STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155197	A. BUILDING -- B. WING	04/26/2018

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

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/26/18 Facility Number: 000104 Provider Number: 155197 AIM Number: 100266590 At this Emergency Preparedness survey, Sanctuary At St Paul's was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 78 certified beds. At the time of the survey, the census was 61. Quality Review completed on 04/27/18 - DA	E 0000		
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: 04/26/18 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	K 0000		

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.

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	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 61 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/27/18 - DA			
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 interview, the facility failed to maintain 2 of 5 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of	K 0211	The Plan of Correction constitutes the written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that the deficiency exists or that one was cited	05/18/2018

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	egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 32 residents. Findings include: Based on observation with the Environmental Service Director on 04/26/18 between 11:49 a.m. and 1:34 p.m., an alcohol based hand rub stand was in the corridor near the 3rd floor elevator. Then again, an alcohol based hand rub stand was in the corridor near the 2nd floor elevator. Based on interview at the time of each observation, the Environmental Service Director acknowledged that impediments such as the alcohol based hand rub stand were potential impediments to full use of the means of egress access corridors. 3.1-19(b)		correctly. This plan of correction is submitted to meet the requirements established by state and federal law. St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered for Desktop Review. 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The Environmental Services Director removed all alcohol based hand rub dispenser stands from the corridor at the time of the survey in accordance with Life Safety Code. (Appendix 0) 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; The Environmental Services Director immediately completed an egress audit of all corridors to ensure all alcohol based hand rub dispensers are in accordance with LSC 19.3.2.6. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; a) The Environmental Service Director will educate the Housekeeping Supervisor on the code to ensure all requirements are met in accordance with LSC	

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			119.3.2.6. (Appendix 1) b) Weekly egress audits will be conducted by Maintenance and documented. (Appendix 1A) 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; Results of the weekly audits will be reviewed monthly by the Administrator and quarterly by the MDQI Committee for review and recommendation until such time the system is deemed compliant. 5. By what date the systemic changes will be completed; May 18, 20018	
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,			

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	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 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			

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	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 3 3rd floor delayed egress locks. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the 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 32 residents. Findings include: Based on observation with Environmental Service Director on 04/26/18 at 12:07 p.m., the 3rd floor W stairwell door 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 confirmed that the magnetic device would not release the door when tested. 3.1-19(b)	K 0222	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The Environmental Services Director immediately had the 3rd floor stairwell door repaired and the 15 second magnetic control was fixed. 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; The Environmental Services Director immediately completed an audit of all delayed egress devices to ensure all devices are working in accordance with LSC 7.2.1.6.1(3). (Appendix 2) 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 Environmental Services Director will complete education with Maintenance Technicians to ensure they understand the code and testing that will be completed to ensure compliance. (Appendix 3) The Environmental Services Director/designee will be responsible for completing audits of all delayed egress devices weekly. (Appendix 4,)	05/18/2018

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			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; Results of the audit will be reviewed monthly by the Administrator and quarterly by the MDQI Committee for review and recommendation until such time the system is deemed in compliance. 5. By what date the systemic changes will be completed; May 18, 20018	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 2nd floor Soiled Linen hazardous room was protected in accordance with 19.3.2.1. LSC 19.3.2.1(5) and (6) requires rooms with soiled linen or collected trash in volume exceeding 64 gallons shall be classified as hazardous. This deficient practice could affect staff and up to 27 residents. Findings include: Based on observation with the Environmental Service Director on 04/26/18 at 12:35 p.m., the 3rd floor soiled utility room contained hazardous storage containers which added up to over 64 gallons. The corridor door failed to latch into the frame when tested. Based on interview at the time of observation, the Environmental Service Director confirmed the latch does not stick out enough to hold the door closed. 3.1-19(b)	K 0321	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The 3rd Floor Soiled Utility room door latch will be replaced and a fire door inspection will be completed to ensure the door meets all requirements of the Life Safety Code. 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; A fire door inspection will be completed by an by maintenance on all fire doors and repairs will be made accordingly to ensure all fire doors meet of all of the requirements in accordance with LSC 19.3.2.1. (Appendix 5) 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 doors will be added to the annual fire door inspections completed by an outside vendor	05/18/2018

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			and the Environmental Services Director/designee will complete quarterly fire door inspections and the results will be logged to ensure all fire doors meet all requirements in accordance with the Life Safety Code. (Appendix 6, Appendix 7) 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; An annual inspection of all fire doors will be completed by an outside vendor to ensure doors meet all requirements in accordance with LSC 19.3.2.1. Results of the quarterly inspection will be reported to the Administrator and to the MDQI Committee quarterly for review and recommendation until such time the system is deemed in compliance. 5. By what date the systemic changes will be completed; May 18, 20018	
K 0353 SS=E 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			

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	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 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. This deficient practice could affect staff and up to 15 residents. Findings include: Based on observation with the Environmental Service Director on 04/26/18 at 1:24 p.m., the 2nd floor antifreeze loop sprinkler gauge above the drop ceiling indicated the manufacturer's date was 2012. Based on interview at the time of observation, the Environmental Service Director confirmed the sprinkler gauge date and was unable to provide documentation that the gauge had been recalibrated. 3.1-19(b)	K 0353	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The 2nd Floor antifreeze loop gauge was replaced April 26, 2018. (Appendix 8) 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; All gauges for the sprinkler system were inspected to ensure they meet all requirements in accordance with Life Safety Code. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; a) Inspection and replacement of the gauge will be completed every 5 years by an outside vendor. b) An auto-generating work order will be placed in our electronic work order system to ensure notification of preventive maintenance scheduled to be completed. (Appendix 9)	05/18/2018

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			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 Director of Environmental Services and the Administrator will review gauge replacement status annually and report status to the MDQI Committee quarterly until such time the system is deemed in compliance. 5. By what date the systemic changes will be completed; May 18, 20018	
K 0531 SS=F Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke			

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	detectors.) 19.5.3, 9.4.2, 9.4.3 Based on interview and observation, the facility failed to maintain testing of 2 of 2 elevators provided with firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect all occupants on the 2nd and 3rd floor. Findings include: Based on observation with the Environmental Service Director on 04/26/18 at 1:08 p.m., there was an elevator located in the health care portion of the building equipped with elevator firefighter recall. Based on record review, the elevator equipment room contained documentation showing the firefighter recall is tested once a year. Based on interview at the time of record review, the Environmental Service Director confirmed the firefighter recall documentation indicated annual testing and was unaware of the monthly testing requirement. 3.1-19(b)	K 0531	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Elevator fire fighter recall was tested to ensure proper operation. 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; a) Education regarding the "Monthly Fire Fighters Emergency Operation and log" was provided to the Maintenance Technicians that will be assigned to test the Fire Fighters Recall. (Appendix 10) b)Monthly operation tests will be performed and documented on the "Fire Fighters Emergency Operations Log. (Appendix 11) c) The auto generating work order will be entered into the facilities electronic work order system to ensure monthly operation is being performed. (Appendix 12) 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 Director of Environmental Services and the Administrator will	05/18/2018

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			review the log monthly. The results of the audit will be reported to the MDQI Committee quarterly and will be monitored until such time it is deemed in compliance. 5. By what date the systemic changes will be completed; May 18, 20018	