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	02/07/2017

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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/29-30/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/03/17 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this PSR 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	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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	facility has the capacity for 189 and had a census of 155 at the time of this survey. Quality Review completed on 02/09/17 - DA			
K 0131 SS=B 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 1 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	K 0131	1. The one inch unsealed penetration around wires in the resident room B226 fire barrier wall was immediately sealed and brought to code. 2. Director of Plant Operations checked all ceilings to ensure all penetrations through fire walls are properly sealed to maintain the integrity of the fire barrier wall. Any noted areas were corrected at that time. Director of Plant Operations along with consulted	02/23/2017

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	and exhaust vents, wires, and similar items to accommodate electrical, 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 10 residents. Findings include: Based on an observation with the Maintenance Assistant #1 on 02/07/17 at 12:03 a.m., a one inch unsealed penetration around wires in the resident room B226 fire barrier. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition and provided the measurement. 3.1-19(b) This deficiency was cited on 12/30/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		outside vendor, Valley Fire, inspected all areas of the building to ensure penetrations are properly sealed and that no additional penetrations have been found. 3. The Administrator/designee will monitor (on-going) fire barrier wall penetrations to ensure penetrations are properly sealed. Any areas noted to be deficient will be communicated to Plant Operations for immediate repair. Valley Fire has been contracted to return to facility in two weeks to re-check to ensure no additional fire barrier wall penetrations are found. This system will remain on-going. 4. Results of on-going monitoring will be reviewed at QAPI Committee meeting monthly beginning March 2017 for continued compliance. The QAPI Committee will monitor data presented for any trends and determine if further education is warranted. 5. Systematic changes will be completed by 2-23-2017	

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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, 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 could affect staff and up to 10 residents. Findings include: Based on observation with the Maintenance Assistant #1 on 02/07/17 at 10:54 a.m., a chair was located in the corridor outside of resident room 271. When tested, the chair was able to be moved around the corridor. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition and confirmed the chair was not secured.	K 0232	1. 1. The chair located in the corridor outside resident room 271 was removed from the corridor and returned to the dining room. 1. 2. The facility will ensure the corridor width requirements of 19.2.3.4(5) are met per code. Daily rounds will be conducted to ensure compliance. 1. 3. The Administrator/designee will monitor (on-going) furniture in the corridor to ensure the furniture is securely attached to the floor or wall. Any furniture found in the corridor that is not secured will be removed and staff member responsible will be educated at that time to the requirement. 1. 4. Results of on-going monitoring will be reviewed at QAPI Committee meeting monthly beginning March 2017 for continued compliance. The QAPI Committee will monitor data presented for any trends and determine if further education is warranted. 1. 5. Systematic changes will be completed by 2-6-2017	02/23/2017

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	3.1-19(b) This deficiency was cited on 12/29/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on observation and interview, the facility failed to maintain 1 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 any resident in the smoke compartment. Findings include: Based on observation with the Maintenance Assistant #1 on 02/07/17 at 10:45 a.m., there was a very large soiled linen container outside the 2nd floor elevators. Based on interview, the Administrator confirmed the larger container is stored there until it is filled by the smaller containers throughout the wings and gets taken down via elevator. 3.1-19(b)		2. 1. The large soiled linen container was removed from the corridor. Systemic process was reviewed and updated to ensure that no large soiled linen containers or other obstructions are left in the corridors unattended for an extended period of time. 2. 2. The facility will ensure that the corridors are free from obstructions. Daily observation rounds will be conducted to ensure compliance with facility practice. 2. 3. The Administrator/designee will monitor (on-going) the corridors to ensure that no obstructions are present. Any obstructions found in the corridors will be removed and staff member responsible will be educated at that time to the facility expectation. 2. 4. Results of on-going observations will be reviewed at QAPI Committee meeting monthly beginning March 2017 for continued compliance. The QAPI Committee will monitor data presented for any trends and determine if further education is warranted. 2. 5. Systematic changes will be completed by 2-6-2017	

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	This deficiency was cited on 12/29/16. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K 0351 SS=F 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 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) 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	K 0351	1. The wire support that was connected to the sprinkler pipe in the drop ceiling attached to the ceiling grid by resident room A112 was immediately removed. 2. The facility will ensure the sprinkler system is not being used to support the drop ceiling grid system. Director of Plant Operations checked ceilings to ensure drop ceiling grid system is	02/23/2017

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	non-system components. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Assistant #1 on 02/07/17 at 11:55 a.m., the drop ceiling by resident room A112 was being supported by the sprinkler pipe above it. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the aforementioned condition. 3.1-19(b) This deficiency was cited on 12/29/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		properly secured. Any noted areas were corrected at that time. Director of Plant Operations along with consulted outside vendor, Valley Fire, will inspect all areas of the building to ensure the sprinkler system is not being used as a form of support and that the work performed to remove the wiring is complete and in compliance per code. 3. The Administrator/designee will monitor (on-going) the sprinkler system to ensure it is not being used to support non-system components. Valley Fire has been contracted to return to facility in two weeks to re-check to ensure no additional wires supporting the drop ceiling grid system are affixed to the sprinkler system. Any grid found to be hung in a deficient manner will be corrected at that time. 4. Results of on-going monitoring will be reviewed at QAPI Committee meeting monthly beginning March 2017 for continued compliance. The QAPI Committee will monitor data presented for any trends and determine if further education is warranted. 5. Systematic changes will be completed by 2-23-2017	