STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155511	A. BUILDING -- B. WING	06/28/2018

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/28/18 Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720 At this Emergency Preparedness survey, Terre Haute Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 38 certified beds. At the time of the survey, the census was 28. Quality Review completed on 07/10/18 - DA	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/28/18 Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720 At this Life Safety Code survey, Terre Haute	K 0000		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 (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 and had a census of 28 at the time of this survey. 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. Quality Review completed on 07/10/18 - DA			
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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 unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 06/28/18 from 10:36 a.m. to 12:00 p.m., the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four digit code, but the code was not posted at the exit: a. the main entry / exit door b. the entry / exit door between resident rooms # 3 and # 4 c. the rear entry / exit door between resident rooms # 10 and # 11 Based on interview at the time of the observations, the Maintenance Director stated the aforementioned facility exits were indeed marked as exits, and could be opened by entering a four	K 0222	**K222** **Egress Doors** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** The Maintenance Director placed the door codes on top of the keypads at each exit door on June 28, 2018. **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affect by this alleged deficient practice. The alleged deficient practice will not recur as the Maintenance Director placed the door codes at each exit doors on June 28, 2018. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** All staff was in-serviced that the codes must stay on the keypads. Maintenance Director was in-serviced on replacing the codes	07/28/2018

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	digit code, but the code was not posted. During the exit conference with the facility Administrator and the Maintenance Director on 06/28/18 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		on the keypads when code changes or when needed. Maintenance Director will be monitoring keypads at the exit doors to ensure that codes are in place. **How will the facility monitor its corrective action?** The Maintenance Director/Administrator will monitor that door/keypad codes are in posted as required> QAPI audits weekly for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and the corporate risk management team for review. **Date Completed:** July 28, 2018	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting 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 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages, and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with	K 0291	**K291** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** Maintenance Director conducted an annual 90 minute test of the Battery Operated Emergency	07/28/2018

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	Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 06/28/18 at 10:52 a.m. with the Maintenance Director, the Battery Operated Emergency Light Test Log on TELS for 2018 indicated a battery operated light located near the generator. Based on an interview at the time of record review, the Maintenance Director indicated the facility has battery operated emergency lights that are tested on both a monthly and annual basis and documented in the "Battery-operated emergency lighting testing log in TELS. Further record review indicated that although a 30 second test was documented, but an annual 90 minute test had not been documented within the last twelve months. The lack of annual testing of the battery operated light at the generator was verified by the Maintenance Director at the time of record review. During the exit conference with the facility Administrator and the Maintenance Director on 06/28/18 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		Lighting on June 29, 2018. **How will the facility identify residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affected by this alleged practice. On June 29, 2018, the Maintenance Director conducted the 90-minute test of the Battery Operated Emergency Lighting. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** On June 29, 2018 the Maintenance Director conducted the 90-minute test of the Battery Operated Emergency Lighting. An audit tool was developed to ensure that 90-minute testing of the Battery Operated Emergency Lighting would be documented annually. **How will the facility monitor its corrective action?** To ensure compliance, the Maintenance Director will audit weekly for one month, bi-weekly for two months, and monthly for three months for a total of six months. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI and action plans are submitted to the regional operations staff and	

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			corporate risk management team for review. **Date completed:** July 28, 2018	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 14 residents, as well as staff and visitors on the room #1 through room #13 smoke compartment. Findings include: Based on observation on 06/28/18 at 12:01 p.m. during a tour of the facility with the Maintenance Director, the set of smoke barrier doors located near resident room # 4 did not fully close. There	K 0374	**K374** **Subdivision of Building Spaces-Smoke Barriers** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** On June 28, 2018, the Administrator placed an order through Direct Supply for four (4) Gravity Door Coordinator Arms to replace the existing Coordinator Arms. By July 6, 2018, the Maintenance Director replaced all Gravity Door Coordinator Arms facility's 4 sets of Smoke Barrier Doors **How will the facility identify**	07/28/2018

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	was a two inch gap between the doors when closed to their fullest. Based on interview during the time of observation, the Maintenance Director acknowledged these smoke barrier doors did not close and seal completely, and gave the aforementioned measurement. During the exit conference with the facility Administrator and the Maintenance Director on 06/28/18 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**residents having the potential to be affected by the same deficient practice?** All residents that reside within the facility could potentially be affect by this alleged deficient practice. The alleged deficient practice will not recur as the Maintenance Director replaced the Gravity Door Coordinator Arms on each Smoke Barrier door. **What measures were put into place or systematic changes made to ensure the deficient practice not recur?** The Maintenance Director replaced all Gravity Door Coordinator Arms facility's 4 sets of Smoke Barrier Doors. **How will the facility monitor its corrective action?** The Maintenance Director will conduct weekly audits for four weeks and monthly for six months thereafter until compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved **Date completed:** July 28, 2018	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.			

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	The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Logbook Documentation / Direct Supply - TELS" report form with the Maintenance Director on 06/28/18 at 10:36 a.m., there was no documentation for a third shift fire drill in the fourth quarter (October, November, and December), of 2018. Based on interview at the time of record review, the Maintenance Director acknowledged the missing fire drill. During the exit conference with the facility Administrator and the Maintenance Director on 06/28/18 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)	K 0712	**K712** **Fire Drills** **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** The Maintenance Director was in-serviced by the Corporate Director of Plant Operations on July 18, 2018 regarding fire drill policies and procedure and his responsibility for planning and conducting fire drills at unexpected times under varying conditions, at least quarterly on each shift. **How will the facility identify residents having the potential to be affected by the same deficient practice?** The Maintenance Director was in-serviced by the Corporate Director of Plant Operations on July 18, 2018 regarding fire drill policies and procedure and his responsibility for planning and conducting fire drills at unexpected times under varying conditions, at least quarterly on each shift. **What measures were put into place or systematic changes made to ensure the deficient**	07/28/2018

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			practice not recur? The Maintenance Director was in-serviced on July 18, 2018 regarding fire drill policies and procedure and is responsible for planning and conducting fire drills at unexpected times under varying conditions, at least quarterly on each shift. The Maintenance Director was in-serviced on the Fire Drill Schedule Form regarding the required times/shifts for fire drills. The Maintenance Director will use the TELS system for monitoring that the fire drills are done at the required times/dates. **How will the facility monitor its corrective action?** To ensure compliance, the Maintenance Director will provide the results of the fire drill records. The results of these audits will be reviewed by the QAPI committee monthly. If 95% compliance is not achieved, an action plan will be developed and implemented. Monthly QAPI and action plans are submitted to the regional operations staff and corporate risk management team for review. **Date completed: July 28, 2018**	