STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155604	A. BUILDING -- B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/11/22 Facility Number: 000535 Provider Number: 155604 AIM Number: 100267250 At this Emergency Preparedness survey, Saint Anthony Rehab and Nursing Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 75. Quality Review on 08/12/22.	E 0000	Saint Anthony Rehabilitation and Nursing Center, Inc. is requesting paper compliance to the Life Safety Code Survey conducted on August 11, 2022. Survey Event ID: MSHI21 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Saint Anthony Rehabilitation and Nursing Center, Inc. does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/11/22 Facility Number: 000535	K 0000	Saint Anthony Rehabilitation and Nursing Center, Inc. is requesting paper compliance to the Life Safety Code Survey conducted on August 11, 2022. Survey Event ID: MSHI21 This Plan of Correction is prepared	

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

Any defiencystatement 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 disclo days 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
	Provider Number: 155604 AIM Number: 100267250 At this Life Safety Code survey, Saint Anthony Rehab and Nursing Center, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired detectors in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached garage and two woodsheds used for facility storage, which were not sprinklered. Quality Review on 08/12/22.		and submitted as required by law. By submitting this Plan of Correction, Saint Anthony Rehabilitation and Nursing Center, Inc. does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the	K 0211	**K211 Means of Egress –**	08/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
	facility failed to maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations (D.P.O.) on 08/11/22 at 1:28 p.m. during a tour the facility, there was a 3-drawer plastic chest of drawers containing personal protective equipment (P.P.E.) stored in the corridor immediately outside resident room #C124. Based on interview with the D.P.O. at the time of the observation, he acknowledged the items in the corridor and added that he has several other 3-drawer plastic chests and they were on wheels and that he would switch this out immediately. During the exit conference with the facility Administrator and the D.P.O. at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**General** · The 3-drawer plastic chest of drawers containing P.P.E. stored in the corridor immediately outside the resident room #C124 was replaced with a chest of drawers containing wheels. · All 8 corridors were inspected to ensure any 3-drawer plastic chest of drawers containing P.P.E. outside of residents' rooms contained wheels. · Housekeeping, Plant Operations personnel, and Infection Preventionist were in-serviced on the need to have 3-drawer chest of drawers containing P.P.E. outside residents' rooms to have wheels. The in-service included the proper relocation of wheeled equipment in corridors in the event of a fire or similar emergency. · Director of Plant Operations (D.P.O.) or designee will inspect all corridors weekly to ensure all 3-drawer plastic chests outside of residents' room contain wheels. Findings will be submitted to the QAPI team monthly for monitoring compliance. After 3 months of consecutive compliance the QAPI team will review for continuance of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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 0345 SS=F 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review with the Director of Plant Operations (D.P.O.) on 08/11/22 at 12:20 p.m., it was determined that no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The fire alarm inspection	K 0345	**K345 Fire Alarm System – Testing and Maintenance** · Alarm monitoring service vendor, Electrical Service Group (ESG), were immediately notified and a visual semi-annual fire alarm system inspection was scheduled and performed by vendor ESG on August 26, 2022. No issues noted. · All residents have the potential to be affected. · ESG will continue to perform visual semi-annual fire alarm system inspections per NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. · ESG's findings will be submitted to the Director of Plant Operations (D.P.O.) or designee semiannually. Semi-annual fire alarm system inspections report will be submitted to the QAPI team for review of compliance.	08/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
	documentation provided was dated 03/04/2022, but nothing was available for review six month before or after that inspection. Based on interview at the time of record review, the D.P.O. agreed that visual semi-annually inspections of the fire-alarm system was not available for review as of the time of this survey. During the exit conference with the facility Administrator and the D.P.O. at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing	K 0511	**K511 Utilities – Gas and Electric** · Electric panel outside resident's room F147 was immediately locked per NFPA 70, 230.62(A) and 230.62(B). · All other corridor electric panels were inspected to ensure they were properly secured per NFPA 70, 230.62(A) and 230.62(B). · All residents have the potential to be affected. · D.P.O. or designee will	08/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(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
	access to energized parts shall be provided. This deficient practice could affect residents and staff on the F Hall. Findings include: Based on observations made with the Director of Plant Operations (D.P.O.) on 08/11/22 at 1:28 p.m. during a tour the facility, the electrical panel on the F hall immediately outside resident room F 147 was unlocked when tested. Based on interview at the time of observation, the Executive Director stated the Fire Marshal told them that the fire panels needed to be unlocked so they (The Fire Department) could access them in the event of a fire or emergency. During the exit conference with the facility Administrator and the D.P.O. at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		inspect corridor electric panels monthly to ensure they are properly secured per NFPA 70, 230.62(A) and 230.62(B). Findings will be submitted to the QAPI team monthly for review. QAPI will continue to monitor findings for 3 months. Upon completion of 3 months QAPI will review and determine if further monitoring is required.	