

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 12/14/2011
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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, IN47807
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K0000	<p>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).</p> <p>Survey Date: 12/14/11</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)</p>	K0000		

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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K0038 SS=F	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 38 and had a census of 33 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/19/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exit doors equipped 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</p>	K0038	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 038 Egresses – Exit door signage (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Signage has been posted at all 3 exit doors with wording (Current 4 digit year *)</p>	01/14/2012

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	<p>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 33 residents.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 12/14/11 between 11:05 a.m. and 3:10 p.m., emergency exit doors were magnetically locked. The locks released upon activation of the fire alarm, a power outage, or by inserting a code in a keypad adjacent to the exit doorways. The code was not posted at the side and back exits. A code posted at the front entrance was keyed in at 3:05 p.m. with the maintenance director and the door lock failed to open. The maintenance director said at the</p>		<p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Resident/family/employees who are not cognitively impaired have the potential to be affected by the exit door key pad lock signage – but done where identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Access codes will be posted at each door. It was discussed at resident council and staff was in-serviced as to the new procedure.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The monitoring of this will be a joint effort between the NHA and Director of Maintenance as they make their weekly joint facility rounds which will include a visual check of exit door wording. A Report of these finding will be reviewed at the monthly Risk management/QA meeting to determine if this remains in compliance.</p> <p>(e) Date of compliance: 1/14/12</p>	

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K0066 SS=E	<p>time he had changed the code and failed to post the new code. When the correct code was keyed in by the maintenance director the doors unlocked and could be opened.</p> <p>3.1 – 19(b)</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>Based on observation, record review, and interview; the facility failed to provide and enforce a</p>	K0066	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared	01/14/2012	

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	<p>complete and effective smoking policy for 1 of 1 smoking areas. This deficient practice could affect 4 or more staff, visitors and any resident near the main entrance.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 12/14/11 at 11:50 a.m., the facility Smoking Policy revised 04/20/09 noted smoking was permitted in outside designated areas. The areas were not specified in the written smoking policy but the maintenance director said at the time of record review, everyone was notified at the time of admission and orientation. He said the smoking area was located outside the back exit where appropriate waste receptacles and a sitting area were provided, however, the mulched area around the covered front entry porch, observed with the maintenance director on 12/14/11 at 3:10 p.m. was carpeted with cigarette butts. The maintenance director said the area was not designated for smoking and the butt receptacle beside the front entry door was for</p>		<p>and/or executed solely because required.</p> <p>K 066 Smoking regulations. Cigarette butts</p> <p>a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <ol style="list-style-type: none"> 1. Cigarette butts on the covered front entry porch were cleaned up. 2. Employees were in-serviced on designated smoking area and how to dispose of smoking debris. <p>b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>A facility wide audit was completed to identify any other areas with cigarette debris. None were found.</p> <p>c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Maintenance Director and staff have been in-serviced as to the required components of this tag. The standard monitoring and any needed adjustments identified will be during routine environmental rounds and monthly preventative maintenance rounds as the Maintenance Director checks for: discarded smoking debris. Reviewed of the designated appropriate smoking areas was presented at the resident council meeting. Facility employee staff were also re-educated as to the appropriate location if they so desire to smoke.</p> <p>d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what</p>		

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K0068 SS=E	<p>the disposal of butts for anyone entering the building.</p> <p>3.1-19(b)</p> <p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect any resident in the corridor as well as visitors and staff.</p> <p>Findings include:</p>	K0068	<p>quality assurance program will be put into place: The NHA and/or the Maintenance Director will make weekly walking rounds to check all areas for cigarette butts for the next four weeks and monthly for there after. Quarterly monitoring by the Regional director of Plant Operations/Designee will be conducted. A Report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met and quarterly monitoring is recommend.</p> <p>e) Date of compliance: 1/14/12</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>K 68 Clean air in-take</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: 1. Clean air in-take duct were installed in the laundry area.</p> <p>.How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: 1.A laundry audit was completed to identify any other issues. None were found.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the practice</p>	01/14/2012	

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	<p>Based on observation on 12/14/11 at 11:40 a.m. with the maintenance director, the laundry room had two, gas fueled, commercial sized dryers with no fresh air intake. Based on interview at the time of observation, the maintenance director acknowledged the two gas fueled dryers did not have a fresh air intake.</p> <p>3.1-19(b)</p>		<p>does not recur: Maintenance Director has been inserviced as to the required components of this tag. The standard monitoring and any needed adjustments identified will be during routine environmental rounds and monthly preventative maintenance rounds as the Maintenance Director checks: The clean air in-take to assure it is in compliance with code.</p> <p>(b) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The monitoring of this tag will be a joint effort between the NHA and the Maintenance Director as they will make weekly walking rounds for the next four weeks and bi-monthly for 2 months. A quarterly monitoring by the Assistant of Plant Operations/Designee will be conducted. A Report of their findings will be discussed at the monthly Risk Management/QA meeting to determine when compliance has been met.</p> <p>(c) Date of compliance: 1/14/12</p>		