

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
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NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
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K 0000 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: 08/20/15</p> <p>Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990</p> <p>At this Life Safety Code survey, St. Paul Hermitage LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was surveyed as two separate buildings due to the different construction types of different portions of the building. Building 0102, the one story health care center constructed in 1997, was determined to be of Type II (000) construction and fully sprinklered. Building 0102 had hard wired smoke detectors located near smoke barriers and</p>	K 0000		
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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 0020 SS=E Bldg. 02	<p>in all resident sleeping rooms. Building 0202, consisting of the first floor of the fully sprinklered three story building with a basement adjacent to the health care center, and separated by a two hour wall was determined to be of Type I (332) construction. The first floor and the basement of the adjacent building which was constructed in 1959 was surveyed due to customary access to the chapel and Rehab Room in the building. Building 0202 had a complete corridor smoke detection system. The facility has a capacity of 52 and had a census of 47 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached garage providing facility storage services which was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to enclose 1 of 5 stairwell vertical openings with construction having a fire resistance rating of one hour. This deficient practice could affect 10 residents, staff and visitors in the</p>	K 0020	The two inch hole in the south wall of the north stairway above the suspended ceiling has been filled with fire resistant caulk.	08/24/2015			

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K 0025 SS=E Bldg. 02	<p>vicinity of the Rehab Room on the ground floor.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance during a tour of the facility from 10:45 a.m. to 12:50 p.m. on 08/20/15, a two inch hole for the passage of a one inch in diameter conduit was noted in the south wall of the north stairwell above the suspended ceiling outside the Rehab Room on the ground floor. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the aforementioned hole in the south wall of the north stairwell on the ground floor failed to maintain a fire resistance rating of one hour for the stairwell vertical opening.</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</p>						

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	<p>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 openings through 1 of 7 smoke barrier walls on the ground floor were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Rehab Room on the ground floor.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance during a tour of the facility from 10:45 a.m. to 12:50 p.m. on 08/20/15, a six inch hole for the passage of a four inch in diameter sprinkler pipe was noted above the suspended ceiling above the ninety minute fire rated corridor door set outside the Rehab Room on the ground floor. In addition, a second hole two inches in diameter for the passage of a one inch in diameter conduit was also noted above the suspended ceiling at the</p>	K 0025	The six inch hole for the passage of a four inch sprinkler pipe was filled with concrete and sealed with fire resistant caulk. The second hole for the passage of a one inch conduit was sealed with fire resistant caulk.	08/24/2015			

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K 0033 SS=E Bldg. 02	<p>aforementioned ground floor smoke barrier wall. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the openings in the aforementioned ground floor smoke barrier wall did not maintain the fire resistance rating of the smoke barrier wall.</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. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to enclose 1 of 5 stairwell exits with construction having a fire resistance rating of one hour. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Rehab Room on the ground floor.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Director of Maintenance during a tour of the facility from 10:45 a.m. to 12:50 p.m. on 08/20/15, a two inch hole for the passage of a one inch in diameter conduit was noted in the south wall of the north</p>	K 0033	A two inch hole for the passage of a one inch conduit in the south wall of the north stairway has been sealed with fire resistant caulk.	08/24/2015

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K 0064 SS=E Bldg. 02	<p>stairwell above the suspended ceiling outside the Rehab Room on the ground floor. Based on interview at the time of observation, the Assistant Director of Maintenance acknowledged the aforementioned hole in the south wall of the north stairwell on the ground floor failed to maintain a fire resistance rating of one hour for the stairwell exit.</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 ensure 2 of 30 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect ten residents, staff and visitors.</p> <p>Findings include:</p>	K 0064	One portable fire extinguisher in the Rehab Room on the ground floor and one portable fire extinguisher in the mechanical room on ground floor have been inspected and documented.	08/24/2015

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	<p>Based on observations with the Assistant Director of Maintenance during a tour of the facility from 10:45 a.m. to 12:50 p.m. on 08/20/15, the inspection tag affixed to the portable fire extinguisher in the Rehab Room on the ground floor and the portable fire extinguisher in the elevator machine room in the Main Mechanical Room on the ground floor room each indicated April 2014 as the date the most recent annual maintenance was performed. Based on interview at the time of the observations, the Assistant Director of Maintenance stated no other annual fire extinguisher maintenance documentation was available for review and acknowledged the aforementioned ground floor portable fire extinguishers did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to inspect 2 of 30 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In</p>						

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	<p>addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect ten residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Assistant Director of Maintenance during a tour of the facility from 10:45 a.m. to 12:50 p.m. on 08/20/15, the annual maintenance tag attached to the portable fire extinguisher located in the Rehab Room on the ground floor and the portable fire extinguisher in the elevator machine room in the Main Mechanical Room on the ground floor each indicated a monthly inspection was not documented for October 2014 through July 2015. Based on interview at the time of the observations, the Assistant Director of Maintenance stated no additional documentation of monthly fire extinguisher checks was available for review and acknowledged a monthly inspection for the aforementioned two ground floor portable fire extinguisher</p>			

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	locations was not documented for October 2014 through July 2015. 3.1-19(b)				