

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/09/14</p> <p>Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Terre Haute Nursing and Rehabilitation Center 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.</p> <p>This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke</p>	K010000	<p>06/23/2014Indiana State department of HealthDivision of Long Term Care2 Nothe Meridian Section 4BIndianapolis, In 46204-3006Attn: Kim rhoades, Director, Division of Long Term CareRE: June 9, 2014 Life Safety Code SurveyDear Ms. Rhoades,On June 9, 2014 a survey team from the Indiana State Dept. Of health completed a life safety survey at Terre Haute Nursing & Rehab Center. Attached please find the Statement of Deficiencies with the facility Plan of Correction for these alleged deficiencies.Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our request for a desk review awarding the facility paper compliance as means to verify that the facility has achieved substantial compliance with the applicable requirement as of the date set forth in the Plan of Correction of July 9, 2014.Please feel free to call me with any further questions at (812) 232-7102.Respectfully Submitted,Cathy J. Cox-Parker, B.A., HFAHealth Facility Administrator</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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K010038 SS=F	<p>detectors have been installed in all resident rooms. The facility has a capacity of 38 and had a census of 30 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered with the exception of three detached maintenance, equipment storage and oxygen supply storage sheds.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 the means of egress through 3 of 3 exit doors equipped</p>	K010038	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or	07/09/2014

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	<p>with magnetic locks were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects visitors and 30 residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/09/14 between 9:15 a.m. and 10:45 a.m., emergency exit doors were magnetically locked. The maintenance director demonstrated the locks would release by inserting a code into the keypad attached to the wall beside each locked door. A sign was posted adjacent to each door instructing anyone leaving to ask an employee to provide assistance to exit. The maintenance director said at the time of observations, not all residents were</p>		<p>allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 9, 2014 to the Life Safety Code Survey conducted on June 9, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p>K038</p> <p>It is the practice of Terre Haute Nursing and Rehabilitation to assure that Exit Access is arranged so that exits are readily accessible at all times for residents without a clinical diagnosis requiring specialized security measures.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Signs posted at each exit detailing the door code were placed up immediately.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents, visitors and staff had</p>	

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K010067	NFPA 101 considered to have a diagnosis for which locks might be indicated. The administrator confirmed his claim on 06/09/14 during a record review at 12:10 p.m. 3.1-19(b)		<p>the potential to be affected, but none were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted with all staff regarding accessibility and proper signage.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that randomly observes door exit postings are accessible and appropriate. The Maintenance Supervisor, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool.</p> <p>The date the systemic changes will be completed:</p> <p>July 9, 2014</p>		

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SS=F	<p>LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 central air conditioning cooling towers in accordance with manufacturer's specifications. LSC 19.1.1.3 requires health facilities be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/09/14 at 10:45 a.m., a garden hose attached to the exterior of the building was leaking and water was pooling along the outside of the building. The garden hose ran into the top of the facility's central air cooling tower supplying air conditioning to corridors and common areas for resident use. The maintenance director said at the time of observation the cooling tower was not working properly. He said the system was so badly "limed up" that the cooling tower was unable to maintain it's operating temperature. He said unless he had a constant flow of water from the</p>	K010067	<p>K067 By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 9, 2014 to the Life Safety Code Survey conducted on June 9, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request. It is the practice of Terre Haute Nursing and Rehab to assure that Heating , ventilating and air conditioning are installed and maintained in accordance with manufacturer's specifications. The correction action taken for those residents found to be affected by the deficient practice include: CLR rust and lime remover obtained immediately, enough stocked for the next 8 weeks and drain opened to increase water flow to tower. Other residents that have the potential to be affected have been identified</p>	07/09/2014			

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	garden hose running into the top of the unit, it would overheat. He acknowledged at the time of observation, the garden hose was not part of the manufacturer's specifications for installation and operation of the system. 3.1-19(b)		by: All residents, visitors, vendors and staff had the potential to be affected, but none were identified. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Maintenance Director In-serviced on the importance of following manufacturer's specifications. Obtaining bids to replace water cooled heat pumps with air to air heat pumps and split system units for all inner wall offices/Main dining room and main Halls which will eliminate boiler and cooling tower. le 6/17/2014- Master Built and 06/18/2014 Cochran Design. Both have been sent facility Blue Prints. Stand-alone P-Tach Units have already been installed in all resident rooms. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews manufacturers' specifications are followed in maintaining central air conditioning tower, checking for appropriate agents for Delime until new system is acquired. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled		

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			meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: July 9, 2014		