STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150008	A. BUILDING 01 B. WING	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST CATHERINE HOSPITAL INC	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 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. 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 0355 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 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 two pieces of stored medical equipment. Based on interview at the time of observation, the Chief of Nursing Operations and Nursing Quality Manager agreed that the fire extinguisher was obstructed. It was noted that this condition was corrected prior to the exit. This deficient finding was reviewed with the Chief of Nursing Operations at the time of exit.	K 0355	· Upon identification of the deficiency, the obstruction was moved from the blocked fire extinguisher. This was corrected while the surveyors were on-site April 22nd, 2021. The organization reviewed and revised the General Safety policy (SAFE 12.01) on June 7th, 2021 to include: o Fire extinguishers shall be readily accessible and immediately available in the event of fire. o Fire extinguishers shall not be obstructed or obscured from view. o A 36-inch clearance in front of the fire extinguisher shall be maintained · The organization will prevent the deficiency from reoccurring in the future by re-educating Acute Rehabilitation staff on the revised General Safety Policy. · The Director of Support Services, Regulatory Compliance Coordinator and Acute Rehab Manager will be responsible. Random audits will occur weekly for two (2) months, every other week for two (2) months then monthly for two (2) months. If QA	06/14/2021

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			finds 2 or more deficiencies the auditing will be extended for an additional two (2) months. · The organization reviewed and updated the General Safety policy and Acute Rehabilitation staff were re-educated and the deficiency was corrected on June 14th, 2021.	
K 0500 Bldg. 01	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 appliance involved in the fire was a Whirlpool	K 0500	· The organization reviewed and revised the Preventive and Corrective Maintenance Program policy (ENG 4.12) on May 13, 2021 to include: o Following manufacturer recommendation when making repairs or adjustments. o Review operator's manual prior to servicing equipment. o Review the Safety Data Sheet (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 re-educating Plant Operations and Maintenance personnel on the	05/18/2021

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	Stackable Washer Dryer, Model Number WET3300XQ2. The Whirlpool Washer/Dryer Use and Care Guide for the appliance, states "Disconnect power before servicing" on page 16. Based on interview at the time of record review, the Director of Support Services stated that the appliance was plugged in, and was energized, when the appliance was being serviced at the time of the fire. He agreed that the appliance should have been disconnected from power before servicing. 2) 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 Safety Data Sheet for the lubricant used, Red Grease Lubricant, SDS #1000023427, states that the lubricant is an extremely flammable aerosol, and to be kept aware from heat, hot surfaces, sparks, open flames, and other ignition sources. Based on interview at the time of record review, the Director of Support Services stated that the lubricant used was not the proper lubricant as it was flammable. This deficient practice was reviewed with the Chief of Nursing Operations at the time of exit. This federal tag relates to Complaint Number IN00348453		revised Preventive and Corrective Maintenance Program policy by following manufacturer recommendation when making repairs or adjustments, reviewing the operator's manual prior to servicing equipment and reviewing the Safety Data Sheet (SDS) prior to using any chemicals and/or lubricants. · The Director of Support Services and Regulatory Compliance Coordinator will be responsible. · The Plant Operations Manager and Maintenance Supervisor reviewed the updated Preventive and Corrective Maintenance Program policy and procedure on May 13, 2021, and personnel were re-educated and the deficiency was corrected on May 18, 2021.	
K 0711 Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan,			

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	and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire In addition, LSC 19.3.4.2 states that healthcare occupancies shall be provided with a fire alarm system in accordance with Section 9.6. Section 9.6.4.2 states that the fire alarm system shall be arranged to transmit the alarm automatically. This deficient practice could affect all occupants. Findings include: 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 fire safety plan, titled "Code Red - Fire Safety" (adopted	K 0711	1. The Plant Operations Manager, Maintenance Supervisor, and Security Manager reviewed the updated Fire Alarm Notification policy (ENG 1.50) and procedure and Fire Alarm System Bypass Process on March 1st, 2021 and May 13th, 2021. Anecdotal re-education of involved staff. 2. We will prevent the deficiency from recurring in the future by re-educating Plant Operations and Maintenance personnel, along with the Security Coordinators on the revised Fire Alarm Notification policy and Fire Alarm System Bypass Process. Random audits of fire events will occur weekly for two (2) months, every other week for two (2) months then monthly for two (2) months. If QA finds 2 or more deficiencies the auditing will be extended for an additional two (2) months. 3. The Director of Support Services, Regulatory Compliance Coordinator and Security Manager will be responsible. 4. The Plant Operations Manager, Maintenance Supervisor,	05/18/2021

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	08/05/2019) and the policy titled "Fire Alarm and Safety Guidelines" did not specifically address transmission of the fire alarm to the fire department (2) or a secondary emergency phone call to the fire department (3). Based on interview with the Director of Support Services at the time of record review, the hospital had placed the fire alarm system on "by-pass" due to maintenance at the time of the incident. When the hospital fire alarm is on "by-pass", the off-site monitoring organization disregards alarms and the hospital Command Center is responsible for fire department notification. 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 "Fire Event Report" indicates that on 02/24/2021 at 12:40 p.m. the fire alarm was initiated by Waterflow alarm, Pull Station, and Smoke Detector. The Fire Response Team arrived at the incident location at 12:45 p.m. The Fire Event Report does not indicate that the East Chicago Fire Department was contacted automatically, or via a secondary emergency telephone call. Based on interview with the Director of Support Services at the time of record review, he stated that after the conclusion of the fire, he contacted the East Chicago Fire Department and spoke to the Fire Inspector. After telling the Fire Inspector the fire was out, the Fire Inspector agreed that the Fire Department would not need to respond. On 04/22/2021 at 12:30 p.m. the Fire Chief of the East Chicago Fire Department was interviewed. He stated that the department received no		and Security Manager reviewed the updated Fire Alarm Notification policy and procedure and Fire Alarm System Bypass Process on March 1st, 2021 and May 13, 2021. Plant Operations and Maintenance personnel, along with the Security Coordinators were re-educated and the deficiency was corrected on May 18, 2021.	

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	dispatch, or emergency communication from the hospital regarding the fire. The Fire Inspector was contacted non-emergency after the incident. This deficient finding was reviewed with the Director of Support Services. This federal tag relates to Complaint Number IN00348453			