STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

(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: 10/30/17 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Life Safety Code survey, St Anthony Home 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 facility with a partial basement, was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms. The facility has the capacity for 189 and had a census of 161 at the time of this survey.	K 0000	St. Anthony Home - Crown Point submits this Plan of Correction in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determine that the disputed finding: (1) are relied upon to adversely influence or serve as a basis, in any way, the selection and/or imposition of future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services, the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

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

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	Quality Review completed on 11/01/17 - DA			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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 Area Automatic Sprinkler Seperation N/A 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 K3220) Based on observation and interview, the	K 0321	We request desk compliance	11/29/2017

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	facility failed to maintain protection of 1 of 1 2B Center Soiled Linen room, 1 of 1 Kitchen, 1 of 1 Central Supply, and 1 of 1 Laundry in accordance of 19.3.2. This deficient practice could affect staff and up to 33 residents. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 between 12:59 p.m. and 3:08 p.m., the following was discovered: a) the 2B Center Soiled Linen room contained over 64 gallons of soiled linen. When the corridor door was tested, the door hit the frame and failed to latch. b) the Kitchen contained fuel-fired equipment. The corridor double doors lacked an astragal and one of the two doors failed to latch when tested. c) the Central Supply room contained over 50 cardboard boxes and other miscellaneous storage. The corridor double doors lacked an astragal, a coordinating device and positive latching hardware. d) the Laundry room contained double corridor doors. When tested, the door with an astragal closed first preventing the second door from fully closing. Based on interview at the time of each observation, the Director of Plant		K321 1.Vendor was contacted and will come to facility 11-15-17 to correct deficiency with the closure of the doors. 2.Items identified will be ordered as priority to correct the door closures. These items will assure proper closure and will be installed by the vendor upon receipt. 3. Vendor will return to correct the deficiency with the closure of the doors. Director of Plant Operations in-serviced the Plant Operations staff 11-14-17 (See attachment 1 & 1a) on proper door closures. Doors will be added to the monthly door PM maintenance schedule to ensure inspection for proper closure.(see attachment #2) 4. Director of Plan Operations/designed will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning November, 2017.The QAPI Committee will monitor data presented for any items for trends and determine if further	

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	Operations and Plant Operations Assistant #1 acknowledged each hazardous area corridor door improper operation. 3.1-19(b)		auditing is warranted. 5. Systemic changes will be completed by 11-29-17	
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 a clearance of 1 of 1 sprinkler head in the walk-in freezer accordance with LSC 9.7.5. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.1.2 requires the minimum clearance required by the installation	K 0353	We request desk compliance K 353 1.The cardboard box which was completely blocking the sidewall sprinkler head in the walk-in freezer was corrected immediately(10-30-17).(see attachment #3) 2.Inspection conducted of the	11/29/2017

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	standard shall be maintained below all sprinkler deflectors. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 at 2:12 p.m., one cardboard box was completely blocking the sidewall sprinkler head in the walk-in freezer. Based on interview at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the obstructed spray pattern. 3.1-19(b)		other walk-in refrigerator/freezer to assure that any blocking of sprinklers was corrected, no other deficiencies noted. 3.Director of Dietary in-serviced the Kitchen staff 11-14-17 on the code for proper storage in refrigerator/freezers to assure no blockage of sprinkler heads. Dietary manager will monitoring for proper procedure daily five(5) times per week. Any issues regarding blockages will be corrected as they observed. (see attachment #4 & 4a) 4.Director of dietary/designee will report findings to the QAPI Committee meeting beginning November, 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5.Systemic changes will be completed by 11-29-17	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved			

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	sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 4 3rd floor smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 21 residents. Findings include: Based on observations with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 at 10:47 a.m., there was a three quarter inch gap inside conduit in the the resident room A312 smoke barrier above the ceiling tile. Based on interview at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the aforementioned condition and provided the measurement.	K 0372	We request desk compliance K 372 1.The penetration by wire and/or conduit was sealed on 10-30-17. 2.Director of Plant Operations inspected third(3rd) level, no other penetrations through the smoke barrier wall noted. 3.Director of Plant Operations in-serviced the Plant Operations staff 11/14/17 on the code related to penetrations. (see attachment #1 & 1a) 4.Once repair was made, no further actions are warranted. 5.Systemic changes will be completed by 11-29-17	11/29/2017

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	3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 4 2nd floor sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect staff and up to 10 residents. Findings include:	K 0374	We request desk compliance K374 1.Smoke barrier door by resident room 200 had the coordinator readjusted immediately. Repeated testing indicated that it is functioning correctly. 2.No other doors inspected found to have coordinator issues at this inspection 3.Director of Plant Operations in-serviced the Plant Operations staff 11-14-17 (See attachment 1 & 1a) on proper door closures and observation of	11/29/2017

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	Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 at 12:40 p.m., the 2nd floor set of smoke barrier doors by resident room 200 were tested. One of the doors caught up on the coordinator and failed to close. Based on interview at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the coordinator prevented the door from closing. 3.1-19(b)		smoke barrier door coordinators that they properly function or are replaced immediately. Doors will be added to the monthly door PM maintenance schedule to ensure inspection for proper closure. 4.Director of Plan Operations/designed will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning November, 2017. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted. 5.Systemic changes will be completed by 11-29-17	
K 0531 SS=E 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			

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	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 detectors.) 19.5.3, 9.4.2, 9.4.3 Based on interview and observation, the facility failed to maintain testing of 1 of 1 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 staff and up to 140 residents above the first floor. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 between 8:45 a.m. and 10:15 a.m., there was an elevator located in the health care portion of the building equipped with elevator firefighter recall. Based on interview at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the elevators	K 0531	We request desk compliance K 531 1. Elevator in question was immediately tested for firefighter recall in accordance with 9.4.6 Elevator Testing. (see attachment #5) 2.Director of Plant Operations/designee reviewed and tested other elevators for compliance with 9.4.6 Elevator testing related to firefighter recall and found no deficiencies. (see attachment #5, a & b) 3.The Director of Plant Operations/designee re-inserviced plant staff regarding testing for firefighter recall in accordance with 9.4.6 Elevator testing. The document for recording testing added to monthly preventive maintenance and will be reviewed to assure compliance on a monthly basis for six(6) months.(See attachment 1 & 1a) 4.The Director of Plant Operations/designee will report audit findings to the QAPI Committee monthly for six (6) months beginning November 2017. The QAPI Committee will	11/29/2017

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	were equipped with elevator firefighter recall; no monthly operation documentation was available for review and were unaware of the monthly inspection requirement. 3.1-19(b)		monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 5.Systemic changes will be completed by 11-29-17	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 12 of 12 candles was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 64 residents. Findings include:	K 0753	We request desk compliance K753 1.Candles located in the pastoral Care office, Human resource office, Resident rooms: 373, 217, 208 were removed immediately. Chapel candles were extinguished immediately following the service. 2.100% audit focused on candles was conducted 11-14-17 with no other candles located.	11/29/2017

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	Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 between 11:10 a.m. and 2:34 p.m., the following was discovered: a) a candle with a wick in resident room 373 b) a candle with a wick in resident room 217 c) a candle with a wick in resident room 208 d) a candle with a wick in the Pastoral Care office e) seven separate candles with wicks in the Chapel f) a candle with a wick was in the Human Resources office Based on interview at the time of each observation, the Director of Plant Operations and Plant Operations Assistant #1 confirmed each aforementioned candle contained a wick. 3.1-19(b)		3.Director of Plant Operations in-serviced plant staff as well as the Director of Staff Development in-serviced at house meeting staff related to combustible decorations. Administrator visited Resident Council meeting 11-13-17 and discussed the issue of no one being allowed candles in their room and why. No candles with wicks are permitted in any location within the facility. Zone techs will check for candles in the facility daily, five times per week while on daily rounds. Any candle found will be removed at once. If residents are found with candles, Social Service will be involved to assist in removal and giving explanations of the policy. Policy will also be shared with the family/caregivers by letter to assure they understand and will comply. New policy covered with pastoral care related to candle use in the chapel. Concerns will be brought to the Director of Plant Operations. (see attachment #1 and 1a, #6 & 6a) 4.Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly beginning November, 2017. The QAPI Committee will monitor audit results presented for trends and determine if further auditing is warranted. 5.Systemic changes will be completed by 11/29/17	

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K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, interview, and record review, the facility failed to enforce 1 of 1 policy for the use of portable space heaters in accordance with 19.7.8. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 at 2:10 p.m., a space heater was discovered in the Kitchen Chef's office. Based on interview and record review at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the space heater and confirmed that the facility's space heater policy does not allow space heaters in the facility. 3.1-19(b)	K 0781	We request desk compliance K781 1.The portable space heater was removed immediately. (see attachment #7) 2.The Director of Plant Operations ordered a permanent wall mounted heater in the Kitchen Chef's office. 3.Director of Plant Operations in-serviced all Facility Directors 10-30-17 that any type of space heater is prohibited. No other space heaters found on audit. Portable space heaters will be added to monthly preventive maintenance audit conducted by plant staff for six(6) months. 4.Director of Plant Operations/designee will report audit findings to the QAPI Committee meeting monthly beginning November, 2017. The QAPI Committee will monitor audit results presented for trends and determine if further auditing is warranted. 5.Systemic changes will be completed by 11-29-17	11/29/2017

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ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation, record review, and interview, the facility failed to install 1 of 1 multiplug and 5 of 5 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be	K 0920	We request desk compliance K 920 1.The power strips were immediately removed from A305, A347,203, 202, 2nd floor nurses station and 122. 2.100% audit was conducted and no other power strips found being utilized inappropriately for	11/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 42 residents. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 between 10:25 a.m. and 1:40 p.m., a) a power strip was powering a mattress in resident room A305 b) a power strip was powering a nebulizer and a CPAP machine in resident room A347 c) a power strip was powering a nebulizer in resident room 203 d) a multiplug outlet was powering an oxygen concentrator in resident room 202 e) a power strip was powering a medical cart at the 2nd floor Center Nurse's station f) a power strip was powering an oxygen concentrator in resident room 122 Based on interview at the time of observation, the Director of Plant Operations and Plant Operations Assistant #1 was unable to provide UL 60601-1 documentation for the permanently installed power strip in a patient care area. 3.1-19(b)		medical devices. 3.Staff re-educated that it is against life safety code to plug medical equipment into power strips. Housekeeping and zone techs will monitor weekly to ensure all power strips are utilized according to life safety code.(see attachment #1 & 1a, 2) 4.Director of Plant Operations/designee will report findings to the QAPI Committee meeting monthly beginning November, 2017. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 5.Systemic changes will be completed by 11-29-17	

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	2. Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 1 2nd floor Center Nurse's station above the drop ceiling according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. Additionally, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Plant Operations and Plant Operations Assistant #1 on 10/30/17 at 12:55 p.m., a junction box was missing a cover above the drop ceiling near the 2nd floor Center Nurse's station. Based on interview at the time of each observation, the Director of Plant Operations and Plant Operations Assistant #1 acknowledged the exposed wiring. 3.1-19(b)			