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| 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 12/20/2011 | |
| NAME OF PROVIDER OR SUPPLIER ST ANTHONY HEALTH CARE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1205 N 14TH ST LAFAYETTE, IN47904 | | | |
| (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 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: 12/20/11</p> <p>Facility Number: 000535 Provider Number: 155604 AIM Number: 100267250</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St. Anthony Health Care 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 one story facility was determined to be of Type V (111) construction and was fully</p> | K0000 | <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, St. Anthony health Care does not admit that the deficiency listed on this form exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Facility 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.</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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| K0046 SS=C | <p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 120 and a census of 99 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review, and interview; the facility failed to provide complete test documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 10 of 10 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1</p> | K0046 | <p>K046 NFPA 101 Life Safety Code Standard No residents were indentified. All 10 battery powered emergency lighting fixtures were tested and documented. Environmental Director or designee will conduct monthly inspections of emergency lights and exit lights to ensure proper operation in accordance with NFPA 101 section 7.9. Any non-compliance issues will be addressed immediately. Monthly inspection form will be implemented concerning the inspection of all facility battery back- up emergency lights and exit lights. This inspection form will contain</p> | 01/20/2012 | |

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| | <p>1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Monthly Preventive Maintenance Checklists with the maintenance director on 12/20/11 at 12:50 p.m., the records to evidence testing of battery operated emergency light fixtures for the past year noted, "emergency lights" and a check. The maintenance director said at the time of record review this meant every light was tested and passed, however, there was no record for the testing of each emergency light, its location and a test result. The same was true for the 1 1/2 hour annual test. The maintenance director said at the time of review, she knew where all the lights were so a more detailed record had not been kept. The emergency lights were checked with the maintenance director on 12/20/11 between 1:15 p.m. and 3:20 p.m. and were all working.</p> <p>3.1-19(b)</p> | | <p>the date inspected, location of the unit, pass or fail status, repairs/correction made to the unit and initials of person completing the inspection and repairs. Results will be reviewed at monthly QA meeting for the next 3 months. Compliance date: 1-20-12</p> | | |

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| K0048 SS=E | <p>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</p> <p>Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> | K0048 | <p>K048 section 101 NAPA Life Safety Code Standard No residents were identified The use of the K class fire extinguisher was added to the Facility Fire Action Plan.The Environmental Director will do monthly audits of the Facility Fire Action Plan to ensure information is within accordance with NFPA 101 section 19.7.1. Any non-compliance issues will be addressed immediately. Results will be reviewed at the monthly QA meetings for the next 3 months and then annually thereafter. Compliance date: 12-20-11</p> | 01/20/2012 | |

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| | <p>Based on review of the facility Fire Prevention Policy Plan on 12/20/11 at 1:15 p.m. with the maintenance director, the Fire Action Plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, the K class fire extinguisher had not been included as part of the written plan.</p> <p>3.1-19(b)</p> | | | | |