STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	12/30/2016

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

(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
K 0000 Bldg. 01	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: 12/29-30/16 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 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 2012 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 facility has the capacity for 189 and had a census of 156 at the time of this survey.	K 0000	St. Anthony Home - Crown Point ("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 finding: (1) are relied upon to adversely influence or serve as a basis, in any way, the selection and/or imposition of 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

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	Quality Review completed on 01/05/17 - DA			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure the penetration in 2 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical,	K 0131	1:1. The identified areas in need of fire stopping were repaired and brought to code immediately. 1:2. Director of Plant Operations/designee inspected other fire barrier walls for compliance with any additional areas corrected at that time. 1:3. A300, B327, C378, D309, A212 and B226 areas have all been properly fire stopped. The Director of Plant Operations in-serviced Plant Operations staff on 1-9-17 regarding the life safety standard for appropriate fire barriers/fire stopping for	01/29/2017

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	mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, *Standard Test Method for Fire Tests of Through Penetration Fire Stops*, or ANSI/UL 1479, *Standard for Fire Tests of Through-Penetration Fire Stops*. This deficient practice could affect staff and at least 75 residents. Findings include: Based on an observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 between 10:13 a.m. and 10:44 a.m., the following fire barriers had unsealed penetrations above the drop ceiling: a) three separate one inch gaps around wires in the resident room A300 fire barrier. Additionally, a three quarter inch gap around copper pipe. b) a two inch gap around conduit in the resident room B327 fire barrier c) a quarter inch gap around cables in the resident room C378 fire barrier d) a three quarter inch gap inside conduit in the resident room D390 fire barrier e) a two inch by two inch piece of		equipment that passes through fire barriers. The Construction and Renovation policy was reviewed to assure it clearly outlined this life safety requirement for internal/external workers. Contractors will be informed of fire stopping policy when completing work within the facility. Director of Plant Operations/designee will inspect all work where fire stopping could be compromised after each job is completed internally or externally to assure proper fire stopping has been completed per code. Director of Plant Operations/designee will randomly audit ten (10) fire barrier walls weekly for eight (8) weeks and then monthly for four (4) months for compliance. Any areas found deficient were corrected at that time 1:4. Director of Plant Operations/designee will report audit finding to the QAPI Committee meeting monthly for six (6) months beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 1:5. Systemic changes will be completed by 1-29-2017 2:1 The separation door between health care and assisted living was identified as not meeting code. New fire separation doors were ordered to meet code.	

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	drywall was missing in the resident room A212 fire barrier f) a quarter inch penetration around wires in the resident room B226 fire barrier Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition and provided the measurements. 3.1-19(b) Based on observation and interview, the facility failed to ensure 1 of 1 Health Care/ Assisted Living separation was protected. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies. Table 8.3.4.2 requires 2 hour fire rated walls and partitions to have fire door assemblies with a rating of at least 1 1/2 hours fire rating. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 2:57 p.m., the Health Care/ Assisted Living separation doors contained a fire resistance rating of 45 minutes. Based on interview at the		2:2 The 100% audit was conducted to ensure each door meets fire code. No other doors were identified. 2:3 Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related to fire doors and fire ratings. Bids were received and new fire rated doors were ordered 1-17-2017 and will be installed by vendor immediately upon receipt. 2:4 Once fire separation doors are installed, no further action will be warranted. 2:5 Systemic changes will be completed once doors are installed 1-29-2017.	

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	time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5			
	Based on observation and interview, the facility failed to ensure 1 of 6 2nd floor fire door sets were arranged to automatically close and latch. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80 6.1.4.3.1 states the fire door shall latch upon closing. This deficient could affect at least 10 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 1:20 p.m., the 2nd floor C Wing fire doors failed to latch. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1	K 0226	1. The identified door on 2C that failed to latch was ordered 1-17-2017 and will be replaced with new HM door to ensure self latching to meet fire code. 2. Director of Plant Operations/designee inspected all other fire doors and all latched properly per code. All fire door sets with automatic closing assemblies were inspected. No other doors were identified. 3. Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related to proper latching of fire doors. Audits of all fire doors will be conducted monthly by Plant Operations staff to assure fire doors shut properly per code. Any doors found non-compliant will be corrected at that time. Results of audit will be given to Director of Plant Operations. 4. Director of Plant Operations/designee will report	01/29/2017

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	confirmed the cross corridor doors were fire barrier doors and had 90 minute fire resistive labels. 3.1-19(b)		audit finding to the QAPI Committee meeting monthly beginning February 2017. The QAPI Committee will monitor data presented for any trends/recommendations. Auditing of fire doors will continue monthly through preventative maintenance policy. 5. Systemic changes will be completed by 1-29-2017	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1. Based on observation and interview, the facility failed to maintain 1 of 2 3rd floor and 2 of 2 2nd floor corridors from obstructions per 19.2.3.5. LSC 19.2.3.4.5 requires aisles, corridors, and ramps to be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. This deficient practice could affect staff and up to 33 residents in three smoke compartments. Findings include:	K 0232	1:1 Carts left in the corridors were immediately removed. 1:2 Plant Operations Director went to other corridors to ensure compliance of all carts removed. 1:3.Staff working in the areas where carts were left unattended was immediately educated on code related to non-affixed items in the corridors. Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related to obstructions in corridors. Staff was in-serviced 1-13-2017 and on-going related to removal of items from corridor when not in use. Director of Plant	01/29/2017

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	Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 between 11:07 p.m. and 3:06 p.m., a) two sets of linen carts were in the 3rd floor B Wing corridor. b) a trash can was in the outside of the 2C Dining room corridor. c) two sets of linen carts were in the 2nd floor C Wing corridor. d) two sets of linen carts were in the 2nd floor D Wing corridor Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 at 10:45 a.m., e) two sets of linen carts were in the 2nd floor B Wing corridor. Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation, the facility failed to meet 1 of 1 2nd floor C Wing corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. 19.2.3.4(5) (a) the fixed furniture is securely attached to the floor or to the wall. This deficient practice		Operations/designee, Administration and Management staff will monitor corridor obstructions daily. Any unattended obstructions will be removed immediately and staff member educated per code. Director of Plant Operations/designee will audit for corridor obstructions daily five (5) times per week for four (4) weeks, weekly for eight (8) weeks and monthly for three (3) months to ensure compliance. 1:4. Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly for six (6) months beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 1:5. Systemic changes will be completed by 1-29-2017 2:1. Chair left in the corridor was immediately removed. 2:2. Plant Operations Director went to other corridors to ensure compliance of all chairs removed. 2:3.Staff working on 2C where the chair was left unattended was immediately educated on code related to non-affixed items in the corridors. Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related to obstructions in	

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	could affect staff and up to 10 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 1:27 p.m., a chair was located in the corridor outside of the 2C Dining room. When tested, the chair was able to be moved around the corridor. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition and confirmed the chair was not secured. 3.1-19(b) 3. Based on observation, the facility failed to meet 1 of 2 Basement corridors clear width requirement exception per 19.2.3.4(1). LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 11/30/16 at 9:51 a.m.,		corridors. Staff was in-serviced 1-13-2017 and on-going related to removal of items from corridor if not in use. Director of Plant Operations/designee, Administration and Management staff will monitor corridor obstructions daily. Any unattended obstructions will be removed immediately and staff member educated per code. Director of Plant Operations/designee will audit for corridor obstructions daily five (5) times per week for four (4) weeks, weekly for eight (8) weeks and monthly for three (3) months to ensure compliance. 2:4. Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly for six (6) months beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 2:5. Systemic changes will be completed by 1-29-2017 3:1. The drywall was immediately removed and properly stored. 3:2. Plant Operations Director assessed facility to ensure no other areas for egress were blocked. 3:3 Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related to obstructions in corridors. Staff was in-serviced 1-13-2017 and	

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	drywall boards were stacked next to a bed in the basement corridor outside the Basement Mechanical room. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 provided the measurement and acknowledged the clear width was measured at 36 inches. 3.1-19(b)		on-going related to removal of items from corridors if not in use. Director of Plant Operations/designee, Administration and Management staff will monitor corridor obstructions daily. Any unattended obstructions will be removed immediately and staff member educated per code. Director of Plant Operations/designee will audit for corridor obstructions daily five (5) times per week for four (4) weeks, weekly for eight (8) weeks and monthly for three (3) months to ensure compliance. 3:4. Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly for six (6) months beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 3:5. Systemic changes will be completed by 1-29-2017	
K 0300 SS=D Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview,	K 0300	1. Paperwork was located and	01/09/2017

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	the facility failed to maintain 1 of 1 FM200 system in accordance with LSC 9.7.3.1. LSC 9.7.3.1 requires in any occupancy where the character of the fuel for fire is such that extinguishment or control of fire is accomplished by a type of automatic extinguishing system in lieu of an automatic sprinkler system, such system shall be installed in accordance with the appropriate standard, as determined in accordance with Table 9.7.3.1. NFPA 2001, *Standard on Clean Agent Fire Extinguishing System,* Section 7.1.1 requires at least annually, all systems shall be thoroughly inspected and tested for proper orientation by personnel qualified in the installation and testing of clean agent extinguishment systems. Section 7.1.3 requires at least semiannually, the agent quantity and pressure of refillable containers shall be checked. This deficient practice could affect staff only. Findings include: Based on record review with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 between 8:25 a.m. and 10:38 a.m., no documentation was available for review for the clean agent extinguishing system in the server room. Based on interview at the time of record review, the Director of		forwarded to surveyor 1-9-2017 however, deficiency had already been cited. 2. Director of Plant Operations set up a file to assure no further paperwork gets misplaced. 3. All annual FM200 inspections have been completed as stated per regulation and are maintained in file in Director of Plant Operations office. 4. Inspection cycles will be continued per code and will be brought to QAPI Committee for review. 5. Systemic changes were completed 1-9-2017.	

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	Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING 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 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 2 of 2 stairway in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect staff and at least 17 residents in the smoke compartment. Findings include: Based on observation with the Director of	K 0311	1. The missing fire rating tag was located at the bottom of the doors and installed in the proper location on the doors. No deficiency existed. 2. Director of Plant Operations checked every door to ensure compliance. 3. Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on proper locations of fire rating tags on fire doors. Per suggestion from surveyor, facility was encouraged to look for the rating tag at the bottom portion of the door. Doors were removed and tags were located where	01/02/2017

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	Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 1:12 p.m. then again on 12/30/16 at 9:21 a.m., the 2nd floor B Dining room stairwell door did not have a fire resistance rating. Then again, the Basement Elevator Stairwell door did not have a fire resistance rating. Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition. 3.1-19(b)		stated. Fire classification tags were removed and properly affixed to the hinged side of the doors so they can be clearly visible. Any replacements doors will be checked for proper location of fire classification tag prior to installation to assure visibility. 4. No QAPI reporting is necessary at this time. 5. Systematic changes completed on 1-2-2017	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	12/30/2016

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

(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
	Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Based on observation and interview, the facility failed to maintain protection of 1 of 1 Kitchen in accordance of 19.3.2. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 3:01 p.m., the Kitchen double doors would only close and latch when one of the doors closed first. No coordinating device was installed. The room contained fuel-fired equipment and over 64 gallons of trash. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition.	K 0321	1. Vendor came to facility 12-30-2016 to correct the deficiency with the closure of the doors. 2. Items have been ordered 1-17-2016 to correct the door closure. A coordinator and closing astragal was order to assure proper closure and will be installed by the vendor upon receipt. 3. Vendor came to facility 12-30-2016 to correct the deficiency with the closure of the doors. Director of Plant Operation in-serviced the Plant Operations staff 1-9-2017 on the code for proper door closures. Door will be added to the monthly door PM maintenance schedule to ensure inspection for proper closure. 4. Director of Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning February 2017. The QAPI Committee will monitor data	01/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	12/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	3.1-19(b)		presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-29-2017	
K 0341 SS=D Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches. This deficient practice could affect staff only.	K 0341	1. Vendor was contacted 12-30-2016 to have smoke detector relocated in that coverage area to an alternate location to meet code specifications. 2. Vendor will relocate smoke detector away from HVAC vent per code. 3. Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on proper spacing of smoke detectors. Vendor will perform service no later than 1-29-2017. 4. Once smoke detector is relocated, no further monitoring or audits will be warranted.	01/29/2017

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	155214	A. BUILDING 01 B. WING	12/30/2016

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

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	Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 2:36 p.m., the 1B lounge area had an HVAC vent next to a smoke detector. Based on interview at the time of record review, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition and confirmed it was closer than thirty six inches. 3.1-19(b)		5. Systemic changes will be made by 1-29-2017.	
K 0345 SS=D Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in	K 0345	1. Vendor was contacted regarding the two (2) smoke detectors that weren't tested during last inspection (due to medical conditions of residents residing in two (2) Hospice rooms). 2. Director of Plant Operations	01/19/2017

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	155214	A. BUILDING 01 B. WING	12/30/2016

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	accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect staff and at least two residents. Findings include: Based on record review with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 9:28 a.m., the annual fire alarm testing documentation from Commercial Electronics Systems Inc. on 01/11/16 indicated that two smoke detectors were "untested." Based on interview at the time of record review, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition and confirmed those two detectors are in Hospice rooms. 3.1-19(b)		reviewed testing report and no other smoke detectors went untested. 3. Vendor was contacted 12-30-2016 to retest entire facility smoke detectors, which will include the two (2) untested detectors at that time. Scheduled testing for 1-23-2017. Director of Plant Operation in-serviced the Plant Operations staff 1-9-2017 on the code for proper testing and timeframes for smoke detectors throughout the facility. Report with testing results will be reviewed by Director of Plant Operations to assure no smoke detectors have been missed or failed testing. 4. Director of Plant Operations/designee will report test findings to the QAPI Committee meeting annually beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-23-2017.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic			

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	155214	A. BUILDING 01 B. WING	12/30/2016

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ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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	sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all occupants. Findings include: Based on observations with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 11:00 a.m., the drop ceiling by resident room A112 was being supported by the sprinkler pipe above it. Based on	K 0351	1:1. The ceiling tile was immediately removed from the sprinkler pipe on 12-30-2016. 1:2. Director of Operations reinstalled ceiling tile utilizing proper wire material. 1:3. Director of Plant Operation in-serviced the Plant Operations staff 1-9-2017 on the code for proper installation of ceiling tile. 100% audit will be completed by 1-29-2017 to ensure all ceiling tiles are secured properly. Any areas found deficient will be immediately corrected. 1:4. After 100% audit is completed, no further auditing is warranted. 1:5 Systemic changes will be completed by 1-29-2017 2:1 Vendor was contacted 12-30-2016 to correct sprinkler coverage. 2:2 Vendor will install sprinklers in	01/29/2017

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	155214	A. BUILDING 01 B. WING	12/30/2016

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	interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure complete sprinkler coverage in 1 of 1 Tile room and 1 of 1 Transfer room was installed in accordance with 9.7.1.1. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 at 9:36 p.m., there was no sprinkler coverage in the Tile room or Transfer room. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b)		the Tile room and Transfer room by 1-29-2017. 2:3 Director of Plant Operation in-serviced the Plant Operations staff 1-9-2017 on the code for proper sprinkler coverage. Vendor completed audit to ensure sprinkler coverage is sufficient. 2:4 Once sprinkler coverage is added to both areas, no further auditing is warranted. 2:5 Systemic changes will be completed by 1-29-2017	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	155214	A. BUILDING 01 B. WING	12/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 3 floors. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 11:34 a.m. then again at 3:17 p.m., the 3C Nurse's station had a ceiling tile missing. Then	K 0353	1. Ceiling tiles in both areas were corrected 12-30-2016. 2. Facility inspection was conducted and any ceiling tiles not set properly were corrected at that time. 3. Director of Plant Operation in-serviced the Plant Operations staff 1-9-2017 on the code for proper ceiling tile placements. Zone Tech/Director of Plant Operations/designee will monitoring ceiling tiles for proper placement daily five (5) times per week during daily rounds on-going. Any ceiling tiles not set properly will be corrected when noted. Issues will be shared with Director of Plant Operations when found. Clips will be added to the ceiling tiles if needed. 4. Director of Plant Operations/designee will report findings to the QAPI Committee meeting annually beginning February 2017. The QAPI	01/29/2017

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	155214	A. BUILDING 01 B. WING	12/30/2016

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ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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	again, outside the Administrator's office a two inch by four inch penetration in the drop ceiling. Based on observation, with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 at 9:44 a.m., one of the ceiling tiles was not smoke resistive due to grid-shape squares that allowed air flow to pass. No HVAC tubing was connected. Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition. 3.1-19(b)		Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-29-2017	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 Front Lobby portable fire extinguishers was installed correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 6.1.3.8.3 in no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4	K 0355	1. Fire extinguisher was returned to the housing mechanism for the wall bracket immediately. 2. 100% whole house audit was completed 12-30-2016 to insure all extinguishers were in place. No other deficiencies were noted. 3. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code for	01/29/2017

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	155214	A. BUILDING 01 B. WING	12/30/2016

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

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	inches. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 at 8:47 a.m., the Front Lobby fire extinguisher was sitting on the floor. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)		proper fire extinguisher placement on 1-9-2017. Audit will be conducted monthly (on-going) to ensure proper location of all extinguishers per PM schedule. Corrections will be made at the time of the audit as necessary. 4. Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-29-2017	
K 0362 SS=D Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give			

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	155214	A. BUILDING 01 B. WING	12/30/2016

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

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	the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to maintain protection of 1 of 3 1st floor corridor walls in accordance of 18.3.6.2. LSC 18.3.6.2, Construction of Corridor Walls, requires corridor walls shall form a barrier to limit the transfer of smoke. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 2:25 p.m., two separate one eight inch penetrations in the corridor outside the Life Enrichment office. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0362	1. Penetrations were repaired immediately when noted on 12-29-2016. 2. Facility will be inspected and any other penetrations noted will be corrected by 1-29-2017. 3. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code related to penetrations. Zone techs will monitor facility for penetrations daily five (5) times per week on-going. Corrections will be made at the time as necessary. Concerns will be brought to Director of Plant Operations. 4. Director of Plant Operations/designee will report findings to the QAPI Committee meeting monthly beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-29-2017	01/29/2017
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other			

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	155214	A. BUILDING 01 B. WING	12/30/2016

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

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	than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 2 3rd floor and 2 of 2 2nd floor corridors in accordance of 19.3.6.3. This deficient practice could	K 0363	1. 3C Tub Room door, 2C Janitor room door and 2D Nurses' station door have been/will be repaired for code. 2. All corridor doors have been inspected by Director of Plant	01/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	12/30/2016

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ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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	affect staff and at least 35 residents in three smoke compartments. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 between 11:48 a.m. and 2:31 p.m., the following corridor doors were discovered: a) the 3C Tub room door did not have positive latching hardware installed. Inside the room contained clothing, chairs, and cabinets. b) the 2C Janitor room door contained a seven sixteenth inch penetration c) the 2D Nurse's station medication room contained only the bottom half of a Dutch door. Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition. 3.1-19(b)		Operations and repairs being made accordingly. 3:A. 3C Tub Room door will be repaired by adding a positive latching lock assembly by 1-29-2017. 3:B 2C Janitor room door was repaired by adding sex bolts to compensate penetrations on 12-30-2016. 3:C 2D Nurses' station does have a Dutch door to ensure residents safety on the dementia wing. The 2D medication room located behind said nurses station does have a full door installed with a locking device per code. No further repair was necessary. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code related to protection of corridor doors. 4. Once repairs are made, no further action will be warranted. 5. Systemic changes will be completed by 1-29-2017	
K 0372 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a			

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	155214	A. BUILDING 01 B. WING	12/30/2016

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	1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 Basement ceiling barrier was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff only. Findings include: Based on observations with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/20/16 at 9:42 a.m., a two foot by two foot piece of drywall was removed from the ceiling in the Basement Locker room. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned	K 0372	1. Drywall was replaced on 1-10-17. 2. Director of Plant Operations inspected lower level basement, no other drywall replacement needed. 3. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code related to penetrations. 4. Once repair was made, no further action is warranted. 5. Systemic changes will be completed by 1-10-2017	01/10/2017

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	condition and provided the measurement. 3.1-19(b)			
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 192 resident rooms and 1 of 1 Nurse Manager's office was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observations with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 2:17	K 0753	1. Candles located in the nurse manager's office and resident room 112 were immediately removed 12-29-2016. 2. 100% audit focused on candles was conducted 1-3-17 and no other candles were located. 3. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code related to combustible decorations. Staff was in-serviced 1-13-2017 on policy stating that no candles with wicks are permitted in any location within the facility. Zone techs will check for candles in the facility daily five (5)	01/03/2017

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	p.m. then again at 2:19 p.m., a candle with a wick was discovered in resident room 112. Then again, a candle with a wick was discovered in the Nurse Manager's office. Based on interview at the time of each observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged each aforementioned condition. 3.1-19(b)		times per week on-going during daily rounds. Any candles found will be removed at once. If residents are found with candles, Social Services will be involved to assist in removal and explanation of the policy to resident and family members. Concerns will be brought to Director of Plant Operations. 4. Director of Plant Operations/designee will report findings to the QAPI Committee meeting monthly beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-3-2017	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 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 affects staff and at least 6 residents. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/29/16 at 2:31 p.m., an extension cord was powering a surge protector powering Christmas tree lights in Activities. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition.	K 0920	1. Extension cord and surge protector was immediately removed. Exposed outlet was immediately repaired. 2. 100% audit was conducted and no other extension cords/power cords or exposed junction boxes were found. 3:1. LEC was re-educated on use of extension cords and surge protectors 1-3-2017. Director of Plant Operations in-serviced the Plant Operations staff 1-9-2017 on the code related to usage of power cords and extension cords. Staff was in-serviced 1-13-2017 on power cord and extension cord usage. Zone techs will perform PM schedule for extension cords/power cords monthly on-going for compliance. Extension cords and/or power cords noted will be removed and education presented as appropriate. Concerns will be brought to Director of Plant Operations. 3:2 Plant Assistant was re-educated on job completion and potential hazards related to exposed outlets on 12-30-2016.	01/03/2017

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 1 Maintenance Shop according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. Additionally, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Engineering, the Administrator, and Plant Assistant #1 on 12/30/16 at 9:08 a.m., an outlet was outside of the junction box with exposed wiring. Based on interview at the time of observation, the Director of Engineering, the Administrator, and Plant Assistant #1 acknowledged the aforementioned condition. 3.1-19(b)		Director of Plant Operations in-serviced Plant Operations staff 1-9-2017 on code related electrical wiring and junction boxes. Zone techs will monitor daily to ensure all electrical junction boxes have covers compatible to the box. Corrections will be made at the time found if non-compliant. Concerns will be brought to Director of Plant Operations/designee. 4. Director of Plant Operations/designee will report findings to the QAPI Committee meeting monthly beginning February 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5. Systemic changes will be completed by 1-29-2017	

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