STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155511	A. BUILDING 01 B. WING	07/13/2017

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

(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
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 483.70(a). Survey Date: 07/13/17 Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720 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 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	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 determined that other safegaurds 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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	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 07/21/17 - DA			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	**K 353** **NFPA 101 Sprinkler System-Maintenance and Testing Sprinkler System-Maintenance and Testing Automatic sprinkler and**	08/12/2017

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of SafeCare's "Inspection and Testing Form" documentation for the most recent twelve month period with the Maintenance Director during record review from 9:05 a.m. to 11:05 p.m. on 07/13/17, monthly wet sprinkler system gauge inspection		**standpipe systems are inspected, tested, and maintained in accordance with NFPA 24. Standard for the Inspection Systems. Record of system design, maintenance, inspection and testing are maintained in a secure location and readily available.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Maintenance Director implemented a "Monthly Sprinkler Riser Inspection Form" to meet the requirements to record system design, maintenance, inspection and testing. -The "Monthly Sprinkler Riser Inspection Form" will be maintained in a secure location and readily available for review. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -All residents in the facility could potentially be affected by this deficient practice, but none were identified. However, the Maintenance will monitor the sprinkler risers monthly.	

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	documentation for the most recent 12 month period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review. 3.1-19(b)		**3. What measures were put into place or systemic changes made to ensure the deficient practice not recur?** -On 7/27/17due to the implementation of the "Monthly Sprinkler Riser Inspection Form" the deficient practice will not recur. **4. How will the facility monitor its corrective action?** -The Maintenance Director is responsible for maintaining and testing the Sprinkler Riser System QAPI audits once a week for four weeks and once 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, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	

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			Completion Date: August 12, 2017	
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 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 14 residents, as well as 3 staff and 2 visitors. Findings include:	K 0374	**K 374** **3.1-19(b) NFPA 101 Subdivision of Building Spaces-Smoke Barrier Door. Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Non-rated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Door are self-closing or automatic closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provide a minimum clear width of 32 inches for swinging or horizontal doors.**	08/12/2017

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	Based on observation on 07/13/17 at 11:07 a.m. with the Maintenance Director, the West hall smoke door set nearest to the Administrators office would not fully close leaving a two inch gap along the center where the doors came together in the closed position. This was verified by the Maintenance Director at the time of observation. 3.1-19(b)		**1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -The west hall smoke door set nearest to the Administrator's office was repaired immediately. -All other smoke barrier doors were inspected by Maintenance Director to ensure proper closure. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -14 residents, 3 staff, and 2 visitors could potentially be affected by this practice. However, the Maintenance Director conducted a facility wide audit to ensure all smoke barrier doors closed properly. **3. What measures were put into place or systemic changes made to ensure the deficient practice not recur?** -on 7/13/17, Maintenance Director completed a facility wide audit of all smoke barrier doors closed correctly	

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			-The Maintenance Director will conduct monthly audits on all smoke barrier doors. **4. How will the facility monitor its corrective action?** -The Maintenance Director is responsible for ensuring all smoke barrier doors close properly. Maintenance Director will do QAPI audits once a week for four weeks and once 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, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. Completion Date: August 12, 2017	

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K 0511 SS=B Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 3 electrical lights above the exit to the "pavilion" or smoking area, were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect up to 4 residents, as well as any staff or visitors using the above mentioned exit. Findings include: Based on observation with the Maintenance Director during the tour of the facility at 11:15 a.m. on 07/13/17, there were exposed wires hanging from a conduit above the door near the emergency light. The above mentioned exposed wires were acknowledged by the	K 0511	**K 511** **NFPA 101 Utilities-Gas and Electric. Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -On July 14, 2017 the exposed wiring hanging from the conduit above the door near the emergency light was repaired with a junction box pertaining to code by Maintenance. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -This deficient practice could affect	08/12/2017

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	Maintenance Director at the time of the observation. 3.1-19(b)		up to 4 residents, as well as staff and visitors that use that exit. **3. What measures were put into place or systemic changes made to ensure the deficient practice not recur?** -Maintenance Director will monitor all outside wiring and report to the Administrator of any wiring that may be exposed to the elements. **4. How will the facility monitor its corrective action?** -The Maintenance Director is responsible for inspecting and repairing any outside wiring that may be exposed to the elements QAPI audits once a week for four weeks and once 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, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	

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K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms	K 0711	K 711 NFPA 101 Evacuation and Relocation Plan. There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan	08/12/2017

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	(5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the "Disaster Manual -" Fire - Policy and Procedure" documentation with the Maintenance Director during record review at 10:45 a.m. on 07/13/17, the written fire safety plan did not address item (8): Preparation of floors and building for evacuation and the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Maintenance Director during a tour of the facility from 11:05 a.m. to 12:55 p.m. on 07/13/17, crash carts, Hoyer Lift assists, and Hoyer lifts in use were all being stored in the corridor. 3.1-19(b)		components per 18/19.2.2. **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -On 8/2/17 all staff members were in-serviced on removing wheeled equipment from hallways during any type of emergency. New employees will be trained at their respective orientation meetings **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -All residents have the potential to be affected. However none were identified. **3. What measures were put into place or systemic changes made to ensure the deficient practice not recur?** -On 8/2/17 all staff were in-serviced on removing wheeled equipment out of the hallways during any type of emergency.	

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			4. How will the facility monitor its corrective action? -The Maintenance Director is responsible for ensuring hallways are clear of any wheeled equipment during fire drills and other emergency situations. Maintenance Director will conducted QAPI audits for once a week for four weeks and once 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, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review. Completion Date: August 12, 2017	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8			

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	Based on observation and interview, the facility failed to regulate the use of portable space heaters. This deficient practice could affect as many as 20 residents, as well as visitors and staff in or near the main dining area. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 11:06 a.m. on 07/13/17, a faux fireplace / portable space heater was noted in the main dining area. When asked if the faux fire place put out heat, the Maintenance Director stated he thought the heating element had been removed. Upon testing the faux fire place, the heating element was functional and did in fact put out heat. Manufacturer's documentation for the portable space heater was also not available for review. Based on interview at the time of the observations, the Maintenance Director acknowledged the faux fireplace / portable space heater was used at the aforementioned location. 3.1-19(b)	K 0781	**K 781** **NFPA 101 Portable Space Heaters. Portable Space Heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius)** **1. How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** -Faux fireplace/portable space heater that was in dining room area was removed from the facility and disposed of. **2. How will the facility identify residents having the potential to be affected by the same deficient practice?** -All residents have the potential to be affected by this alleged deficient practice. However, Maintenance Director conducted a facility wide audit to ensure there were no other portable space heaters in use.	08/12/2017

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			3. What measures were put into place or systemic changes made to ensure the deficient practice not recur? On 7/17/17, the Maintenance Director completed a facility wide audit to ensure there were no other faux fireplaces/portable space heaters in the facility. **4. How will the facility monitor its corrective action?** -The Maintenance Director is responsible for the completion of portable space heater QAPI audits for once a week for four weeks and once 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, and action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional operations staff and corporate risk management team for review.	

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	155511	A. BUILDING 01 B. WING	07/13/2017

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

(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
			Completion Date: August 12, 2017	