		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150008	(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/22/2021		
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP COD 4321 FIR STREET EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE			
K 0000	indeed.ii ei		1110		J.II.E		
Bldg. 01	An investigation of Complaint Number IN00348453 was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b).  Complaint Number IN00348453 was Substantiated. Federal/State deficiencies related to the allegation were cited K500, and K711.  Federal/State deficiency unrelated to the allegation was cited at K355.		K 0000				
	Survey Date: 04/22/2021  Facility Number: 005008  Provider Number: 150008  AIM Number: 100268310A						
	At this Complaint survey, St. Catherine's Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 482.41(b).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 facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 197 and had a census of 102 at the time of incident. The Acute Rehabilitation Unit (ARU) had a census of 14 at the time of incident.  Quality Review completed on 04/26/21						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	COMPLETED	
		150008	B. WING 04/22/2021				/2021	
	ROVIDER OR SUPPLIER			4321 FI	ADDRESS, CITY, STATE, ZIP COD R STREET CHICAGO, IN 46312			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0355	NFPA 101							
Bldg. 01	installed, inspecte	nguishers guishers are selected, d, and maintained in						
	Portable Fire Extir	nguishers.						
	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 2 portable fire extinguishers in the Acute Rehabilitation Unity (ARU)  Activity/Dining Room were not obstructed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Chapter 6. Section 6.1.3.1 states that fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire; and Section 6.1.3.3.1 which states that fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect all occupants of the ARU Activity/Dining Room.  Findings include:  During a facility tour of the ARU with the Chief of Nursing Operations and Nursing Quality Manager on 04/22/2021 at 10:20 a.m. fire extinguisher #506 was obstructed from access and view by chair and		K 0	355	Upon identification of the deficiency, the obstruction was moved from the blocked fire extinguisher. This was correct while the surveyors were on-surveyors were on-surveyors were on-surveyors were on-surveyord and revised the Gen Safety policy (SAFE 12.01) on June 7th, 2021 to include:  o Fire extinguishers shall be readily accessible and immediately available in the evorage of fire.  o Fire extinguishers shall not obstructed or obscured from vorage of a 36-inch clearance in from the fire extinguisher shall be maintained  The organization will prevent the deficiency from reoccurring in the future by re-educating Acute Rehabilitat staff on the revised General Surveyors.	ed ite ation eral vent be iew. t of	06/14/2021	
	Manager agreed that obstructed. It was no corrected prior to the This deficient finding	ons and Nursing Quality at the fire extinguisher was noted that this condition was are exit.  In was reviewed with the Chief ons at the time of exit.			Policy. The Director of Support Services, Regulatory Complian Coordinator and Acute Rehab Manager will be responsible. Random audits will occur wee for two (2) months, every othe week for two (2) months then monthly for two (2) months. If	nce kly r		

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Event ID:

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Facility ID: 005008

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 150008		r í		(X3) DATE SURVEY COMPLETED 04/22/2021
		432	1 FIR STREET	
HERINE HOSPITAL	INC	EAS	31 CHICAGO, IN 46312	
		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
`			CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
			auditing will be extended for additional two (2) months.  The organization revie and updated the General Sat policy and Acute Rehabilitations taff were re-educated and the	he an wed fety on
NFPA 101				
Building Services List in the REMAR Section 18.5 and requirements that provided K-tags, b information, along Safety Code or NF should be included Based on record rev failed to ensure that in accordance with states that maintena shall be performed or responsible person or inspection, and mair intervals in accorda standards or as direct jurisdiction. This d all facility occupant  Findings include: 1) Based on a record 04/22/2021 between the Chief of Nursing Manager, Quality M Support Services pr	- Other RKS section any LSC 19.5 Building Services are not addressed by the out are deficient. This with the applicable Life FPA standard citation, don Form CMS-2567. Fiew and interview, the facility maintenance was completed NFPA 101 4.6.12.5, which nee, inspection, and testing under the supervision of a who shall ensure that testing, intenance are made at specified nee with applicable NFPA cted by the authority having efficient practice could impact s.  In the action of the could be review and interview on a 10:30 a.m. and 12:00 p.m., with go Operations, Nursing Quality Manager, and Director of esent, the written "Detailed"	K 0500	and revised the Preventive a Corrective Maintenance Prog policy (ENG 4.12) on May 13 2021 to include: o Following manufacturer recommendation when makin repairs or adjustments. o Review operator's manua to servicing equipment. o Review the Safety Data S (SDS) prior to using any chemicals and/or lubricants. o Anecdotal re-education of involved staff.  The organization will prevent the deficiency from reoccurring in the future by	nd gram ng I prior heet
	PROVIDER OR SUPPLIER HERINE HOSPITAL  SUMMARY: (EACH DEFICIEN REGULATORY OR  REGULATORY OR  Section 18.5 and requirements that provided K-tags, be information, along Safety Code or NF should be included Based on record reversible for the states that maintenated the states that main	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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, the facility failed to ensure that maintenance was completed in accordance with NFPA 101 4.6.12.5, which states that maintenance, inspection, and testing shall be performed under the supervision of a responsible person who shall ensure that testing, inspection, and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction. This deficient practice could impact all facility occupants.	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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, the facility failed to ensure that maintenance was completed in accordance with NFPA 101 4.6.12.5, which states that maintenance, inspection, and testing shall be performed under the supervision of a responsible person who shall ensure that testing, inspection, and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction. This deficient practice could impact all facility occupants.  Findings include:  1) Based on a record review and interview on 04/22/2021 between 10:30 a.m. and 12:00 p.m., with the Chief of Nursing Operations, Nursing Quality Manager, Quality Manager, and Director of Support Services present, the written "Detailed Master Equipment Report" indicated that the	PROVIDER OR SUPPLIER  #ERINE HOSPITAL INC  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PERCEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101  Building Services - Other  Building Se

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
150008		B. WING 04/22/2021			/2021			
				CTREET	ADDRESS SITE STATE SID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
				4321 FIR STREET				
ST CATHERINE HOSPITAL INC				EASIC	CHICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE	
	Stackable Washer D	Oryer, Model Number			revised Preventive and Correct	tive		
		ne Whirlpool Washer/Dryer Use			Maintenance Program policy b	)V		
		the appliance, states			following manufacturer	,		
		before servicing" on page 16.			recommendation when making	ן נ		
	_	at the time of record review,			repairs or adjustments, review			
		port Services stated that the			the operator's manual prior to	-		
		ged in, and was energized,			servicing equipment and revie			
		was being serviced at the time			the Safety Data Sheet (SDS)	-		
		ed that the appliance should			to using any chemicals and/or			
	_	cted from power before			lubricants.			
	servicing.	1			· The Director of Support			
	8				Services and Regulatory			
	2) Based on a record	d review and interview on			Compliance Coordinator will b	e		
		n 10:30 a.m. and 12:00 p.m., with			responsible.			
		g Operations, Nursing Quality			· The Plant Operations			
		Manager, and Director of			Manager and Maintenance			
		resent, the Safety Data Sheet			Supervisor reviewed the upda	ted		
		ed, Red Grease Lubricant, SDS			Preventive and Corrective			
		s that the lubricant is an			Maintenance Program policy a	and		
		le aerosol, and to be kept aware			procedure on May 13, 2021, a			
	-	ces, sparks, open flames, and			personnel were re-educated a			
		es. Based on interview at the			the deficiency was corrected o			
	_	ew, the Director of Support			May 18, 2021.			
		the lubricant used was not			, -, -			
		as it was flammable.						
	This deficient practi	ice was reviewed with the						
	Chief of Nursing O	perations at the time of exit.						
		•						
	This federal tag rela	ates to Complaint Number						
	IN00348453							
			İ					
K 0711	NFPA 101					ļ		
	Evacuation and R	elocation Plan				ļ		
Bldg. 01	Evacuation and R	elocation Plan				ļ		
	There is a written	plan for the protection of all				ļ		
	patients and for th	eir evacuation in the event				ļ		
	of an emergency.					ļ		
		eriodically instructed and				ļ		
		kept informed with their duties under the plan,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150008		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       04/22/2021			
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC			4321 F	ADDRESS, CITY, STATE, ZIP COD IR STREET CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3. 19.7.2.1.2, 19.7.2. Based on record rever failed to provide a vecomponents in 1 of 19.7.2.2 requires a vecomponent in 1 of 19.7.2.2 requires a vecomponent in 1 of 19.7.2.2 requires a vecomponent in 1 of 19.7.2.3 requires a vecomponent in 1 of 19.7.2.4 requires a vecomponent in 1 of 19.7.2.5 requires a vecomponent in 1 of 19.7.2.6 requires a vecomponent in 1 of 19.7.2.7 requires a vecomponent in 1 of 19.7.2.8 requires a vecomponent in 1 of 19.7.2.9 requires a vecomponent in 1.0 requires in 1	riew and interview, the facility vritten plan that addressed all 1 written fire plans. LSC written health care occupancy shall provide for the alarm to fire department the call to fire department the compartment the compartment the coors and building for	K 0711	1. The Plant Operations Manager, Maintenance Super and Security Manager review the updated Fire Alarm Notific policy (ENG 1.50) and proced and Fire Alarm System Bypas Process on March 1st, 2021 a May 13th, 2021. Anecdotal re-education of involved staff. 2. We will prevent the deficiency from recurring in th future by re-educating Plant Operations and Maintenance personnel, along with the Sec Coordinators on the revised F Alarm Notification policy and I Alarm System Bypass Proces Random audits of fire events occur weekly for two (2) monte every other week for two (2) months. If QA finds 2 or more deficiencies the auditing will be extended for an additional two months. 3. The Director of Support Services, Regulatory Complia Coordinator and Security Mar will be responsible. 4. The Plant Operations Manager, Maintenance Super	ed cation dure ss and ee curity fire Fire ss. will ths, (2) the co (2) the chager

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 150008		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/22/2021			
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP COD 4321 FIR STREET EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 08/05/2019) and the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Policy titled "Fire Alarm and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  and Security Manager review	DATE ed		
	transmission of the department (2) or a call to the fire department. Based on interview Services at the time had placed the fire a to maintenance at the hospital fire alar monitoring organization.	with the Director of Support of record review, the hospital alarm system on "by-pass" due he time of the incident. When rm is on "by-pass", the off-site ation disregards alarms and the Center is responsible for fire		the updated Fire Alarm Notific policy and procedure and Fire Alarm System Bypass Proces on March 1st, 2021 and May 2021. Plant Operations and Maintenance personnel, along the Security Coordinators were-educated and the deficience was corrected on May 18, 202	ess 13, g with re		
	04/22/2021 between the Chief of Nursing Manager, Quality M Support Services pr Report" indicates th the fire alarm was in Pull Station, and Sn Response Team arri 12:45 p.m. The Fire indicate that the East	eview and interview on a 10:30 a.m. and 12:00 p.m., with g Operations, Nursing Quality Ianager, and Director of esent, the written "Fire Event at on 02/24/2021 at 12:40 p.m. nitiated by Waterflow alarm, noke Detector. The Fire eved at the incident location at the Event Report does not at Chicago Fire Department inatically, or via a secondary ne call.					
	Services at the time that after the conclusion the East Chicago Fisher Fire Inspector. The fire was out, the Fire Department wood On 04/22/2021 at 12 East Chicago Fire D	with the Director of Support of record review, he stated sion of the fire, he contacted re Department and spoke to After telling the Fire Inspector Fire Inspector agreed that the buld not need to respond.  2:30 p.m. the Fire Chief of the Department was interviewed.					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150008	` ′	LDING	ONSTRUCTION 01	(X3) DATE COMPI <b>04/22</b>	LETED
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP COD  4321 FIR STREET  EAST CHICAGO, IN 46312			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	hospital regarding t contacted non-emer This deficient findin	ncy communication from the he fire. The Fire Inspector was gency after the incident.					
	Director of Support This federal tag rela IN00348453	services.  Ites to Complaint Number					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 770R21 Facility ID: 005008 If continuation sheet Page 7 of 7