STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155197	A. BUILDING 01 B. WING	05/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT ST PAULS	3602 S IRONWOOD DR SOUTH BEND, IN 46614

(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: 05/15/17 Facility Number: 000104 Provider Number: 155197 AIM Number: 100266590 At this Life Safety Code survey, Sanctuary at St. Paul's 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 building with a partial basement was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 78 and had a census of 72 at the time of this	K 0000		

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

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	survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/18/17 - DA			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised			

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	automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	The facility failed to ensure the delayed egress locking arrangements were installed in accordance with 7.2.1.6.1(3) in 1 of 1 3rd floor delayed egress locks. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the	K 0222	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	06/14/2017

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	direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect staff and up to 37 residents. Findings include: Based on observation with Environmental Service Director on 05/15/17 between 9: 32 a.m. and 11:31 a.m., the 3rd floor stairwell door next to resident room 309 contained a 15 second delay device. When tested, the magnetic control failed to release after 15 seconds. Based on interview at the time of observation, the Environmental Service Director acknowledged the aforementioned condition.		This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request this Plan of Correction be reviewed for Paper Compliance. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No residents were affected 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The delayed egress mag lock on the 3rd floor door was repaired by the EVS Director on 5/15/17. All delayed egress doors will be checked with each fire drill and documented on the Delayed Egress Monthly PM Log. (Attachment: Delayed Egress Monthly PM Log) 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e,, what quality assurance program will be put into place: The results of the audits will be reported to Safety Committee monthly and to MDQI Committee	

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	3.1-19(b)		quarterly until such time the MDQI Committee deems the process is in compliance. 5. By what date the systemic changes will be completed: June 14, 2017	
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 1 of 1 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 37 residents in the smoke compartment. Findings include: Based on observation with the Environmental Service Director on 05/15/17 between 9:32 a.m. and 11:31	K 0311	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken: No residents were affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The 3rd floor fire door will be replaced. (Attachment: Fire Door Quote)	06/14/2017

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	a.m., the 3nd floor stairwell door near resident room 309 did did not have a fire resistance rating. Additionally, the 1st floor Center stairwell contained a quarter inch gap on the left side of an HVAC vent. Based on interview at the time of each observation, the Environmental Service Director confirmed the lack of a fire resistive label and provided the measurement. 3.1-19(b)		The quarter inch gap on the left side of the HVAC vent was filled with fire retardant caulking at the time of the survey. (Attachment: Picture of HVAC Vent with fire retardant caulk in place) Certified fire door inspectors will inspect the doors annually and provide documentation to the Director of Environmental Services. Vendors will sign in on the "Contractor's Sign In Log." Work will be inspected by EVS Director or designee to assure that any penetration has been properly sealed. (Attachment: Contractor's Sign in Log, Policy, Education) 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The EVS Director will review the Contractor's Sign In Log and randomly inspect one vendor monthly to ensure that the completed work is in compliance. Trends will be reported to the Safety Committee monthly and the MDQI Committee quarterly until such time the MDQI Committee deems the process is in compliance. The EVS Director will present the findings of the report from the certified fire door inspector annually to the Safety Committee and MDQI Committee. 5. By what date the systemic changes will be completed. June 14, 2017	

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K 0353 SS=D 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 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 1 of 1 Nursing suite closet. 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 only.	K 0353	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected the same deficient practice will be identified and what corrective actions will be taken: No residents were effected. 3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: The ceiling tile grids were replaced with rated ceiling tiles.	06/14/2017

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	Findings include: Based on observation with the Environmental Service Director on 05/15/17 at 10:44 a.m., the Nursing suite closet contained two ceiling tiles that were open grids that allowed airflow. Upon further inspection no duct work was directly connected to the openings. Based on interview at the time of observation, the Environmental Service Director acknowledged the aforementioned condition. 3.1-19(b)		(Attachment: Picture of grids and picture of rated ceiling tile replacement) 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The EVS Director will review the Contractor's Sign In Log and randomly inspect one vendor monthly to ensure that the completed work is in compliance. Trends will be reported to the Safety Committee monthly and the MDQI Committee quarterly until such time the MDQI Committee deems the process is in compliance. (Attachment: Contractor's Sign In Log, Policy, and Education) 5. By what date the systemic changes will be put into place: June 14, 2017	