STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155604	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
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: 02/24/14 Facility Number: 000535 Provider Number: 155604 AIM Number: 100267250 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Saint Anthony Rehab and Nursing Center 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident	K010000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **St. Anthony Rehab and Nursing Center, Inc.** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	

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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	rooms and in spaces open to the corridors. The facility has a capacity of 120 and a census of 95 at the time of this survey. All areas where the residents have customary access were sprinklered. A detached garage and two wood sheds for equipment storage were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/03/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	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 Roller latches are prohibited by CMS regulations in all health care facilities.			

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	Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 7 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the Twin Gardens and dining room smoke compartments. Findings include: a. Based on observation with the Director of Plant Operations on 02/24/14 at 12:30 p.m., the double door set providing access to the electrical room near room 148 had positive latching doors. The latch for the inactive door however, had to be manually set to secure the door into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. b. Based on observation with the Director of Plant Operations on 02/24/14 at 2:35 p.m., the double door set providing access to the copy/ electrical room had slide bolt latches at the top and bottom of the inactive door to secure it into the door frame. This required the inactive door to be manually latched into the door frame before the second door would latch into the first door and secure them both	K010018	**K018 NFPA LIFE SAFETY CODE STANDARD** I. Vendor was contacted to make needed repairs to identified room doors to ensure that they automatically latch into the door frame. Doors are scheduled for repairs on 3/13/14. II. All other doors protecting corridor openings in smoke compartments were inspected to ensure compliance. III. Plant Operation or designee will conduct monthly inspections of all other doors protecting corridor openings in smoke compartments to ensure compliance. IV. Maintenance department will add inspection of doors to their Monthly Preventive Maintenance Task Sheet. Task Sheet will be reviewed by the Quality Assurance committee monthly for three months to determine if deficient practice is corrected. Audits will continue at the discretion of the QA committee. V. Date of completion: March 26, 2014	03/26/2014

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	tightly into the door frame. The Director of Plant Operations acknowledged at the time of observations, each door could not latch independently into the door frame. 3.1-19(b)			
K010029 SS=E	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 Based on observation and interview, the facility failed to provide automatic latching on self closing doors providing access to 1 of 8 hazardous areas such as a rooms storing soiled linens and trash in excess of 32 gallons. Sprinklered hazardous areas are required to be	K010029	**K029 NFPA LIFE SAFETY CODE STANDARD** I. Vendor was contacted to make repairs to Twin Garden shower room door. Door is scheduled for repair on 3/13/14. II. All other shower room doors were inspected for proper door closer and latch. III. Plant Operation or designee will	03/26/2014

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	equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the Twin Gardens unit. Findings include: Based on observation with the Director of Plant Operations on 02/24/14 at 1:45 p.m., the door separating the Twin Gardens shower room, used for the collection of two, 50 gallon barrels which were three quarters full of soiled linen and trash, failed to latch automatically when the door self closed. The door was tested twice. The Director of Plant Operations acknowledged at the time of observation, the door had not latched when self closing. 3.1-19(b)		conduct monthly inspections of all shower room doors to ensure compliance. IV. Maintenance department will add inspection of doors to their Monthly Preventive Maintenance Task Sheet. Task Sheet will be reviewed by the Quality Assurance committee monthly for three months to determine if deficient practice is corrected. Audits will continue at the discretion of the QA committee. V. Date of completion: March 26, 2014	
K010044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 8 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with	K010044	**K044 NFPA LIFE SAFETY CODE STANDARD** I. Maintenance adjusted noted fire door in the set near the pastoral office to ensure it properly latched. II. All other Fire doors were checked for proper closer	03/26/2014

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	7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff, and 10 or more residents in this lobby and dining room smoke compartment. Findings include: Based on observation with the Director of Plant Operations on 02/24/14 at 1:40 p.m., the fire door set near the pastoral office was tested three times with the Director of Plant Operations. One door in the fire door set failed to latch each time the doors were released to close, and again at 2:10 p.m. when the fire alarm was activated. The Director of Plant Operations acknowledged at the times of observation, the doors failed to latch. 3.1-19(b)		and latching. III. Director of Plant Operation or designee will conduct biweekly inspections of all fire doors, concerning proper closer and latching function. IV. Maintenance department will inspect fire corridor doors bi-weekly to ensure proper latching. Inspection reports will be reviewed by the Quality Assurance committee monthly. Audits will continue at the discretion of the QA committee. V. Date of completion: March 26, 2014	
K010064 SS=D	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 Based on observation and interview, the	K010064	**K064 NFPA LIFE SAFETY**	03/26/2014

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	facility failed to maintain 1 of 2 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 using combustible 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 4 kitchen staff, visitors and any residents in the adjacent dining room. Findings include: Based on observation on 02/24/14 at 2:05 p.m. with the Director of Plant Operations, a placard was not posted near the K-class fire extinguisher in the kitchen. The Director of Plant Operations acknowledged at the time of		**CODE STANDARD**I. New sign above K-class fire extinguisher has been installed. II. There are no other K-class fire extinguishers located in the facility.III. Maintenance department will add inspection of sign to their Monthly Dietary Inspection Task Sheet. IV. Task Sheet will be reviewed by the Quality Assurance committee monthly for three months to determine if deficient practice is corrected. Audits will continue at the discretion of the QA committee.V. Date of completion: March 26, 2014	

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	observation, there was no placard. 3.1-19(b)			
K010147 SS=E	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 in 1 of 7 smoke compartments. NFPA 70, 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 visitors, staff, and 10 or more residents in the activity room smoke compartment Findings include: Based on observation with the Director of Plant Operations on 02/24/14 at 1:00 p.m., a power strip extension cord was	K010147	**K147 NFPA LIFE SAFETY CODE STANDARD**I. Power strip was removed from effected room and medical equipment was plugged directly into wall receptacle.II. Resident rooms were inspected for any medical equipment plugged into surge protectors. III. Staff were in-serviced on 3/06/14 concerning the importance of not having medical equipment plugged into surge protectors. New employees will be educated at time of their hire.IV. Maintenance department will inspect residents' rooms monthly for any use of surge protectors with medical equipment. This inspection will be added to their Monthly Preventive Maintenance Task Sheet. Task Sheet will be reviewed by the Quality	03/26/2014

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	used to charge medical equipment in resident room D134. The Director of Plant Operations acknowledged at the time of observation, the powerstrip was in use for multiple medical devices. 3.1-19(b)		Assurance committee monthly for three months to determine if deficient practice is corrected. Audits will continue at the discretion of the QA committee.V. Date of completion: March 26, 2014	