STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155511	A. BUILDING 01 / B. WING	05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE NURSING AND REHABILITATION CENTER	830 S 6TH ST TERRE HAUTE, IN 47807

(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 000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/15/15 Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720 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. 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 spaces open to the corridors. The facility has the capacity for 38 and had a census of 36 at the time of this survey.	K 000	I am Respectfully Requesting Paper compliance for LSC Survey as well as I would like to IDR the following Tags- K 50, K 69 and K 130. This Administrator was not in facility during time of survey and the covering maintenance director was not aware of location of some of our information. Our normal regular full time Maintenance Director (8 + years) was off with an injury.	

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.

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	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.			
K 018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure corridor doors protecting openings in 1 of 3 smoke compartments did not have an impediment to closing. This deficient practice would affect visitors, staff and 10 or more residents in the center smoke compartment. Findings include:	K 018	**This plan of correction is to serve as Terre Haute Nursing and Rehabilitation Centers' credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Terre Haute**	06/14/2015

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	Based on observation with the acting maintenance director on 05/15/15 at 1:05 p.m., the unoccupied dietary storage room door was propped open with a plastic box usually used to hold milk cartons. The door continued to be left open when the fire alarm was activated on 05/15/15 at 2:10 p.m., was not closed until the condition was mentioned to the acting maintenance director afterward. The cook said when the acting maintenance director immediately notified kitchen staff the door was not to be propped open; it had been held open to resupply the room. This activity was not observed during the survey. 3.1-19(b)		**Nursing and Rehabilitation Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Terre Haute Nursing and Rehabilitation Center is in full compliance and respectfully request paper review.** **K018** I. Plastic box has been removed. Dietary Manager given a teachable moment as to not propping door open. II. A facility wide audit was completed to verify if any other doors propped open. None were identified.	

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			III. Maintenance Director, Dietary Manager and Kitchen staff has been in-serviced to Not prop open Dietary Supply door. Maintenance Director will observe for any occurrence of propping open doors be during routine life safety rounds and monthly Preventative maintenance rounds. IV. The NHA and/or the Maint Director will make weekly walking rounds to make sure the door is not propped open weekly x 3, Monthly x 3 and quarterly x3. A Report of their findings will be discussed at the monthly risk management/ QAPI meeting.	
K 027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure a door in a smoke barrier door set separating 2 of 3 smoke	K 027	**K027**	06/14/2015

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	compartments would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors and 10 or more residents in the center and east smoke compartments. Findings include: Based on observation with the acting maintenance director on 05/15/15 at 2:05 p.m., the smoke barrier double door set located near room four was tested twice manually to observe its ability to close when released from magnets holding the doors open. Each time, one door in the door set failed to self close leaving a one inch gap between the meeting edges of the doors. The result was the same when the fire alarm was activated on 05/15/15 at 2:10 p.m. The acting maintenance director acknowledged at the time of observations, the door was not self closing as it should have. 3.1-19(b)		I. The Door Closure by Room #4 has been adjusted and is closing appropriately. II. Any resident, visitor, employee or vendor had the potential to be affected but none were identified. III. Maintenance Director has been In-serviced on adjusting door closures. . Maintenance Director will observe/test closing of fire doors during routine life safety rounds and monthly Preventative maintenance rounds. IV. The NHA or designee will make weekly walking rounds to assure proper door closure weekly x 3, monthly x 3 and quarterly x 3. A report of the findings will be discusses at the monthly risk management/QAPI meeting.	
K 038 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			

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	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 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, staff, and 10 or more residents. Findings include: Based on observations with the acting maintenance director on 05/15/15 between 1:00 p.m. and 2:40 p.m., emergency exit doors were magnetically locked. The acting maintenance director demonstrated the locks would release by entering a code into a keypad located beside each of the locked doors. However, the code was not posted at the north emergency exit, and codes posted at	K 038	**K038** I. Code placed at North Emergency Exit. New Signage that states, " Enter the 2 digits of the month and the last 2 digits of the Year" were placed at all Emergency Exits including the North. II. Any resident, visitor, employee or vendor had the potential to be affected but none were identified. III. The importance of this regulation has been reviewed with the Director of Maintenance and during his daily rounds he will assure that proper signage is posted. IV. The NHA/Director of Maint. Or designee as they make their facility rounds which will include a visual check of the signage at each Emergency Exit This will be an ongoing plan of correction. A report of the findings will be presented at the risk management/QAPI meeting for review.	06/14/2015

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	the west and east exits required knowledge of the zip code where signs were posted instructing anyone leaving to enter it to override the lock to provide exit access. The acting maintenance director said, and confirmed with the nurse on duty at the time of observations, not all residents were considered to have a diagnosis for which locks might be indicated. 3.1-19(b)			
K 064 SS=E 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, the facility failed to ensure a portable fire extinguisher protecting 1 of 3 smoke compartments were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects residents, staff and visitors in the kitchen with 3 staff and the 300 hall with a census of 15 residents.	K 064	**K064** I. The portable fire extinguisher at the front entry was lowered to permissive height. II. Any resident, staff member, vendor had the potential to be affected, but none were identified. III. An Audit was conducted of all portable fire extinguishers for proper Height. All were found in acceptable perimeters.	06/14/2015

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	Findings include: Based on observation with the acting maintenance director on 05/15/15 at 1:15 p.m., the portable fire extinguisher at the front entry was mounted 63 inches above the finished floor. The acting maintenance director measured the height of the fire extinguisher to confirm the placement and acknowledged it was higher than the minimum height permitted. 3.1-19(b)		IV. The NHA and/or the Maintenance director will make weekly walking rounds to ensure that portable fire extinguishers are at proper height weekly x3, monthly x 3 and quarterly x 3. A report of their findings will be discussed at the monthly risk management/QAPI meeting.	
K 070 SS=E 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 and interview, the facility failed to ensure portable space heaters were not used not in 1 of 1 areas used by residents. This deficient practice could affect any resident using the therapy room. Findings include: Based on observation with the acting maintenance director on 05/15/15 at 1:45 p.m., an electric fireplace was plugged into an electrical outlet in the therapy	K 070	**K070** I. Space Heater was removed. Therapy and Maintenance was given a teachable moment regarding the use of space heaters. II. An entire sweep of the facility was performed and no other areas were found to be affected.	06/14/2015

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	room. The therapy assistant said at the time of observation, staff used the fireplace to keep the room warm. The acting maintenance director said at the time of record review, he was sure the use of space heaters was prohibited by company policy but he could provide no documentation specifically addressing the use of space heaters. 3.1-19(b)		III. The Maintenance Director will check for any space heaters during his daily facility rounds and life safety audits weekly x 3, Monthly x 3 and quarterly x 3. IV. Weekly and monthly inspections will be reviewed by the NHA and a report of these findings will be discussed at the monthly risk management/QA PI meeting.	
K 135 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. Based on observation and interview, the facility failed to store flammable liquids in an approved cabinet away from other materials with which they could come in contact. This deficient practice could affect any resident, visitor, or staff in the smoking area outside the east emergency exit.	K 135	**K135** I. Can of Varnish was removed. II. Any resident, staff member, vendor had the potential to be	06/14/2015

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	Findings include: Based on observation with the acting maintenance director on 05/15/15 at 2:30 p.m., a gallon and a quart can of partially used varnish were sitting immediately adjacent to the smoke tower provided for the disposal of cigarette butts in the smoking areas provided outside the east emergency exit. The use of the varnish was evidenced by spills of the contents on the lip and sides of each can. The cans were clearly marked as oil based and flammable. The acting maintenance supervisor agreed at the time of observation, cigarette butt disposal could result in accidental ignition of these accelerants if hot ash or a cigarette butt were to drop onto the cans. 3.1-19(b)		affected, but none were identified. III. All staff was in-serviced on proper storage of flammable material. The NHA/Director of Maint. Or designee as they make their life safety rounds which will include a visual check for proper storage of flammable material weekly x 3, monthly x 3 and quarterly x 3. IV. Inspections will be reviewed by the NHA and a report of these findings will be discussed at the monthly risk management/QA PI meeting.	