

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010000	<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: 03/18/14</p> <p>Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare 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), Chapter 19, Existing Health Care Occupancies 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 hard wired smoke detection in the corridors, in resident rooms and in spaces open to the</p>	K010000	Signature HealthCARE of Terre Haute is requesting a desk review of the plan of correction rather than an on sire 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.

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>corridors. The facility has a capacity of 207 and had a census of 139 at the time of this survey. The 900 hall is currently unoccupied.</p> <p>All areas providing facility services were sprinklered. A detached storage pod was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/25/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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 03/18/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
K010015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure the interior finish for room walls in 1 of 12 smoke compartments had a flame spread rating (FSR) of Class A, B, or C. This deficient practice affects staff, visitors and 40 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 at 2:15 p.m., the training room was accessed by going through the main dining room. The lower half of three walls in the training room were covered with carpet. The maintenance director said at the time of observation, no documentation was available to demonstrate the wall coverings provided a flame spread rating of Class A, B, or C.</p>	K010015	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 treated the lower carpeted half of the three walls with an approved flame retardant	04/04/2014			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	3.1-19(b)			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010018 SS=E	<p>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 1¼ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure corridor doors in 3 of 12 smoke compartments would latch into their door frames. This deficient practice affects staff, visitors and 30 or more residents in the 600, 700, and 800 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 between 12:30 p.m. and 4:15 p.m., doors protecting corridor openings to resident rooms 802, 805, 705, and 603 were each tested twice for reliable latching. The doors failed to latch each time and could be pushed open without resistance after they had been closed into their door</p>	K010018	<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 immediately corrected the three doors found. They completed an immediate inspection of all doors in the facility. Maintenance Director will complete the PTAC and door closing record. This will be submitted to the PI committee on a monthly basis by the maintenance director. Maintenance director is responsible for validating the working condition of all room doors.</p>	04/04/2014
-----------------	---	---------	---	------------

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	frames. The maintenance director acknowledged at the time of observations, latches for these doors were not working. 3.1-19(b)			

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 03/18/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway 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:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure smoke barrier doors in 2 of 12 smoke compartments were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 20 or more residents in the 700 and 900 hall smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 03/18/14 at 1:15 p.m., a rated smoke barrier door was part of a smoke barrier wall which separated two rooms housing the physical therapy department. The door was equipped with a working magnet designed to hold the door open and release upon activation of</p>	K010021	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 weight from the base of the door and educated the staff on the door being a fire door. The maintenance director placed a shim in the 700 shower room door that enables that door to work correctly. The director of maintenance will check on these deficient practices monthly and report to the PI meeting.	04/04/2014			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>the fire alarm system. A weight was observed at the base of the open door. When the magnet released, the weight prevented the door from closing. Physical therapy staff said at the time of observation, the weight was put in front of the door to prevent it from closing.</p> <p>b. Based on observation with the maintenance director on 03/18/14 at 12:50 p.m., the 700 hall shower room was used for the collection of four soiled linen and trash receptacles with a capacity for more then 32 gallons each. The door separating the room from the corridor was equipped with a self closer, however, when the door was pushed open wide it was prevented from closing when it caught on the uneven floor surface. The maintenance director acknowledged at the time of observation, the uneven surface was preventing the door from self closing.</p> <p>3.1-19(b)</p>			

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 03/18/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
K010022 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 2 of 3 paths in the exit means of egress from the 500 and 600 halls were clearly identified. This deficient practice affects visitors, staff and 30 or more residents on the 500 and 600 halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 at 1:55 p.m., the public way evacuation point for exits from the northwest 600 hall exit and the southwest 500 hall exit each required passing through a six foot wooden fence. Two gates in the fence were of the same material as the fencing and were not clearly distinguishable from the fence. No exit signs were posted. The maintenance director acknowledged at the time of observation, there was no way to tell where to exit from the enclosed space.</p> <p>3.1-19(b)</p>	K010022	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 has placed proper exit signage where exit egress to the public way requires passing through gates in a six foot tall wooden fence. Signage for access to exits will be checked monthly by the Maintenance Director to ensure that the deficient practice does not occur. Director of Maintenance is responsible to validate proper signage is readily apparent to the occupants. Director of Maintenance will report validation monthly at facility PI meeting.	04/04/2014	

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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

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 03/18/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
K010025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure openings in ceiling smoke partitions were sealed to limit the transfer of smoke in 6 of 12 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 40 or more residents in the 100, 300, 400, 500, 600, and 700 hall smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 03/18/14 between 12:30 p.m. and 4:15 p.m., 18 by 30 inch attic access panels in janitor's closets on the 100, 300, 400, 500, 600 and 700 halls hung open. The maintenance director said at the time of observations, the doors were opened to allow heat into the attic to prevent pipes from freezing. The outside temperature</p>	K010025	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 shut the six access panels maintenance, housekeeping and administrator was educated about not opening these access panels at any time other than to access the attic space The maintenance director will ensure that this deficient practice does not occur Director of Maintenance will report validation at the monthly PI meeting	04/04/2014			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>was reported by the local radio station to be 53 degrees Fahrenheit on 03/18/14. The maintenance director said the access panel had been opened weeks prior when leaks were occurring in attic sprinkler system piping.</p> <p>b. Based on observation with the maintenance director on 03/18/14 at 1:05 p.m., the 700 hall storage room had three displaced ceiling tiles leaving two gaps of 24 by 12 inches, and a six by 24 inch opening into the attic above. The maintenance director commented at the time of observation, he was unaware the tiles had been moved.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010029 SS=E	<p>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 protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic closers for doors providing access to hazardous areas such as combustible materials storage rooms larger than 50 square feet in 1 of 12 smoke compartment. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in 900 hall smoke compartment where the physical therapy department is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 between 12:30 p.m. and 4:15 p.m., former resident rooms 900, 902, 903,</p>	K010029	<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 placed automatic closers on rooms 905 and 908 All other rooms including 900 902 903 904 910 911 and 914 were emptied out and prepared for Resident use Director of Maintenance is responsible to validate that the deficient practice does not occur Maintenance Director will report validation to the monthly PI committee</p>	04/04/2014
-----------------	--	---------	--	------------

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>904, 905, 908, 910, 911 and 914 were each larger than 50 square feet and used to store combustible cardboard cartons, upholstered furniture, and miscellaneous fabric items in plastic bags. The doors had no self closers. The maintenance director said at the time of observations, he didn't know doors to these storage rooms were required to self close.</p> <p>3.1-19(b)</p>			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010038 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 exit doors met all the conditions of LSC, Section 7.2.6.1. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6.1(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could visitors, staff and 10 or more residents in the physical therapy smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 03/18/14 at 1:25 p.m., the exit door from the physical therapy department was equipped with an electromagnetic lock which released after fifteen seconds with pressure on the latch stile, but it lacked the proper signage. The maintenance director acknowledged the delayed egress</p>	K010038	<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 placed the appropriate signage stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS on the therapy room door. Director of maintenance is responsible to validate proper fire safety signage on all doors. Validation will be submitted to the monthly PI meeting.</p>	04/04/2014
-----------------	---	---------	---	------------

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	accessibility was not marked. 3.1-19(b)			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010051	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 contracted with Fesco fire safety to find and identify the circuit breakers for the fire systems. The maintenance director will validate monthly at the PI meeting our proper fire safety procedures	04/04/2014
-----------------	--	---------	---	------------

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>maintenance director on 03/18/14 between 12:30 p.m. and 4:15 p.m., the fire alarm system circuit breaker was not identified. Circuit breaker panels were checked with the maintenance director, but a circuit serving the fire alarm system was not located. The maintenance director stated at the time of observations, he did not know where the breaker was and was not aware the fire alarm circuit breaker was to be identified.</p> <p>3.1-19(b)</p>			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure the campus wide no smoking policy was enforced and cigarette butts were deposited into a noncombustible container. This deficient practice had the potential to affect any visitors and staff using the staff entrance and any resident on the adjacent 600 hall who might have an open window.</p> <p>Findings include:</p> <p>Based on observation on 03/18/14 with</p>	K010066	<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 revised the smoking policy to define that there is no smoking on property. The city land to the west of the facility has been identified as the appropriate smoking area and two non-combustible containers have been placed at that site. The maintenance director will walk to facility weekly to ensure that there are no cigarette butts in non-approved areas. Our compliance will be reported at the monthly PI</p>	04/04/2014
-----------------	--	---------	---	------------

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 03/18/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
	<p>the maintenance director at 2:10 p.m., the grassy and mulched area outside the staff entrance was carpeted with a layer of discarded cigarette butts. The maintenance director said at the time of observation smoking was to be done off campus in an area across the street. He acknowledged the cigarette butts had the potential to ignite the mulch and grass when it was dry. On 03/18/14 at 4:00 p.m., a Tobacco Use policy was provided which noted the prohibition of smoking "except in designated smoking areas." Those areas were not identified. The maintenance director acknowledged a smoking policy with specific information would be appropriate and at least, some noncombustible container would be useful in the identified butt disposal area.</p> <p>3.1-19(b)</p>		meetings		

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 03/18/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 exits was readily accessible. This deficient practice could affect visitors, staff and 20 or more residents on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 at 9:45 a.m., the southeast emergency exit discharge was inaccessible with a crash cart parked in front of the exit door. On 03/18/14 at 1:50 p.m., the crash cart remained in front of the exit. The maintenance director acknowledged at the time of observations, the cart obstructed access to the exit.</p> <p>3.1-19(b)</p>	K010072	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 crash cart from in front of the exit door The 500 hall staff was educated on blocking the exit and another area was found to store the crash cart Maintenance Director will monitor monthly and maintenance will validate monthly at the PI meeting	04/04/2014	

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 03/18/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure decorative films, curtains, and valances in 3 of 12 smoke compartments were rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging fabrics serving as furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects visitors, staff and 40 or more residents in the main dining room and the north and south</p>	K010074	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 immediately removed the decorative plastic from the nurses station. The appropriate fire retardant (attached) was applied to the curtains on 700 hall medicine room, on the valances in the activities room, in laundry, and in the HR office. The maintenance director will ensure that all future decorations and window treatments will have the appropriate fire rating. This will be validated monthly at the PI meeting.	04/04/2014	

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>nurses station smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 between 12:30 p.m. and 4:00 p.m., flame resistance labeling was not found on the decorative plastic used to wrap the north and south nurses stations for decorating purposes, on the curtain in the 700 hall medicine room, or on valances in the activities room, laundry, and human resources office. The maintenance director said at the time of observations, he had no evidence these materials were flame resistant.</p> <p>3.1-19(b)</p>			
--	---	--	--	--

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
--------------------	--	---------------	---	----------------------

K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gas was secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage. NFPA 99, 8-5.2.1 requires the construction for nonpatient gas cylinder carts and hand trucks shall be constructed for the intended purpose and shall be self-supporting. They shall be provided with appropriate chains or stays to retain cylinders in place. This deficient practice affects visitors, staff and 10 or more residents in the sun room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 at 2:20 p.m., a helium cylinder was free standing in the activities directors office. The activities director said at the time of observation, "I was told it was empty." The maintenance director agreed at the time of observation, the tank should have been secured. He called an assistant to remove the tank immediately.</p> <p>3.1-19(b)</p>	K010130	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 immediately secured and removed the helium tank from the activity director's office. The maintenance director will ensure that the helium tank will be secured in a hand truck with the appropriate chains to prevent damage. Compliance will be reported at the monthly PI meeting.	04/04/2014
-----------------	--	---------	---	------------

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 03/18/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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

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 03/18/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 12 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more residents in the 900 hall smoke compartment where the physical therapy department is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 03/18/14 at 1:40 p.m., the 900 east mechanical/electrical room housed a bank of electrical circuit panels. Maintenance equipment and materials were stored less than three feet from the panels with some of the materials abutting the panels' wall. The</p>	K010147	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 immediately cleaned the 900 mechanical room and verified all other mechanical rooms in the facility were in compliance. The maintenance director will ensure that we have a minimum of three feet of clear distance from all electrical equipment. Our validation will be reviewed monthly at the PI meeting.	04/04/2014			

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 03/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>maintenance director acknowledged at the time of observation, the room was being used to drop off materials which were not in use.</p> <p>3.1-19(b)</p>			