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 01/08/2015
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

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K010000	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). Survey Date: 01/08/15 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 Surveyor: Bridget Brown, Life Safety Code Specialist 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. This three story facility with a 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 resident rooms. The	K010000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	facility has the capacity for 189 and had a census of 172 at the time of this survey. All areas where residents have customary access were sprinklered except those cited at K56. All areas providing facility services were sprinklered. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K010017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 5 third floor use areas was separated from the corridors by a partition capable of	K010017	1.1 Vendor was contacted on 1/8/15 regarding electronic supervision element of the 3A dining room smoke detection system; vendor came on 1/9/15 to	01/23/2015

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	resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect visitors, staff and 24 residents on 3A. Findings include: Based on observation with the Director of Plant OPs on 01/08/15 at 1:00 p.m., the 3A dining room was open to the corridor. The corridor was protected by an electrically supervised automatic detection system but the 3A dining room lacked protection from an electrically supervised automatic smoke detection system. The Director of Plant OPs acknowledged the aforementioned observation. 3.1-19(b)		assess equipment needed to complete update to the system. 1.2 Automatic smoke detector systems within the facility were assessed to ensure appropriate electronic supervision elements in place, with any other deficiencies noted addressed. 1.3 The Director of Plant Operations / designee re-inserviced the Plant Operations Department regarding the need for automatic smoke detector systems to have the appropriate electronic supervision elements in place. Director of Plant Operations / designee will audit five (5) automatic smoke detector systems per unit per month for nine (9) months to ensure compliance. 1.4 Director of Plant Operations / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 1/23/15.	

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K010038 SS=E	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 Based on observation and interview, the facility failed to ensure 2 of 3 activity room exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 20 or more residents in the activity room. Findings include: Based on observation with the Director of Plant Ops on 01/08/15 at 2:10 p.m., two exit discharge surfaces for the activities room were snow covered The Director of Plant Ops acknowledged at the time of observations, the discharge surface was slippery, irregular and a potential trip hazard for anyone using these emergency exits.	K010038	1.1 The identified two exits immediately had the snow removed on 1/8/15. 1.2 Other exits within the facility were assessed to ensure clear of snow, with any other deficiencies noted addressed. Director of Plant Operations met with contracted snow removal vendor on 1/9/15 regarding need to ensure all exits are clear of snow as part of their service to the facility. 1.3 The Director of Plant Operations / designee re-inserviced the Plant Operations Department regarding the need for exits to be clear of snow. Director of Plant Operations / designee will audit five (5) exits weekly for nine (9) months to ensure compliance. 1.4 Director of Plant Operations / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be	01/23/2015

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	3.1-19(b)		completed by 1/23/15.	
K010054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors located in the first floor fitness room and connected to the fire alarm system was properly separated from an air supply or return vent. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff and 6 or more residents in the fitness room. Findings include:	K010054	1.1 The Director of Plant Operations / designee contacted vendor on 1/9/15 who visited to assess the materials needed to deflect / redirect the air away from the smoke heads. 1.2 Other smoke detectors in the facility were assessed for placement near air return vents with no other deficiencies noted. 1.3 The Director of Plant Operations / designee re-inserviced the Plant Operations Department regarding the need for smoke detectors to be located away from air return vents. Director of Plant Operations / designee will audit five (5) smoke detectors per unit to ensure air is being deflected / redirected from smoke heads weekly for nine (9) months to	01/23/2015

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	Based on observation with the Director of Plant Ops on 01/08/15 at 2:15 p.m., a smoke detector in the first floor fitness room was located 12 inches from an air return vent. The Director acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function. 3.1-19(b)		ensure compliance. 1.4 Director of Plant Operations / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 1/23/15.	
K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5			
	Based on record review, observation and interview; the facility failed to ensure 2 of 8 resident shower rooms were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect any staff or visitor in the vicinity of the kitchen freezer.	K010056	1.1 The Director of Plant Operations / designee contacted vendor on 1/9/15 to schedule installation of sprinkler heads in the 2A and 3A shower rooms. 1.2 Other shower rooms in the facility were assessed for presence of sprinkler heads with no other deficiencies noted. 1.3 The Director of Plant	01/23/2015

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	Findings include: Based on observation with the Director of Plant OPs on 01/08/15 between 11:45 a.m. and 3:45 p.m., sprinkler coverage was not provided in a shower stall in the 3A and 2A showers. The Director of Plant OPs acknowledged at the time of observations other sprinklers in these shower rooms could not protect the aforementioned shower stalls. 3.1-19(b) 3.1-19(ff)		Operations / designee re-inserviced the Plant Operations Department regarding the need for shower rooms to have sprinkler heads present. Director of Plant Operations / designee will audit 50% (four) of total shower rooms to ensure sprinkler heads present monthly for nine (9) months to ensure compliance. 1.4 Director of Plant Operations / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 1/23/15.	
K010062 SS=F	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 1. Based on observation and interview, the facility failed to ensure sprinkler valves and components for 1 of 1 automatic sprinkler systems were maintained accessible and free of obstructions . NFPA 25, 1-4.1 requires the owner shall provide ready accessibility to components of water	K010062	1.1 Regarding the sprinkler riser and valve, the area was immediately cleared so it was accessible and free of obstructions. Regarding the sprinkler head escutcheons identified as missing or loose, all were immediately repaired. 1.2 Other sprinkler heads in the facility were assessed for	01/23/2015

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	based fire protection systems that require inspection, testing or maintenance. This deficient practice affects all occupants. Findings include: Based on observation with the Director of Plant Ops on 01/08/15 at 2:45 p.m., a sprinkler riser and valve for the automatic sprinkler system was located in a room designated for dietary storage. Boxes of supplies were stacked six feet high immediately in front of the sprinkler valve using the protruding part of the valve to hold the boxes upright. Other storage was immediately adjacent to the valve and would have to be cleared to operate, maintain, or test the valve. The Director of Plant Op agreed at the time of observation, the sprinkler valve and pipes were inaccessible and subject to damage. 3.1-19(b) 2. Based on observation, the facility failed to ensure sprinkler heads providing protection for 6 of 6 smoke compartments were maintained. This deficient practice could affect all kitchen staff, visitors and 10 or more residents on the third floor Findings include:		presence of escutcheons with any deficiencies noted corrected at that time. 1.3 The Director of Plant Operations / Dining Services Manager / designee re-inserviced Plant Operations Department and Dining Department of the need to ensure sprinkler riser and valve areas are accessible and free of obstructions. The Director of Plant Operations / designee re-inserviced the Plant Operations Department regarding the need for sprinkler heads to have escutcheons in place / in proper condition. Dining Services Manager / designee will audit the sprinkler riser and valve area for compliance weekly for nine (9) months. Director of Plant Operations / designee will audit five (5) sprinkler heads per unit to ensure escutcheons present and in proper condition weekly for nine (9) months to ensure compliance. 1.4 Director of Plant Operations / Dining Services Manager / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 1/23/15.	

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	Based on observation with the Director of Plant Ops on 01/08/15 between 11:45 a.m. and 3:45 p.m., sprinkler head escutcheons were missing and /or displaced leaving a gaps of 1/2 inch into the spaces above: a. Missing, on the third floor In the center core medicine room and medical storage room; b. Missing In the corridor near room 392; c. Falling off the sidewall sprinkler in freezer number 1 in the kitchen. Th Director of Plant Ops acknowledged , at the times of observations these sprinker assemblies were not complete. 3.1-19(b)			

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K010069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 commercial cooking appliances was protected by the commercial extinguishing system. NFPA 96, 7-2.2 requires automatic fire extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could visitors, staff and 20 or more residents in the adjacent dining room. Findings include: Based on observation of the commercial kitchen range hood protection system with the Director of Plant OPs on 01/08/15 at 3:00 p.m., protection was not provided for the tilt skillet which was located under another hood which had no hood protection system. The Director of Plant OPs acknowledged at the tithe time of observation the tilt skillet was in an unprotected area. 3.1-19(b)	K010069	1.1 Regarding the range hood protection system for the tilt skillet, the Director of Plant Operations / designee contacted the appropriate vendor on 1/8/15 to schedule installation of same. 1.2 Other commercial cooking appliances in the facility were assessed for presence of a range hood protection system with no other deficiencies noted. 1.3 The Director of Plant Operations / Dining Services Manager / designee re-inserviced the Plant Operations Department and Dining Department regarding the need for commercial cooking appliances to have a range hood protection system present. Dining Manager / designee will audit the tile skillet daily during meal preparations for appropriate usage (i.e., no frying) until installation of range hood protection (anticipated by 1/20/15). 1.4 Dining Manager / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.	01/23/2015

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K010147 SS=B	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 flexible cords were not used as a substitute for fixed wiring on 1 of 3 floors. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 visitors, staff and 20 or more residents on the third floor. Findings include: Based on observation Director of Plant Ops on 01/08/15 at between 11:45 a.m. and 3:45 p.m., power strip extension cords were used to supply power in	K010147	1.1 Director of Plant Operations / designee corrected the placement / use of the identified power strip extension cords immediately on 1/8/15. 1.2 Other resident rooms were assessed for proper placement / use of power strip extension cords with any deficiencies noted immediately corrected. 1.3 The Director of Plant Operations / designee re-inserviced the Plant Operations Department regarding proper placement and use of power strip extension cords. Director of Plant Operations / designee will audit five (5) rooms per unit for proper placement and use of power strip extension cords weekly for nine (9) months to ensure compliance. 1.4 Director of Plant Operations /	01/23/2015

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	resident room 305 A to a microwave and under the head of the bed in resident room 350. The director of Plant Ops acknowledged the use of power strips in these rooms at the time of observations. 3.1-19(b)		designee will report audit findings to the QAPI committee monthly for nine (9) months beginning January 2015. The QAPI committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Systemic changes will be completed by 1/23/15.	