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	10/19/2015

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: 10/19/15 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 2000 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 172 at the time of this survey.	K 0000	St. Anthony Home – Crown Point (“the provider”) submits this Planof Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission ofany alleged deficiency cited. TheProvider submits this POC with the intention that it be inadmissible by anythird party in any civil or criminal action against the Provider or anyemployee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right tochallenge the findings of this survey if at any time the Provider determinesthat the disputed findings: (1) are relied upon to adversely influence or serveas a basis, in any way, for the selection and / or imposition of futureremedies, or for any increase in future remedies, whether such remedies areimposed by the Centers for Medicare and Medicaid Services (“CMS”), the state ofIndiana or any other entity;	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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
	155214	A. BUILDING 01 B. WING	10/19/2015

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
	All areas where residents have customary access were sprinklered except those cited at K56. All areas providing facility services were sprinklered. Quality Review completed 10/20/15 - DA		or (2) to serve, in any way, to facilitate orpromote action by any third party against the Provider. Any changes to Provider policy or proceduresshould be considered to be subsequent remedial measures as that concept isemployed in Rule 407 of the Federal Rules of Evidence and should beinadmissible in any proceeding on that basis.	
K 0020 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation, the facility failed to ensure the passage of pipe through 1 of 2 Lower Level vertical openings was protected as appropriate for the fire resistance rating of the barrier. LSC Section 8.2.5.2 requires openings through floors, such as stairways, to be enclosed with fire barrier walls. The passage of building service materials such as pipe shall be protected so that the space between the penetrating item and the fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an	K 0020	1. Thegap around the conduit in the lower level center stairwell was repaired and broughtto code immediately. 2. Directorof Plant Operations / designee reviewed other pipe passages / vertical openingsfor compliance with any other deficiencies noted corrected. 3. TheDirector of Plant Operations / designee re-inserviced Plant Operations	11/13/2015

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	10/19/2015

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
	approved device designed for the specific purpose. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 5:34 p.m., there was a four inch unsealed penetration gap around conduit in the Lower Level Center stairwell. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)		staffregarding the life safety standard for appropriate fire barriers / firestopping for vertical openings / pipe passages. The *Construction and Renovation* policy was reviewed and revised to moreclearly outline this life safety requirement for internal / external workers. The Director of Plant Operations / designeewill audit ten (10) pipe passages (random floors / wings) weekly for four (4)weeks, then ten (10) monthly (random floors / wings) for five (5) months forcompliance. 4. TheDirector of Plant Operations / designees will report audit findings to the QAPIcommittee monthly for six (6) months beginning November 2015. The QAPI committee will monitor the datapresented for any trends and determine if further monitoring / action isnecessary for continued compliance. Systemic changes willbe completed by 11/13/15.	
K 0021 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway			

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	10/19/2015

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
	enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 3 first floor fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect staff and visitors, and at least 7 residents in resident rooms and at least 35 residents who frequent the Chapel. Findings include: Based on observation with the Director of Plant Operations and the Director of	K 0021	1. New door operators with closure assist were ordered for the identified door. 2. Director of Plant Operations / designee reviewed other fire door sets for compliance with no other deficiencies noted. 3. The Director of Plant Operations re-inserviced Plant Operations staff regarding the life safety standard for fire door automatic closure requirements. The Director of Plant Operations / designee will audit the all facility automatic fire doors monthly for six (6) months to ensure appropriate automatic closure and latching. 4. The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. Systemic changes	11/13/2015

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	10/19/2015

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
	Plant Operations Assistant on 10/19/15 at 6:12 p.m., there was a two hour fire wall separating the nursing home of Type I (332) construction, and the entrance to the Hospital. When the fire alarm was tested, the doors were released but kept open by the air flow coming from the Hospital. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)		will be completed by 11/13/15.	
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice	K 0025	1.The identified ceiling penetrations were repaired immediately to code. 2.The Director of Plant Operations / designee reviewed other ceiling smoke barriers for penetrations with any other deficiencies noted corrected. 3.The Director of Plant	11/13/2015

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	10/19/2015

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
	could affect staff only. Findings include: Based on observations with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:00 p.m. then again at 4:04 p.m., the Kitchen Mechanical Room had four ceiling penetrations ranging from a quarter inch to a half an inch. Then again in the Elevator Room on first floor by Dietary there was a one inch penetration in the ceiling. Based on interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned conditions and provided the measurements for each unsealed penetration. 3.1-19(b)		Operations / designee re-inserviced Plant Operations staff regarding the life safety standard for ceiling smoke barriers. The Construction and Renovation policy was reviewed and revised to more clearly outline this life safety requirement for internal / external workers. The Director of Plant Operations / designee will audit ten (10) rooms / common areas (random floors / wings) weekly for four (4) weeks, then ten (10) monthly (random floors / wings) for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	
K 0029 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied			

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	10/19/2015

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
	protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Hotel Storage Room, 1 of 1 Hospice Storage Room, 1 of 1 A Wing Mechanical Room, 1 of 1 Lower Level Mechanical Room, and 1 of 1 Lower Level Laundry room, which are hazardous areas, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 between 5:30 p.m. and 5:58 p.m., the following was discovered: a. the Hotel Storage room contained 6 desks, 15 chairs, 4 mattresses, 50 filter boxes, plus miscellaneous storage. The Hotel Storage room had two doors that self closed, but did not latch into the frame. b. the Hospice Storage room contained 60 cardboard boxes of medical records and the door did not self close when tested. c. the A Wing Mechanical room contained fuel burning equipment and	K 0029	1.The rooms outlined in the 2567 and identified during the survey on 10/19/15 had new closures ordered to address self-closing / latching deficiencies. 2.The Director of Plant Operations / designee reviewed other like doors with any other deficiencies noted addressed as above. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff regarding the life safety standard related to fire door / hazardous area self-closure / latching requirements. The Director of Plant Operations / designee will audit five (5) of these fire doors (random floors / wings) weekly for four (4) weeks, then ten (10) monthly (random floors / wings) for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	11/13/2015

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	10/19/2015

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
	two doors that did not latch into the frame. d. the Lower Level Medical Records room contained at least 40 cardboard boxes of medical records and the door did not self close when tested. e. the Lower Level Laundry room contained fuel burning dryers and had two sets of doors that did not latch into the frame. The Lower Level Laundry room also contained a single door that did not self close into the frame. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged each aforementioned condition. 3.1-19(b)			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 2 of 5 stairwell exits on the Second Floor exit discharge paths were readily accessible at all times. This deficient practice could affect staff, visitors, and at least 37 residents. Findings include:	K 0038	1. Thestairwell exit door in the 2nd floor 2B wing and the 2ndfloor 2D wing were both repaired so they would open immediately. 2. TheDirector of Plant Operations / designee checked facility stairwell exit doors toensure ability to open and	11/13/2015

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	10/19/2015

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
	Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 2:13 p.m. then again at 2:35 p.m., the stairwell exit door in the 2nd floor B Wing would not open. Then again the stairwell exit door on the 2nd floor D Wing would not open as well. Based on an interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. The Director of Plant Operations later explained that the 2nd floor B Wing door had a screw loose on the frame preventing the door from opening. Then again, the 2nd floor B Wing door was stuck at the bottom of the door from a build up of floor wax. 3.1-19(b)		that exit access / discharge path was readilyaccessible, with no other deficiencies noted. 3. TheDirector of Plant Operations / designee re-inserviced Plant Operations staff andother department staff regarding the life safety standard for exit door anddischarge path accessibility requirements. The Director of Plant Operations / designee will audit five (5)discharge paths / exit doors weekly for four (4) weeks, then five (5) per monthfor five (5) months for compliance. 4. TheDirector of Plant Operations / designees will report audit findings to the QAPIcommittee monthly for six (6) months beginning November 2015. The QAPI committee will monitor the datapresented for any trends and determine if further monitoring / action isnecessary for continued compliance. Systemic changes willbe completed by 11/13/15.	
K 0056 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is			

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	10/19/2015

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
	installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 elevator equipment rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. LSC Section 9.7.3.1 allows alternative automatic extinguishing systems other than an automatic sprinkler system such as a water mist, carbon dioxide, dry chemical foam or a standard	K 0056	1.The appropriate vendor was contacted immediately to schedule the installation of sprinkler coverage in the elevator equipment room. The ceiling box light in the activities janitor storage room was relocated immediately. 2.The Director of Plant Operations / designee checked facility areas that require sprinkler coverage with no other deficiencies noted; also checked facility sprinkler heads to ensure not obstructed with any other deficiencies noted corrected at that time. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard for automatic sprinklers, coverage requirements and requirement to not obstruct sprinkler head spray patterns. The Director of Plant Operations / designee will audit ten (10) sprinkler heads per floor	11/13/2015

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	10/19/2015

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
	extinguishing system of another type in lieu of an automatic sprinkler system. Such systems shall be installed, inspected and maintained in accordance with NFPA standards and shall activate the building fire alarm system. The elevator equipment room was located in the basement and could affect any number of staff. Findings include: Based on an observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 5:20 p.m., the elevator equipment room lacked sprinkler coverage. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinklers in Activities Janitor Storage Room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable		weekly for four (4) weeks, then ten (10) per month for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	

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	10/19/2015

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
	obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect staff only. Findings include: Based on observations with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 3:06 p.m., the spray pattern for the sprinkler head was obstructed by a ceiling box light which was less than six inches away and two inches directly below the sprinkler head. Based on interview, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition and agreed the sprinkler head was being obstructed by the light. 3.1-19(b)			
K 0062 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are			

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	10/19/2015

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
	continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. This deficient practice could affect staff only. Findings include: Based on observations with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 3:12 p.m., the 1B Phone Room was missing 6 of 7 ceiling tiles. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3	K 0062	1.The missing ceiling tiles in the 1B phone room were replaced immediately. The appropriate vendor was contacted immediately to schedule the required inspections / gauge replacements. 2.The Director of Plant Operations / designee checked facility for any other missing ceiling tiles with any deficiencies noted corrected. The Director of Plant Operations / designee checked other sprinkler systems with any deficiencies noted corrected as noted above. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff regarding the life safety standard related to sprinkler system maintenance requirements. The Director of Plant Operations / designee added an every five (5) year PM (preventative maintenance) into facility MVP maintenance program for sprinkler system maintenance requirement compliance moving forward. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will monitor the data presented for any trends and determine if	11/13/2015

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	10/19/2015

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
	percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:57 p.m. then again at 5:42 p.m., the sprinkler system standpipe located in the Lower Level A Wing Mechanical Room had two gauges dated 2001. Then again the sprinkler system standpipe located in the Center Core Stairwell one sprinkler gauge dated 2010. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the aforementioned conditions. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions		further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 11/13/15.	

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	10/19/2015

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
	where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on record review of sprinkler system "Inspection, Testing & Maintenance of Wet Pip Fire Sprinkler System" documentation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 10:14 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been conducted. Based on interview at the time of record review, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)			

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	10/19/2015

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 0064 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the Generator Room requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect staff only. Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 5:04 p.m., the fire extinguisher on the wall indicated the last six year test was completed 2005. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)	K 0064	1.The fire extinguisher in the generator room was replaced immediately. 2.The Director of Plant Operation / designee checked all facility fire extinguishers with no other compliance issues noted. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard for fire extinguisher maintenance / testing. The Director of Plant Operations / designee will audit all facility fire extinguishers monthly for six (6) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	11/13/2015
K 0066 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:			

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	10/19/2015

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
	(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff only and 1 of 1 area where smoking was not permitted were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only. Findings include: Based on observations with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:30 p.m. and then again at 4:51 p.m., there were at least 40 cigarette butts on the ground in the non-designated smoking area. Then again there were at	K 0066	1.The cigarette debris in both areas identified were cleaned immediately. 2.Remaining outdoor areas were inspected for cigarette debris with any noted cleaned / removed at that time. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard regarding proper disposal of cigarette butts as well as facility policy related to approved designated smoking area. The Director of Plant Operations / designee will audit outdoor areas including approved smoking area compliance weekly for four (4) weeks, then bi-weekly for four (4) weeks, then monthly for four (4)	11/13/2015

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	10/19/2015

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
	least 60 cigarette butts in the designated resident smoke area. Based on interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned conditions and provided the estimation of cigarette butts. 3.1-19(b)		months to ensure compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	
K 0070 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 3 of 3 portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff. Findings include: Based on record review with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 between 9:37 a.m. and 11:50 a.m., the space heater policy states the facility does	K 0070	1.All identified space heaters were removed immediately. 2.The Director of Plant Operations / designee rounded facility for other space heaters to be removed with no other deficiencies noted. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard prohibiting space heaters with heating elements that exceed 212 degrees. The Director of Plant Operations / designee will audit five (5) offices / rooms per unit weekly for four (4) weeks, then five (5) offices / rooms per unit	11/13/2015

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	10/19/2015

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
	not allow space heaters. Based on observation at 2:54 p.m. then again at 3:49 p.m., a space heater was discovered at the 1A Nurse Manager's office. Then again a space heater was discovered in the Director of Fund Development office. Based on interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the space heaters were a violation of the facility's policy. 3.1-19(b)		monthly for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	
K 0073 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation, the facility failed to ensure 1 of 1 facility chapels remains free of combustible decorations. This deficient practice affects staff, visitors, and at least 35 residents who regularly use the chapel. Findings include: Based on observations with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:17 p.m., in the chapel, there was one lit candle with no one else in the chapel.	K 0073	1.To meet both life safety and Catholic Church guidelines, an electric candle was ordered to replace the lit candle. 2.There are no other candles utilized within the facility. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard prohibiting decorations of highly flammable character. The Director of Plant Operations / designee will audit the chapel weekly for four (4) weeks, then monthly for five (5) months for compliance.	11/13/2015

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	10/19/2015

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
	Based on interview at the time of observation, the Director of Plant Operations acknowledged the candle is always lit and acknowledged the aforementioned condition. 3.1-19(b)		4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	
K 0075 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 7 2nd floor resident room areas and 1 of 7 3rd floor resident room areas. This deficient practice could affect 17 residents on third floor and 24 on the second floor.	K 0075	1.The identified receptacles were moved to be within the identified regulatory requirements immediately. 2.The Director of Plant Operations / designee rounded facility to assess for any other receptacles to ensure the total capacity / gallon size was not exceeded within a 64 square foot area with any other deficiencies noted corrected at that time. 3.The Director of Plant Operations / designee re-inserviced Plant Operations	11/13/2015

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	10/19/2015

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
	Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 between 12:49 p.m. and 1:38 p.m., the following was discovered stored in the corridor: a. two separate 22 gallon soiled linen and trash near resident room 352 b. three separate 22 gallon soiled linen, clean linen, and trash near resident room 365 c. two separate 22 gallon soiled linen and trash near resident room 206 Based on an interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged each aforementioned condition. 3.1-19(b)		staff and other department staff regarding the life safety standard related to mobile soiled linen or trash receptacles storage requirements. The Director of Plant Operations / designee will audit each unit three (3) times weekly for four (4) weeks, then three (3) times monthly for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/14/15.	
K 0076 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.			

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	10/19/2015

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
	NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as carbon dioxide were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff and about 10 residents. Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:34 p.m., a carbon dioxide cylinder was standing unsupported under the counter in the Snack Shop. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)	K 0076	1.The carbon dioxide cylinder vendor was notified immediately to appropriately secure the cylinder. 2.The Director of Plant Operations / designee reviewed other facility carbon dioxide cylinders for appropriate support with no other deficiencies noted. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff and other department staff regarding the life safety standard for freestanding cylinder support. The Director of Plant Operations / designee will audit the carbon dioxide cylinders weekly for four (4) weeks, then monthly for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	11/13/2015
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in	K 0130	1.The identified areas were repaired and brought to code	11/13/2015

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	10/19/2015

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
	1 of 3 First Floor fire barrier walls and 2 of 2 Lower Level fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose.		immediately. 2.Director of Plant Operations / designee reviewed other fire barrier walls for compliance with any other deficiencies noted corrected. 3.The Director of Plant Operations / designee re-inserviced Plant Operations staff regarding the life safety standard for appropriate fire barriers / fire stopping for service equipment that passes through fire barriers. The Construction and Renovation policy was reviewed and revised to more clearly outline this life safety requirement for internal / external workers. The Director of Plant Operations / designee will audit ten (10) fire barrier walls (random floors / wings) weekly for four (4) weeks, then ten (10) monthly (random floors / wings) for five (5) months for compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	

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	10/19/2015

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
	This deficient practice could affect staff and at least 23 residents. Findings include: Based on an observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 between 6:31 p.m. and 7:22 p.m., the following was discovered: a. two separate three inch by three inch gaps around conduit, and a two inch gap around wires in conduit in the fire barrier wall above the ceiling tile by resident room 111. b. a 24 inch by 19 in block was missing in the Lower Level Center Stairwell fire barrier above the ceiling tile. c. a three inch by six inch gap in Lower level A Wing fire barrier above the ceiling tile Based on interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged each aforementioned condition and provided the measurements. 3.1-19(b)			
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2			

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	10/19/2015

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
	1. Based on observation and interview, the facility failed to ensure 2 of 2 multiplugs and 12 of 12 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 between 12:22 p.m. to 5:24 p.m. the following was discovered: a. a surge protector powering two separate refrigerators in Medication Room 3B b. a multiplug powering a coffee pot and a microwave in 1A Clean Utility c. a surge protector powering two separate refrigerators, a microwave, and a coffee pot in the Director of Resident and Clinical Services office d. a surge protector powering a coffee pot in the Admitting office e. a surge protector powering a microwave in the Director of Fund Development	K 0147	1.All of the identified appliances / equipment were immediately either removed or plugged directly into wall outlets. The chapel mechanical room electrical outlet switch cover was replaced immediately. 2.Other resident rooms and offices were assessed for proper placement / use of power strip extension cords with any deficiencies noted immediately corrected. 3.The Director of Plant Operations / designee re-inserviced the Plant Operations Department and other department staff regarding proper placement and use of power strip extension cords vs. fixing wiring outlets. Director of Plant Operations / designee will audit five (5) rooms / offices per wing weekly for four (4) weeks then monthly for five (5) months for proper placement and use of power strip extension cords to ensure compliance. 4.The Director of Plant Operations / designees will report audit findings to the QAPI committee monthly for six (6) months beginning November 2015. The QAPI committee will 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 11/13/15.	11/13/2015

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	10/19/2015

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
	f. a surge protector powering a microwave and a refrigerator in the Business Office. Additionally a multiplug was powering two separate surge protectors g. a surge protector powering a microwave in the Medical Records office h. a surge protector powering another surge protector powering computer components in the Director of Plant Operations office i. a surge protector powering two separate coffee pots in the Personal Care Services office j. a surge protector powering a microwave and a refrigerator in the Environmental Break Room Based on interview at the time of each observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Chapel Mechanical Room. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.			

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	10/19/2015

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
	Findings include: Based on observation with the Director of Plant Operations and the Director of Plant Operations Assistant on 10/19/15 at 4:24 p.m., an outlet switch cover was missing. Based on interview at the time of observation, the Director of Plant Operations and the Director of Plant Operations Assistant acknowledged the aforementioned condition. 3.1-19(b)			