

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
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K 0000 Bldg. 01	<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: 04/06/16</p> <p>Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360</p> <p>At this Life Safety Code survey, Signature Health Care of Terre Haute 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), and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 207 and had a census of 165 at the time of</p>	K 0000	Signature HealthCARE of Terre Haute is requesting a desk review of the plan of corrections rather than an on site revisit Thank you Sean Medsker, Administrator	

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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K 0044 SS=E Bldg. 01	<p>this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were fully sprinklered.</p> <p>Quality Review completed on 04/11/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 horizontal exit door sets interior to the building did not exceed the maximum clearance allowed for doors swinging in pairs. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4. LSC 7.2.4.3.4 requires any opening in fire barriers be protected as provided in 8.2.3. LSC 8.2.3.2.1 requires fire doors to be installed in accordance with NFPA 80. In addition NFPA 80, Standard for Fire Doors and Windows, 1999 Edition, at 2-3.1.7 states the clearance between the meeting edges of doors swinging in pairs on the pull side shall be 1/8th inch (plus or minus 1/16th of an inch) for steel doors and shall not exceed 1/8th inch for wood doors. This deficient practice could affect 28 residents, staff and visitors in the vicinity of the fire barrier doors near</p>	K 0044	<p>There were not any Residents or Staff found to be affected by this practice In order for Residents and Staff to not be affected, the facility tightened the screws on the hinges of the door to narrow the gap between the doors The Maintenance Director will complete the Smoke/Fire Barrier Inspection sheet monthly and submit it to the monthly QA committee The Maintenance Director is responsible for validating the working condition of all Fire Barrier doors</p>	05/06/2016

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K 0046 SS=C Bldg. 01	<p>the Rehab Room and the Alzheimer's Wing on the north side of the building.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 04/06/16, a one half inch gap was noted in between the meeting edges of the horizontal exit steel door set in the fire barrier near the Rehab Room and the Alzheimer's Wing on the north side of the building. Each door in the door set had a 90 minute fire resistance rating label affixed to the door. Based on interview at the time of observation, the Plant Operations Director stated the aforementioned door set was in a two hour fire resistance rated fire barrier wall and acknowledged the gap in the meeting edges of the door set exceeded 1/8th inch (plus or minus 1/16th of an inch) for steel doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 battery</p>	K 0046	There were not any Residents or Staff to be found to have been affected by this practice In order	05/06/2016			

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	<p>powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 04/06/16, the battery operated emergency light located in the kitchen Mechanical Room at the emergency generator transfer switch location failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Plant Operations Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed five times.</p> <p>3.1-19(b)</p>		<p>for Residents and Staff to not be affected by this practice, the facility removed the battery powered emergency light that was not operational. It is not needed due to generator powered emergency lighting in the area. The Maintenance Director will complete the emergency lighting inspection sheet, which includes battery powered emergency lighting. The maintenance director will be responsible for providing adequate emergency lighting in the facility. Validation will be submitted to the monthly QA committee.</p>	

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K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document activation of the fire alarm system for first and second shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 4 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills"</p>	K 0050	<p>There were not any Residents or Staff found to be affected by this practice. In order for the Residents and staff not to be affected by this practice, the maintenance director ran a fire drill on the night shift which included the activation of the fire alarm and the transmission of the fire alarm signal. The maintenance director will complete the Fire Drill Report which will include the activation of the alarm and the transmission of the fire alarm signal. To verify the reception of the transmission, the maintenance representative will contact the fire department. We will date and time stamp, the time we spoke to the fire department. The finding will be reported to the monthly QA committee</p>	05/06/2016

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K 0052 SS=F Bldg. 01	<p>with the Plant Operations Director during record review from 9:45 a.m. to 12:30 p.m. on 04/06/16, documentation for first and second shift fire drills conducted within the most recent twelve month period did not include activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned first shift fire drills were conducted on 04/30/15 at 10:15 a.m., 07/30/15 at 10:20 a.m., 10/30/15 at 1:45 p.m. and on 01/28/16 at 7:30 a.m. The aforementioned second shift fire drills were conducted on 05/29/15 at 4:39 p.m., 08/31/15 at 7:18 p.m., 11/10/15 at 8:23 p.m. and on 02/29/16 at 2:15 p.m. Based on interview at the time of record review, the Plant Operations Director stated the fire alarm system was activated for the first and second shift fire drills but acknowledged documentation for the aforementioned first and second shift fire drills conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in</p>			

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	<p>accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on record review, observation and interview; the facility failed to ensure documentation of annual functional testing for all facility duct detectors was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system initiating devices such as duct detectors are tested annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of FESCO "Fire Alarm Inspection" documentation dated 08/26/15, 11/19/15 and 02/22/16 with the Plant Operations Director during record review from 9:45 a.m. to 12:30 p.m. on 04/06/16, it could not be assured all facility duct detectors were documented as being functional tested annually. No facility duct detectors were listed as being functionally tested in any of the aforementioned three quarterly fire alarm inspections conducted within the most recent twelve month period. Review of FESCO's "Initiating Devices" documentation dated 08/02/14 indicated</p>	K 0052	<p>There were not any Residents or Staff affected by this practice In order for Residents and Staff to not be affected by this practice, the maintenance director contacted FESCO to ensure that they would conduct functional testing for all facility duct detectors and leave the appropriate documentation at the facility The Maintenance Director is responsible for maintaining the appropriate documentation Compliance will be reported to the monthly QA committee</p>	05/06/2016

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K 0062 SS=F Bldg. 01	<p>a total of nine duct detectors are located in the facility and were sensitivity tested on that date. Based on observations with the Plant Operations Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 04/06/16, two duct detectors were noted on HVAC equipment in the Laundry Boiler Room in the main hall by the employee entrance and two duct detectors were also noted on HVAC equipment in the Fire Riser Room in the main hall by the Chapel. Based on interview at the time of record review and of the observations, the Plant Operations Director acknowledged documentation of functional testing of all facility duct detectors within the most recent twelve month period was not available for review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are 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</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection,</p>	K 0062	I have submitted a contract from Century Fire Protection, LLC stating that they will flush the sprinkler system starting on June 18, 2016 Century will continue to provide this service to us in the future to ensure that we are in compliance	06/20/2016

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	<p>Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Call Report" documentation dated 10/15/14 with the Plant Operations Director during record review from 9:45 a.m. to 12:30 p.m. on 04/06/16, an internal pipe inspection was conducted on 10/15/14 for the facility's sprinkler system. The aforementioned sprinkler inspection documentation stated "Performed internal pipe inspection on three dry Viking Model F-1 Sprinkler Systems. Inspected 4 inch cross main above kitchen, 3 inch cross main above Room # 210 & 211 and 3 inch cross main above Room #903 & 905. Found that all cross mains are filled with rust and debris. Recommend that all three systems be flushed. Send quote to flush sprinkler systems." Based on interview at the time of record review, the Plant Operations Director stated quotes have not been received for sprinkler system flushing, no purchase agreement for sprinkler system flushing has been finalized as of the date of this survey and</p>			

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K 0147 SS=E Bldg. 01	<p>acknowledged sprinkler system flushing has not been performed or scheduled on or after 10/15/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 24 residents, staff and visitors in the vicinity of Room 208.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director during a tour of the facility from 12:30 p.m. to 3:30 p.m. on 04/06/16, a refrigerator was plugged into a power strip in Room 208. Based on interview at the time of observation, the Plant Operations Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p>	K 0147	<p>There were not any Residents or Staff found to have been affected by this practice. In order for Residents and Staff not to be affected by this practice, the facility removed the power strip from room 208. The maintenance director will ensure that we are in compliance with power strips. In order to maintain this compliance, the maintenance director and the Administrator will complete the Maintenance Inspection Checklist for Resident rooms. This checklist will be completed for each room in the facility in the first week of each quarter. Compliance will be reported to the monthly QA committee.</p>	05/06/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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