

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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	<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: 06/06/13</p> <p>Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St. Paul Hermitage 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 except for the kitchenette storage room.</p>	K010000		
---------	---	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107		
(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	
	<p>Building 0102 had hard wired smoke detectors located near smoke barriers and in all resident sleeping rooms. Building 0202 consisting of the first floor of the partially 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 therapy 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 44 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered except for the chapel on the first floor of Building 0202 and the center elevator hoistway for Building 0202. The facility has one detached garage providing facility storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K010038 SS=D	<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 1 of over 100 corridor room doors did not require more than one releasing operation to open. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 2 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the entry door to the Activities Director's Office in the Main Dining Room has two locks on the door and a key was needed to unlock each lock on</p>	K010038	The deadbolt lock has been removed and the resulting hole repaired.	06/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned door required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 kitchenette storage rooms with a sliding door in the Main Dining Room. This deficient practice could affect 30 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the kitchenette storage room with the sliding door in the Main Dining Room measured four feet in length by four feet in width and was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director acknowledged the</p>	K010056	Work is underway. See attached.	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107		
(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	
	aforementioned storage room was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms for Building 0102 was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect five residents, staff and visitors in the elevator in Building 0102 if the sprinkler system was activated in the south elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the elevator machine room for Building 0102 was provided with sprinkler protection and a heat detector but no evidence of shunt trip installation</p>	K010160	Waiver is requested. See attached.	07/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>was noted. Based on interview at the time of observation, the Maintenance Director stated the facility has sought shunt trip installation quotes but acknowledged a shunt trip for the elevator equipment room for Building 0102 has not been installed.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K010211 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 30 alcohol based hand sanitizers in resident sleeping rooms was not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 2 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, an alcohol based hand sanitizer was located approximately four inches above an electrical outlet in the bathroom</p>	K010211	ABHR dispenser has been removed from area above outlet and relocated to wall on the (R) side of the mirror and away from the receptacle.	06/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>for resident sleeping Room 130. The the aforementioned alcohol based hand sanitizer location had isopropyl alcohol listed as an ingredient on the packaging of the sanitizer. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned alcohol based hand sanitizer was installed over an ignition source.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K020018 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. Based on observation and interview, the facility failed to ensure 1 of over 25 corridor doors in the basement were provided with a means suitable for keeping the door closed. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the corridor door set to the basement receiving area was not provided with a latching mechanism. Based on interview at the time of observation, the Maintenance Director stated comprehensive care residents have</p>	K020018	Have contacted the company. Quote has been authorized as previously attached. Company is waiting for confirmation from the factory for needed parts. Will send as soon as I receive their confirmation.	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>customary access to the Therapy Room in the basement of Building 0202 and acknowledged the corridor door set to the basement receiving area was not provided with a latching mechanism.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
--------------------	--	---------------	---	----------------------

K020020 SS=E	<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.</p> <p>Based on observation, record review and interview; the facility failed to maintain a one hour fire resistance rating for 3 of 5 exit stairs. This deficient practice could affect 10 residents using the therapy room in the basement as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the stairwell access doors in the basement and on the first floor next to Room 101, Room 105 and Room 108 did not provide a fire resistance rating of one hour. Each of the aforementioned stairwell access doors was not equipped with fire resistance rating labeling. Based on review of facility blueprint documentation with the Maintenance Director at 2:00 p.m. on 06/06/13, the fire resistance rating of the aforementioned stairwell access doors was not available for review. Based on interview at the time of record review and of the</p>	K020020	Documentation is attached which shows that the doors in question comply with standards.	06/24/2013
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>observations, the Maintenance Director stated comprehensive care residents have customary access to the Chapel on the first floor and the Therapy Room in the basement of Building 0202 and acknowledged fire resistance rating documentation for the aforementioned stairwell access doors was not available for review.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
K020029 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>1. Based on observation and interview, the facility failed to ensure 1 of 11 hazardous areas such as the kitchen was separated from other spaces by smoke resisting partitions and doors. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the basement corridor by the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the kitchen was not separated from the basement corridor by smoke resisting partitions and doors. The kitchen entry door from the dietary office and the dietary office entry door from the basement corridor each had a louver on the lower half of the door which measured four feet high by three feet wide. Based</p>	K020029	Have contacted the company. Quote has been authorized as previously attached. Company is waiting for confirmation from the factory for needed parts. Will send as soon as I receive their confirmation.	07/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>on interview at the time of the observations, the Maintenance Director stated comprehensive care residents have customary access to the Therapy Room in the basement of Building 0202 and acknowledged the kitchen was not separated from the basement corridor because each of the aforementioned doors had a louver on the lower half of each door which was not a smoke resistant partition or door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 15 doors serving hazardous areas such as the kitchen were self closing and would latch into the door frame. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the basement corridor by the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the kitchen entry door from the basement corridor is not provided with a self closing device. The passageway from the basement corridor to the kitchen is through the dietary office and neither the dietary office entry door from the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>basement corridor or the kitchen entry door from the dietary office were equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Director stated comprehensive care residents have customary access to the Therapy Room in the basement of Building 0202 and acknowledged the kitchen entry door from the basement corridor is not provided with a self closing device.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K020033 SS=E	<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, record review and interview; the facility failed to maintain the vertical opening protection for 3 of 5 exit stairs. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the stairwell access doors in the basement and on the first floor next to Room 101, Room 105 and Room 108 did not provide a fire resistance rating of one hour for each of the three exit enclosures. Each of the aforementioned stairwell access doors was not equipped with fire resistance rating labeling. Based on review of facility blueprint documentation with the Maintenance Director at 2:00 p.m. on 06/06/13, the fire resistance rating</p>	K020033	Documentation is attached which indicates that the doors in question comply with standards.	06/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>of the aforementioned stairwell access doors was not available for review. Based on interview at the time of record review and of the observations, the Maintenance Director stated comprehensive care residents have customary access to the Chapel on the first floor and Therapy Room in the basement of Building 0202 and acknowledged the fire resistance rating of the aforementioned stairwell access doors was not available for review.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K020056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 chapels in Building 0202. This deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the chapel was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director stated comprehensive care residents have customary access to the chapel on the first floor in Building 0202 and acknowledged the chapel was not provided with automatic sprinklers.</p>	K020056	Work is underway. See attached.	08/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
	<p>3.1-19(b) 3.1-19(ff)</p> <p>2. Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 2 elevator machine rooms in Building 0202. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect five residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the center elevator equipment room in the third floor penthouse was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director stated comprehensive care residents have customary access to the center elevator in Building 0202 and acknowledged the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107		
(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	
	center elevator equipment room was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K020062 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 a complete automatic sprinkler system was maintained in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect ten residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the following was noted:</p> <p>a. a fifteen foot section of four inch sprinkler pipe in Supply Room 3 in the basement had one telephone cable attached to the sprinkler pipe.</p> <p>b. a ten foot section of two inch sprinkler pipe in the Laundry Room in the basement had two cables attached to the</p>	K020062	Telephone cable has been removed from the sprinkler pipe and attached to wall. Two cables have been removed from the sprinkler pipe and attached away from the sprinkler line.	06/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>sprinkler pipe.</p> <p>Based on interview at the time of the observations, the Maintenance Director stated comprehensive care residents have customary access to the Therapy Room in the basement for Building 0202 and acknowledged the aforementioned sprinkler pipe locations had cables attached to the sprinkler pipe.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013	
NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107			
(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			
K020160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 1 of 2 elevator equipment rooms for Building 0202 was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect five residents, staff and visitors in the north elevator in Building 0202 if the sprinkler system was activated in the north elevator equipment room in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:20 p.m. on 06/06/13, the north elevator equipment room in the basement for Building 0202 was provided with sprinkler protection</p>	K020160	Waiver is requested. See attached.	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST PAUL HERMITAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
---	--

(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
	<p>and a heat detector but no evidence of shunt trip installation was noted. Based on interview at the time of observation, the Maintenance Director stated the facility has sought shunt trip installation quotes but acknowledged a shunt trip for the aforementioned elevator equipment room has not been installed. In addition, the Maintenance Director stated comprehensive care residents have customary access to the north elevator in Building 0202.</p> <p>3.1-19(b)</p>			