Maintenance Director will be corrected.</p> <p>3. staff will be in-serviced on 18" clearance regulation. A new Quarterly PM item will be created for the maintenance director to walk through the building to verify that sprinkler heads are properly installed, not blocked by fans, storage, or other items, and that no lights or other type of fixtures are mounted/supported by the fire suppression system (pipes, etc.). Quarterly, a report will be sent to the QA committee.</p>				

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	<p>Based on interview, The Maintenance Tech #1 acknowledged each missing escutcheon at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for 6 of over 300 sprinklers in the facility was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 47 residents on the first floor, 46 residents on the second floor, 48 residents on the third floor, and any staff in the basement.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Tech #1, the HR Director and Maintenance</p>		<p>4. Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance.</p> <p>5. This will be completed on or before March 28, 2015</p>	

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	<p>Supervisor on 02/26/15 between 10:00 a.m. and 1:30 p.m., the spray pattern for the following sprinkler heads were obstructed:</p> <p>a. there was a ceiling fan less than four inches and directly below a sprinkler head in the Inservice Director office on the first floor.</p> <p>b. there was a ceiling fan less than four inches and directly below a sprinkler head in the MDS Social Service office on the second floor.</p> <p>c. there was a ceiling fan less than four inches and directly below a sprinkler head in the Activities office on the third floor.</p> <p>d. there was a sprinkler head pushed up into the ceiling covering the deflector</p> <p>e. there were items stored less the 18 inches from sprinkler heads in IT room in the basement</p> <p>f. there were items stored less the 18 inches from sprinkler heads in laundry storage room in the basement</p> <p>Based on interview, the Maintenance Supervisor and the Maintenance Tech #1 acknowledged each obstructed sprinkler at the time of each observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure a complete</p>			

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	<p>automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice was not in a patient treatment area but could affect any staff in the basement.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 12:19 p.m., in the phone room located in the basement there was an overhead light chained to the sprinkler pipe for support. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to replace 2 of 8 corroded sprinklers in the dish machine room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires</p>			

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K 064 SS=E Bldg. 01	<p>any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not located in a patient treatment area but could affect any kitchen staff in the area.</p> <p>Findings include:</p> <p>Based on observation during a tour with the HR Director and Maintenance Supervisor on 2/26/15 at 2:24 p.m. two of eight automatic sprinklers in the dish machine room were corroded with a green substance. Based on interview at the time of the observation, the Maintenance supervisor acknowledged the condition of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible</p>	K 064	<p>1. Identified Extinguisher Deficiencies have been corrected in accordance to regulations.</p> <p>2. Maintenance Director or designee will do an additional walk-thru of the building to determine if any other Fire Extinguisher deficiencies exist according to regulation K064 and will correct found deficiencies.</p> <p>3. A new Quarterly PM item will</p>	03/28/2015

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	<p>cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the HR Director and Maintenance Supervisor on 02/26/15 at 1:03 p.m., the K Class fire extinguisher in the kitchen had noticeable green corrosion around the hose connector, the pressure gauge, and the spray nozzle. Based on an interview at the time of observation, the Maintenance Supervisor acknowledged the corrosion on the fire extinguisher.</p> <p>3.1-19(b)</p>		<p>be created for the maintenance director or designee to walk through the building to verify that no deficiencies exist with the fire extinguishers. Quarterly, a report will be sent to the QA committee.</p> <p>4.Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance.</p> <p>5.This will be completed on or before March 28, 2015</p>	

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 2 boiler room fire extinguisher requiring a 12-year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice was not in a patient treatment area but could affect staff in working in the boiler room.</p> <p>Findings include:</p> <p>Based on observation during tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 12:08 p.m. the maintenance tag on the boiler room fire extinguisher indicated the last six year test was completed 2004. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 fire extinguishers in front office was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire</p>			

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K 070 SS=E Bldg. 01	<p>extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice was not in a patient treatment area but could affect any staff in working in the front office.</p> <p>Findings include:</p> <p>Based on an observation during tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 1:45 p.m., access to the front office fire extinguisher located on the wall by the entrance to the offices was obstructed by the door and a large paper recycling container. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 3 of 3 portable space heaters in accordance with</p>	K 070	<p>1. The space heaters in the Admissions Office, Controllers Office, and Accounts Payable office have been removed.</p> <p>2. Maintenance Director or</p>	03/28/2015			

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K 147 SS=E Bldg. 01	<p>NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on record review with the HR Director and the Maintenance Supervisor on 02/26/15/ at 10:20 a.m., the space heater policy states the facility does not allow space heaters. Based on observation during the tour of the facility with the HR Director and the Maintenance Supervisor between 1:40 p.m. and 1:48 p.m., three space heaters were found in the Accounts Payable office, Controllers office, and in the Administration office. Based on interview at the time of observation, the HR Director and the Maintenance Supervisor acknowledged the space heaters were a violation of the facility's policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 6 of 6 flexible</p>	K 147	<p>designee will do an additional walk-thru of the building and determine if any other space heaters exist. If they do, they will be removed immediately.</p> <p>3.Office staff will be in-serviced on not using space heaters. A new Quarterly PM item will be created for the maintenance director or designee to walk through the building to verify that no space heaters are being used. Quarterly, a report will be sent to the QA committee.</p> <p>4.Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance.</p> <p>5.This will be completed on or before March 28, 2015</p> <p>1. The extension cords were removed from the basement training room. 2.Maintenance</p>	03/28/2015

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K 000  Bldg. 03	<p>ords such as extension cords or power strips were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect staff using the training room.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the HR Director and the Maintenance Supervisor on 02/26/15 at 12:28 p.m., there were three extension cord power strips plugged into three extension cords providing power to computer equipment in the basement training room. Based on interview, this was acknowledged by the HR Director and the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and</p>	K 000	<p>Director or designee will do an additional walk-thru of the building and determine if any other extension cords are in use for non-temporary applications. If these situations exist, they will be corrected immediately. 3. Staff will be in-serviced on proper use of extension cords. A new Quarterly PM item will be created for the maintenance director or designee to walk through the building to verify that no extension cords are being used improperly and will remove found deficiencies. Quarterly, a report will be sent to the QA committee. 4. Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance. 5. This will be completed on or before March 28, 2015</p>		

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	<p>State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/26/15</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation unit and Therapy Gym were surveyed with Chapter 18 New Health Care Occupancies.</p> <p>The nursing home is a fully sprinklered three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story</p>			

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K 039 SS=E Bldg. 03	<p>fully sprinklered building of type V (111) construction. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors and hard wired smoke detectors in the Rehabilitation hall resident rooms. The facility has a capacity of 166 and had a census of 157 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/04/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure the corridor width for 1 of 2 Rehabilitation Hall corridors</p>	K 039	This is an ongoing issue with the design of the building. Saint Anne has historically retained RTM Consulting in order to	03/28/2015

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K 040 SS=E Bldg. 03	<p>was at least eight feet wide. This deficient practice affects any of the 16 residents on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on an observation during the tour of the facility with the Maintenance Tech #1 on 02/26/15 at 1:00 p.m., the corridor width measured six feet from resident suite E to resident suite O in the Rehabilitation Hall. Based on interview this was confirmed by the Maintenance Tech #1 at the time of the observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 13 exit doors had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors in the means of egress from nursing homes shall be no less than 41.5 inches. This deficient practice could affect any of the 16 residents on the Rehabilitation Hall in the event of an</p>	K 040	<p>perform the proper risk assessment. An on-site visit has been scheduled with RTM on March 17, 2015. We hope to have the Fire Safety Evaluation System (FSES) shortly thereafter. Saint Anne Home has also engaged MKM architecture to address this issue long-term as part of an overall campus expansion and improvement project.</p> <p>This is an ongoing issue with the design of the building. Saint Anne has historically retained RTM Consulting in order to perform the proper risk assessment. An on-site visit has been scheduled with RTM on March 17, 2015. We hope to have</p>	03/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2015
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NAME OF PROVIDER OR SUPPLIER  SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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K 046 SS=F Bldg. 03	<p>emergency evacuation.</p> <p>Findings include:</p> <p>Based on observation with during the tour of the facility the Maintenance Tech #1 on 02/26/15 at 1:01 p.m., the exit door #12 in the path of egress from the Rehabilitation Hall measured thirty six inches. Based on interview, this measurement was provided and confirmed by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation, record review and interview; the facility failed to ensure 18 of 18 emergency light fixtures were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the</p>	K 046	<p>theFire Safety Evaluation System (FSES) shortly thereafter. Saint Anne Homehas also engaged MKM architecture to address this issue long-term as part of anoverall campus expansion and improvement project.</p> <ol style="list-style-type: none"> <li>1. Batteryoperated Emergency Lighting Equipment was tested to ensure functionality.</li> <li>2. Maintenance Director or designee will do anadditional walkthrough of the building to inspect all the battery operatedemergency lighting systems and to change out any faulty equipment.</li> <li>3. Maintenance Supervisor implementedannual PM test to ensure that the Emergency Lighting System works</li> </ol>	03/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015
NAME OF PROVIDER OR SUPPLIER  SAINT ANNE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805		
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	<p>owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations and record review with the HR Director and the Maintenance Supervisor on 02/26/15 at 11:49 p.m., the Battery Operated Emergency Lights-Test Log for 2014 and 2015 did show a monthly 30 second test but did not show a 90 minute annual test. Based on an interview during the review, the Maintenance Supervisor confirmed there was no 90 minute test recorded.</p> <p>3.1-19(b)</p>		<p>correctly for 90 minutes in accordance to regulation. Quarterly, a report will be sent to the QA committee.</p> <p>4. Results will be reviewed by the Quality Assurance committee to ensure ongoing compliance.</p> <p>5. This will be completed by March 28th, 2015.</p>		