

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2012
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NAME OF PROVIDER OR SUPPLIER  ST ANTHONY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/27/12</p> <p>Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist and Robert Sutton, Trainee</p> <p>At this Life Safety Code survey, St. Anthony Home was found not in compliance with Requirements for Participation in Medicare/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 three story facility with a</p>	K0000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p>	

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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	<p>partial basement was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in 177 resident rooms. Resident rooms 305, 327 and 371 have battery powered smoke detectors. The facility has the capacity for 186 and had a census of 176 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/05/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 6 third floor smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 39 residents in the third floor B and C smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 08/27/12 between 11:45 a.m. and 3:35 p.m., doors to rooms 327 and 352 failed to latch when tested twice with the maintenance</p>	K0018	<p>1.1 The hinge for the door to room 327 was tightened on 8/27/12, allowing the door to latch. The skin on the door to room 352 was removed on 8/27/12, allowing the door to latch. The double door set providing access to the third floor Physical Therapy department and exit corridor was replaced with doors that latch into door frame allowing the second door to latch into the first door to meet the criteria the week of 9/17/12.</p> <p>1.2 All other doors protecting corridor openings were inspected by Plant Operations to ensure they latched into the door frame on 8/27/12 with no other deficiencies noted at that time.</p> <p>1.3 The Maintenance Director will re-in-service Maintenance and related departmental staff regarding need for doors</p>	09/26/2012

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	<p>director. The maintenance director said at the time of observation, the hinges were malfunctioning and the doors were hitting the door frames.</p> <p>b. Based on observation with the maintenance director on 08/27/12 at 12:20 p.m. the third floor double door set providing access to the third floor Physical Therapy department and exit corridor required one door to latch into the door frame before the second door would latch into the first door to secure them both tightly into the door frame. The maintenance supervisor acknowledged at the time of observations, each door could not latch independently into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings in 2 of 6 third floor smoke compartments. This deficient practice affects staff, visitors and 39 residents in the third floor B and C smoke</p>		<p>protecting corridor openings to latch into the door frame by 9/19/12. The Maintenance Director / designee will inspect five random doors protecting corridor openings per unit weekly to ensure they latch into the door frame for six months beginning the week of 9/17/12.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p> <p>2.1 The wedge was immediately removed from the door to room 340. The wooden desk was immediately removed from the path of the door to room 346.</p> <p>2.2 All doors protecting corridor openings were inspected on 8/27/12 for impediments to closing with any other deficiencies noted corrected at that time.</p> <p>2.3 The Maintenance Director / designee will re-in-service Maintenance and related departmental staff regarding ensuring there are no impediments to closing doors that protect corridor openings by 9/19/12. Maintenance Director /</p>		

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	<p>compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 08/27/12 at 12:10 p.m., the door to room 340 was prevented from closing by a wooden wedge. The maintenance director removed the wedge at the time of observation and commented the practice was not permitted.</p> <p>b. Based on observation with the maintenance director on 08/27/12 at 12:10 p.m., the door to room 346 was prevented from closing by a wooden desk which stood in the path of the door's swing. The door gapped 24 inches when it hit the desk and would not close. The maintenance director acknowledged at the time of observation, the desk kept the door from closing.</p> <p>3.1-19(b)</p>		<p>designee will inspect five random doors protecting corridor openings per unit weekly for impediments for six months beginning the week of 9/17/12.</p> <p>2.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>2.5 Systemic changes will be completed by 9/26/12.</p>		

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K0022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 paths in the exit means of egress from the second floor chapel viewing room were clearly identified. This deficient practice affects visitors, staff and 30 or more residents in the chapel.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 2:10 p.m., an exit sign was not visible from the second floor chapel viewing room. Emergency exiting from the room required travel through a short corridor with door openings on each side, including faux storm doors to enter a main corridor which had marked exits at each end. There was no sign to direct occupants to the main corridor where emergency exits were identified. The maintenance director acknowledged an exit</p>	K0022	<p>1.1 An additional exit sign to be visible from the second floor chapel viewing room was ordered on 8/27/12 and installed by 9/14/12.</p> <p>1.2 All facility exits were reviewed to ensure visibility of exit signs by 8/27/12 with no other deficiencies noted at that time.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance staff regarding the need for exit means of egress to be clearly identified by 9/19/12. Maintenance Director / designee will inspect facility exits monthly for six months beginning September 2012 to ensure exit means of egress are clearly identified.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>	09/26/2012

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	<p>sign could prevent confusion in the event of an emergency.</p> <p>3.1-19(b)</p>				

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure a door in 1 of 5 third floor smoke barrier door sets would close to maintain a 20 minute smoke barrier. This deficient practice could affect staff, visitors, and 24 residents on 3A.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 1:10 p.m., one door in the third floor A hall smoke barrier double door set failed to close when tested twice to ensure its proper operation. The door coordinator on the door frame held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving an six inch</p>	K0027	<p>1.1 Regarding the third floor A hall double doors, the door coordinator was repaired on 8/27/12.</p> <p>1.2 All facility smoke barrier doors with coordinators were inspected for proper functioning by 8/27/12 with no other deficiencies noted at that time.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance staff regarding the need for smoke barrier doors to close / proper operation of door coordinators by 9/19/12. Maintenance Director / designee will inspect facility doors with coordinators weekly for six months beginning the week of 9/17/12 to ensure proper closure / proper operation of door coordinators.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and</p>	09/26/2012			

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	gap. The maintenance director acknowledged at the time of observations, the coordinator was malfunctioning.  3.1-19(b)		determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 9/26/12.		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 kitchen door sets closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed to resist the passage of smoke. This deficient practice affects visitors, staff and 40 residents in the South Hall and 23 or more residents in the first floor dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 3:15 p.m., the double doors between the kitchen</p>	K0029	<p>1.1 The double doors between the kitchen and first floor dining room were adjusted to self-latch and self-close on 8/27/12; the vendor was contacted on 8/28/12 and scheduled to provide onsite evaluation with alternate hinges ordered and scheduled for installation to ensure sustainable compliance. The door between the kitchen and dish room was adjusted on 8/27/12.</p> <p>1.2 All other applicable facility doors were checked to ensure they self-latched and self-closed, and those doors to hazardous areas checked to ensure they latched in the door frame when closed by 8/27/12 with no other deficiencies noted at that time.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance staff regarding the need for applicable doors to self-latch and self-close, and those doors to hazardous areas latch in the door frame when closed by 9/19/12.</p>	09/26/2012	

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	<p>and first floor dining room were not equipped with self closers or automatic door closers and a positive latch. The deadbolt in the double doors had to be turned manually to secure the doors into their door frames. The door between the kitchen and dish room did not self close. The maintenance director acknowledged at the time of observations, the doors did not self close and latch.</p> <p>3.1-19(b)</p>		<p>Maintenance Director / designee will inspect applicable facility doors for same bi-weekly for six months beginning the week of 9/17/12.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>		

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K0034 SS=E	<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> <p>Based on observation and interview, the facility failed to ensure 1 of 6 exit stairways were separated from an enclosed usable space by the two hour fire resistance of the stairway exit enclosure. The exception to LSC 7.2.2.5.3 permits enclosed usable space under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the stair enclosure. LSC 7.2.1.8 requires doors normally required to be kept closed shall be self closing or automatic closing. Entrance to such enclosed usable space shall not be from within the stair enclosure. This deficient practice affects visitors, staff, and 44 residents on 3C and 2C.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 2:55 p.m., the enclosed space under the first floor exit stairway near the</p>	K0034	<p>1.1 Corporate Architect / Director of Building and Construction identified vendors and they were contacted the week of 8/27/12 regarding closing the opening for compliance with the standard. Determined the door separating the space from the stairway exit will be removed along with its frame and the opening closed with appropriately fire rated masonry materials by 9/26/12.</p> <p>1.2 All other exit stairways were assessed on 8/27/12 and all non-compliant doors identified. It was determined that these doors and their frames will also be removed and these openings will also be closed with appropriately fire rated masonry materials by 9/26/12.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance staff regarding doors separating the space from the stairway exits having appropriate fire ratings and self-closures by 9/19/12. Maintenance Director / designee will inspect exit stairways for same weekly for six months beginning week of 9/17/12 until bricked.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6)</p>	09/26/2012	

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	<p>reception desk was used for miscellaneous storage. The door separating the space from the stairway exit had no fire rating, no self closer and opened into the stair enclosure opening. A vent opening in the door had been sealed with a piece of plywood which had nothing to hold it securely into the original vent opening and could be easily pushed out. The maintenance director said at the time of observation, he did not know the door opening did not meet the requirements for the exit stairway.</p> <p>3.1-19(b)</p>		<p>months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>		

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K0038 SS=E	<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> <p>Based on observation and interview, the facility failed to ensure 2 of 3 first floor chapel exits were unobstructed. LSC 7.2.1.4 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff, and 30 or more residents in the first floor chapel.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 3:05 p.m., two exit doors from the first floor chapel led to two outside exit doors. The doors to the two outside exit discharges were both damaged and required the full force of ones body weight to open the doors. The maintenance director acknowledged at the time of observation, the doors providing the means to exit were in bad</p>	K0038	<p>1.1 The chapel doors to the two outside exit doors were repaired on 8/27/12 to ensure they operate in accordance with LSC 7.2.1.4.</p> <p>1.2 All chapel doors were inspected to ensure they were unobstructed with free egress and that they operated in accordance with LSC 7.2.1.4 with no other deficiencies noted at that time.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance staff regarding exit doors being unobstructed with free egress by 9/19/12. Maintenance Director / designee will audit all chapel doors for same bi-weekly for six months beginning week of 9/17/12.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>	09/26/2012			

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	<p>condition. He provided documentation of approval for their replacement on 08/27/12 at 3:45 p.m., but the doors had not been ordered yet.</p> <p>3.1-19(b)</p>			

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 176 of 176 residents. This deficient practice could affect occupants in all areas.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 between 11:45 a.m. and 3:30 p.m., hard wired smoke detectors were installed in 177 resident rooms and battery powered smoke detectors were installed in resident rooms 305, 327 and 371. All resident room smoke detectors activated a local alarm only which could be heard inside each resident room and the adjoining corridor if the door were open. Based on review of the facility's Fire Guidelines with the maintenance director on 08/27/12 at 3:50 p.m., there was</p>	K0048	<p>1.1 Safety committee designees met the week of 8/27/12 to develop a written plan for staff response to resident room smoke detectors and schedule training staff to implement same.</p> <p>1.2 Safety committee designees reviewed the orientation program and the annual education calendar and updated same to include the above.</p> <p>1.3 The Maintenance Director / designee will inservice staff regarding written plan for staff response to resident room smoke detectors by 9/26/12. Once current staff has been inserviced, Maintenance Director / designee will conduct monthly audits of all new hire records to ensure orientation including above written plan is completed for six months beginning September 2012.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>	09/26/2012	

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	<p>no procedure specific for response to the local alarms from resident room smoke detectors and no training specific to response to the alarms was found. The maintenance director acknowledged at the time of record review, staff training would familiarize staff to the necessary procedures and the sound of the alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p>			

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K0062 SS=E	<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>Based on observation and interview, the facility failed to ensure the mesh provided for curtains installed in 2 of 6 second floor smoke compartments was at least 1/2 inch diagonal mesh or a 70 percent open weave extending 18 inches below the sprinkler deflectors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. This deficient practice could affect visitors, staff and 47 residents in the 2A and 2C smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 08/27/12 between 1:25 p.m. and 2:50 p.m., two privacy curtains hanging in the 2A tub room and the privacy curtain in C270 lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflectors. The</p>	K0062	<p>1.1 Facility collaborated with identified vendor to locate and order privacy curtains with mesh compliant with NFPA 13 to replace the two privacy curtains in the 2A tub room and the privacy curtain in C270 (expected arrival by 9/26/12).</p> <p>1.2 Facility assessed all other privacy curtains for mesh compliant with NFPA 13 with replacement curtains ordered to replace same if identified (expected arrival by 9/26/12).</p> <p>1.3 The Maintenance Director / designee will re-inservice Maintenance staff regarding privacy curtains with at least 1/2 inch diagonal mesh or 70% open weave top panel extending 18 inches below sprinkler deflectors by 9/19/12. Maintenance Director / designee will conduct monthly audits of all privacy curtains for six months beginning September 2012.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring /</p>	09/26/2012			

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	<p>maintenance supervisor acknowledged at the time of observations, the mesh was less than the minimum size permitted.</p> <p>3.1-19(b)</p>		<p>action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>		

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, interview, and record review; the facility failed to ensure 1 of 1 designated smoking areas was provided with a self closing metal container for ashtray waste disposal. This deficient practice affects visitors, staff and 4 or more residents who might make use of the smoking area.</p> <p>Findings include:</p>	K0066	<p>1.1 Facility initiated research for a metal container with a self-closing lid into which ashtrays could be emptied week of 8/27/12. Appropriate receptacles identified, ordered and installed week of 9/10/12 to replace existing receptacle.</p> <p>1.2 There are no other designated smoking areas.</p> <p>1.3 The Maintenance Director / designee will re-inservice Maintenance staff regarding need for use of a metal container with a self-closing lid into which ashtrays could be emptied in the designated smoking area by</p>	09/26/2012	

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	<p>Based on observation with the maintenance director on 08/27/12 at 2:35 p.m., a designated smoking area outside a first floor exit had no metal container with a self closing lid into which ash trays could be emptied. The butts were discarded into open metal containers and an open trash can was located in the area. The maintenance director said at the time of observation, he was unaware the self closing can was missing.</p> <p>3.1-19(b)</p>		<p>9/19/12. Maintenance Director / designee will conduct bi-weekly inspections of designated smoking area receptacles beginning week of 9/17/12 for six months beginning September 2012.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage room was separated by construction with a one hour fire-resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. Furthermore, sprinklered hazardous areas such as the oxygen storage rooms are required to be equipped with self closing doors with a minimum 45 minute fire rating which latch. This deficient practice affects staff, visitors and 21 residents in the 3C smoke compartment.</p>	K0076	<p>1.1 On 8/27/12 an alternate area was identified in same hallway that meets the NFPA 99 fire-rating requirements for oxygen storage room.</p> <p>1.2 There are no other oxygen supply and transfer rooms.</p> <p>1.3 Maintenance Director / designee will re-inservice Maintenance staff regarding door fire-rating requirements for oxygen supply and transfer rooms by 9/19/12. Oxygen supply and transfer room was relocated to room with door with appropriate fire rating week of 9/17/12.</p> <p>1.4 Oxygen supply and transfer room was relocated to room with door with appropriate fire rating week of 9/17/12.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>	09/26/2012

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 12:40 p.m., seven liquid oxygen supply containers and nine small oxygen cylinders were stored in the oxygen supply and transfer room. There was a 20 minute fire rating label on the door and door frame. The maintenance director said at the time of observation, he did not know the door did not meet the minimum 45 minute rating for the one hour sprinklered enclosure.</p> <p>3.1-19(b)</p>				

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors, and 21 residents in the 3C smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 at 12:40 p.m., seven liquid oxygen supply containers and nine small oxygen cylinders were stored in the oxygen supply and transfer room. There was a</p>	K0143	<p>1.1 On 8/27/12 an alternate area was identified in same hallway that meets the NFPA 99 fire-rating requirements for oxygen storage room.</p> <p>1.2 There are no other oxygen supply and transfer rooms.</p> <p>1.3 The Maintenance Director / designee will re-inservice Maintenance staff regarding door fire-rating requirements for oxygen supply and transfer rooms by 9/19/12. Oxygen supply and transfer room was relocated to room with door with appropriate fire rating week of 9/17/12.</p> <p>1.4 Oxygen supply and transfer room was relocated to room with door with appropriate fire rating week of 9/17/12</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>	09/26/2012

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	<p>20 minute fire rating label on the door and door frame. The maintenance director said at the time of observation, he did not know the door did not meet the minimum 45 minute rating for the one hour sprinklered enclosure.</p> <p>3.1-19(b)</p>				

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on interview and record review, the facility failed to provide complete documentation for inspecting the batteries for 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and</p>	K0144	<p>1.1 On 8/28/12 a battery inspection for the emergency generator was completed and documented including inspection of storage batteries used for generator with no issues noted.</p> <p>1.2 Scheduled weekly documented battery inspections for the emergency generator as part of weekly generator testing re-implemented the week of 9/3/12.</p> <p>1.3 The Maintenance Director / designee will re-inservice Maintenance staff regarding scheduled weekly documented battery inspections for the emergency generator as part of weekly generator testing by 9/19/12. Maintenance Director / designee will conduct weekly audits of scheduled weekly documented battery inspections for the emergency generator to ensure completed beginning week of 9/17/12 for six months beginning September 2012.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring /</p>	09/26/2012	

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	<p>available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the emergency Generator Check Weekly inspection with the maintenance director on 08/27/12 at 4:00 p.m., documentation of weekly battery inspections for the emergency generator was not found since 05/07/12. The maintenance director said at the time of record review, his staff were required to do the weekly checks and document them. He was unaware they had not been documented since May.</p> <p>3.1-19(b)</p>		<p>action is necessary for continued compliance.</p> <p>1.5 Systemic changes will be completed by 9/26/12.</p>		

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords 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 could affect staff, visitors and 21 residents in the 3C smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/27/12 between 11:45 a.m. and 3:30 p.m., power strip extension cords were used to power medical equipment such as the oxygen concentrator in room 374, and located on the resident's bedside walls to power appliances in rooms 370 and 371. The maintenance director acknowledged the power strips</p>	K0147	<p>1.1 On 8/27/12 the oxygen concentrator in room 374 was removed from the power strip extension cord and plugged into the wall outlet. The power strip extension cords in rooms 370 and 371 were removed from the resident's bedside walls on 8/27/12.</p> <p>1.2 By 8/28/12 the Maintenance Department performed rounds of all resident rooms to ensure appropriate use of power strip extension cords with any deficiencies noted corrected at that time.</p> <p>1.3 The Maintenance Director will re-inservice Maintenance and related departmental staff regarding appropriate use of power strip extension cords by 9/19/12. Maintenance Director / designee will inspect five random resident rooms per unit weekly for six months beginning the week of 9/17/12 to ensure appropriate use of power strip extension cords.</p> <p>1.4 The Maintenance Director / designee will report audit findings to the Quality Assurance (QA) Committee monthly for six (6) months with the next meeting held in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued</p>	09/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/27/2012
NAME OF PROVIDER OR SUPPLIER  ST ANTHONY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307		
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	were used in a manner which violated the facility's policy.  3.1-19(b)		compliance. 1.5 Systemic changes will be completed by 9/26/12.		