

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  08/10/2012
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NAME OF PROVIDER OR SUPPLIER  ST PAUL HERMITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107
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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 Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/10/12</p> <p>Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this Quality Assurance Walk-thru survey, St. Paul Hermitage was found not in compliance with 410 IAC 16.2-3.1-19(ff)</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the resident rooms and areas open to the corridor. The facility has a capacity of 52 and had a census of 48 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p>	K0000		

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>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/22/12.</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler coverage throughout the facility before July 1, 2012. This deficient practice could affect any occupant within the facility.</p>	K9999	<p>1. The canvas awning on the patio outside the dining/activity room of the healthcare unit will be removed by 9/9/12. Any replacement will be of non-flammable material. 2. The Simplex-Grinnell company has been contacted to provide sprinkler coverage in the basement elevator machine room. Work will be completed by 9/9/12</p>	09/09/2012	