

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 04/20/2015
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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 000 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: 04/20/15</p> <p>Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360</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, resident rooms and spaces open to the corridors. The facility has the capacity for 207 and had a census of 142 at the time of this survey.</p>	K 000	Signature HealthCARE of Terre Haute is requesting a desk review of the plan of correction 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 027 SS=E Bldg. 01	<p>All areas providing facility services were sprinklered. A detached storage pod was not sprinklered.</p> <p>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 1 of 9 smoke barrier door sets 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 on the 500 hall and adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at 1:15 p.m., one door in the smoke barrier door set separating the 500 hall from the</p>	K 027	<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 and sanded the doors on the 500 hall smoke barrier door set. This allowed the doors to close in the proper manner. Maintenance Director will complete the Smoke Barrier Inspection sheet monthly and submit it to the monthly QA committee. The Maintenance Director is responsible for validating the working condition of all smoke barrier doors.</p>	05/18/2015

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K 029 SS=E Bldg. 01	<p>adjacent smoke compartment failed to close leaving a two inch gap between the doors when tested manually. The result was the same upon activation of the fire alarm on 04/20/15 at 2:00 p.m. The Maintenance Director acknowledged at the time of observation, the doors could not resist the passage of smoke.</p> <p>3.1-19(b)</p> <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 ensure doors to hazardous areas, such as a storage rooms for soiled linen and trash receptacles closed automatically or upon activation of the fire alarm system in 1 of 12 smoke compartments. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient</p>	K 029	There were not any Residents or Staff found to be affected by this practice. In order for Residents and Staff not to be affected by this practice, the Maintenance Director placed a shim in the 300 hall shower room door that enables the door to work correctly. The Maintenance Director will check on these deficient practices monthly and will report to the QA meeting.	05/18/2015

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K 038 SS=E Bldg. 01	<p>practice affects visitors, staff and 10 or more residents in the 300 hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at 12:20 p.m., the 300 hall shower room was used for the collection of six soiled linen and trash receptacles, each with larger than a 32 gallon capacity and one half or more full. The door separating the room from the adjacent exit corridor did not self close and latch into the door frame. The Maintenance Director acknowledged at the time of observation, the door was not working properly.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the discharge components for emergency exits for 2 of 11 smoke compartments were maintained to allow instant use in the event of an emergency. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions</p>	K 038	<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 lock from the gate in the 500/600 hall courtyard. The facility also removed the garden posts and supplies from the emergency exit area. The</p>	05/18/2015

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	<p>made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to be carried by staff at all times, or other such reliable means available to the staff at all times. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 20 or more residents on the 500 and 600 halls.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director on 04/20/15 at 1:10 p.m. and 1:40 p.m., the emergency exit from the 600 hall dining/activities room and the 500 hall each discharged onto a common concrete surface. The discharges continued to a six foot privacy fence with a gate which could open to allow evacuation to the public way. The gate was padlocked. The Maintenance Director said at the time of observation, the padlock could be pulled open and was surprised to find the lock had been secured in the locked position and the gate could not be opened. He had no key to open the gate, no key was located in close proximity to the gate and the Maintenance Director said no staff had a key to unlock the padlock.</p>		<p>facility also replaced the concrete exit discharge surface outside of the laundry room exit. The Maintenance Director is responsible for maintaining that we can rapidly remove Residents from 500 and 600 halls and that their means of egress shall be continuously maintained free of all obstructions Validation of this will be submitted to the monthly QA committee</p>	

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	<p>b. Based on observation with the Maintenance Director on 04/20/15 at 1:40 p.m., the emergency exit discharged onto a 12 foot long sidewalk and a larger concrete surface. The width of the exit discharge surface was diminished to 28 inches by a line of large garden posts and supplies for a length of eight feet. The Maintenance Director acknowledged at the time of observation, these items would interfere with the immediate evacuation of residents in the room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure an exit in 1 of 11 smoke compartments was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect any occupant using the laundry exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at</p>			

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K 046 SS=E Bldg. 01	<p>1:15 p.m., the concrete exit discharge surface for the laundry was cracked across the width of the exit discharge surface, and damaged by pitting which made the surface unlevel. The Maintenance Director acknowledged at the time of observation, the surface could pose a trip hazard.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge paths for 2 of 13 emergency exits were provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 10 or more resident in the 400 and main dining room smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 between 11:30 a.m. and 2:45 p.m., exit discharge paths were not provided with</p>	K 046	<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 added emergency lighting to: The 200 hall exit, the Activities Room exit and the exit from the dining room to the courtyard. The Maintenance Director is responsible for providing adequate emergency egress lighting. Validation will be submitted to the monthly QA committee</p>	05/18/2015

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K 062 SS=E Bldg. 01	<p>the emergency lighting required to evacuate to a public way:</p> <p>A. From the 200 hall for a distance of 35 feet. The Maintenance Director agreed at the time of observation, the two bulb emergency powered light fixture at the point of exit discharge could not illuminate the discharge walkway behind shrubs and around the building to the parking lot evacuation point;</p> <p>B. The room for activities and dining on the 400 hall and the main dining room exit discharge over the courtyard did not have emergency exit discharge lighting to cover the courtyard paths of exit to the public way.</p> <p>The Maintenance Director acknowledged at the times of observation these exit discharge paths lacked the minimum light required for emergency exit discharge paths.</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 observation, the facility failed to ensure a sprinkler head providing protection in 1 of 11 smoke</p>	K 062	There were not any Residents or Staff found to have been affected by this practice. In order for Residents and Staff not to be	05/18/2015

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K 064 SS=E Bldg. 01	<p>compartments was maintained. This deficient practice could affect visitors, staff and 10 or more residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at 12:10 p.m., escutcheon was missing from the sprinkler head in the 300 hall utility room leaving a half inch gap into the attic above. The Maintenance Director acknowledged at the time of observation, the missing escutcheon was part of the sprinkler assembly.</p> <p>3.1-19(b)</p> <p>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 portable fire extinguishers in 5 of 11 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</p>	K 064	<p>affected by this practice, the facility replaced the escutcheon in the 300 hall utility room. The facility checked all sprinkler heads in the facility for missing or improper escutcheons and replaced any that were deficient. The Maintenance Director will validate monthly and report to the QA committee</p> <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 replaced the portable fire extinguishers at the 500 hall nurses station, in the 600 hall corridor, in the activities/dining room on the 600 hall, in the 400 hall, near room 308 and in the entry corridor. The Maintenance Director will validate proper fire</p>	05/18/2015

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K 070 SS=E Bldg. 01	<p>no more than three and one half feet (42 inches) above the floor. This deficient practice affects visitors, staff and 20 or more residents in the main entry, 300 hall, 400 hall 500 hall and 600 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 between 11:30 a.m. and 2:00 p.m., portable fire extinguishers were measured at 64 inches above the finished floor: at the 500 hall nurses station, in the 600 hall corridor, the activities/dining room on the 600 hall, in the 400 hall near the activities room, in the corridor near room 308 and in the entry corridor. The Maintenance Director confirmed the measurements at the times of observations.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 space heaters was not used in a resident area.</p>	K 070	<p>extinguishers monthly at the QA meeting.</p> <p>There were not any Residents or Staff found to have been affected by this practice. In order for</p>	05/18/2015			

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K 130 SS=E Bldg. 01	<p>This deficient practice affects 5 or more residents as well as visitors and staff in the sun room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at 12:05 p.m., an electric fireplace was observed in the sun room. The Maintenance Director acknowledged at the time of observation the sun room was an area used by residents.</p> <p>3.1-19(b) NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure a cylinder of non-flammable gas was secured in a cart or hand truck with appropriate chains or stays to prevent accidental damage in 2 of 11 smoke compartments. 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 20 or more residents in the north smoke</p>	K 130	<p>Residents and Staff not to be affected by this practice, the facility removed the fireplace from the Resident's sun room. The Maintenance Director is responsible for ensuring that the facility does not use portable space heaters. Maintenance Director will validate monthly and take to the QA meeting.</p> <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 secured the carbon dioxide gas cylinder in the maintenance storage room as well as the carbon dioxide gas cylinder in the north oxygen storage room. The Maintenance Director will ensure that all carbon dioxide gas cylinders will be secured. Compliance will be reported at the monthly QA meetings</p>	05/18/2015

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K 147 SS=E Bldg. 01	<p>compartment near the nurses ' station and near the maintenance storage room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 at 1:00 p.m. a carbon dioxide gas cylinder was free standing in the maintenance storage room, at 1:10 p.m., a carbon dioxide gas cylinder was observed to be free standing in the north oxygen storage room. The Maintenance Director agreed at the time of observation, these tanks should have been secured.</p> <p>3.1-19(b)</p> <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 extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring in 2 of 7 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless</p>	K 147	<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 central supply, we removed the power strip in room 208, and we removed the power strip and multi plug adapter from room 213. The Maintenance Director will ensure that we are in compliance with power strips and nonfused multiplug adapters.</p>	05/18/2015

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	<p>specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect least visitors, staff and 10 or more residents in the center and 200 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/20/15 between 11:00 a.m. and 3:00 p.m.:</p> <p>a. A power strip extension cord was piggybacked to a surge protector in the central supply storage room.</p> <p>b. A power strip extension cord was located at the head of the bed in room 208 to power a refrigerator;</p> <p>c. A power strip extension cord and multiplug adapter were used to supply powered to equipment in resident room 213.</p> <p>The Maintenance Director acknowledged at the times of observation, the power strips were in use.</p> <p>3.1-19(b)</p>		Compliance will be reported to the monthly QA committee		