

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/07/2016
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NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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(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
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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: 04/07/16</p> <p>Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720</p> <p>At this Life Safety Code survey, Terre Haute Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000		
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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 0038 SS=F Bldg. 01	<p>and had a census of 30 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached wood sheds used for facility storage.</p> <p>Quality Review completed on 04/08/16 - DA</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>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 locked emergency exit doors were readily accessible for residents and visitors. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 04/07/16 between 11:00 a.m. and 11:45 a.m. during a tour of the facility with the Activity Director, all three exit doors were provided with magnetic locks which required a four digit code on the adjacent keypad or activation of the fire alarm system to release. The code to unlock</p>	K 0038	<p>All door codes were changed and made accessible to residents and visitors</p> <p>All residents, staff ,and visitors could be affected by this finding</p> <p>Maintenance staff was made aware of findings and was educated to the rule</p> <p>Administrator will monitor monthly and ensure compliance</p>	04/22/2016

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K 0066 SS=E Bldg. 01	<p>these magnetic locks were not posted near the exit doors. This was acknowledged by the Activity Director at the time of observation.</p> <p>3.1-19(b) 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 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked. This deficient practice could affect more than 5 residents, as well as staff and visitors at a time while in the smoking area.</p>	K 0066	The smoking area was cleaned of all cigarette butts All residents, visitor ,and staff could be affected by this finding In service was conducted with All staff related to proper disposal of cigarette butts Hsking and or maintenance staff will monitor smoking area daily to	04/22/2016

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	<p>Findings include:</p> <p>Based on observation on 04/07/16 at 11:15 a.m. during a tour of the facility with the Activity Director, there where at least 5 cigarette butts mixed with combustible trash in the trash receptacle at the smoking area. This was acknowledged by the Activity Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>assure proper disposal of cigarette butts</p>		