

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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NAME OF PROVIDER OR SUPPLIER  VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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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: 07/07/15</p> <p>Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660</p> <p>At this Life Safety Code survey, Vernon Manor Children's Home 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) and 410 IAC 16.2. The original section of the building consisting of Dahlia Lane, Rose Harbor, Babbling Brook, Hanson Blvd., Dotties Dream and the Service hall was surveyed with Chapter 19, Existing Health Care Occupancies</p> <p>This original section of this one story facility was determined to be of Type II (111) construction and was sprinklered. A service hall and the 300 hall were of Type V (111) construction and were</p>	K 0000	<p><b>Preparation and/or execution of this plan of correction in general or this corrective action in particular, does not constitute and admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. Date of compliance is July 24th, 2015.</b></p>	

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 0027 SS=E Bldg. 01	<p>sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors. Hard wired smoke detectors were provided in the resident rooms. The facility has a capacity of 119 and had a census of 73 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the room housing generator # 1, canopies at the 200 north exit and at the generator exit door, and a detached storage building was used for the storage of nursing supplies and 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 facilities failed to ensure 2 of 3 sets of smoke barrier doors in the 200 hall were self closing and had a 20-minute fire</p>	K 0027	<b>K027=E: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</b>	07/24/2015

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	<p>protection rating or were at least constructed with a 1¾-inch thick solid bonded wood core. This deficient practice could affect 25 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 07/07/15 at 12:36 p.m., it was determined the smoke barrier wall in the 200 hall ran through the entrance of room 204 and through the entrance of the 200 hall shower room. Both doors lacked a self closing device and the fire rating of the door to the shower could not be determined. Based on interview at the time of observation, the Maintenance Director acknowledged the doors were a part of the smoke wall, both lacked a self closing device, and the fire rating for the door to the shower could not be provided.</p> <p>3.1-19(b)</p>		<p>No resident was effected.</p> <p><b>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>Smoke barrier walls and doors checked to ensure self closure devices were in place to all other areas in the facility</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>A self closing (spring loaded) hinge installed and fire hold magnet completed on 7-20-15 to Room 204. 200 hall shower room door that was determined to be part of the smoke barrier wall was replaced with a steel door with a 20 minute fire rating.</p> <p>All smoke barrier walls will be inspected monthly times 6 months and quarterly thereafter times 6 months. The Maintenance Director will be responsible to monitor these acts and verify continued compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Results of the inspection audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months and quarterly thereafter.</p>		

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K 0056 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system was provided for 2 of 5 canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or combustible canopies exceeding 4 ft. in width. This deficient practice can affect 25 residents using the 200 north exit and any staff using the exit near the generator.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 07/07/15 at between 10:00 a.m. and</p>	K 0056	<p><b>K056=E: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</b></p> <p>Residents on the 200 hall had the potential to be affected , but no staff or residents affected.</p> <p><b>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>Sprinkler heads started on 7/21/15 and will be completed to 200 Hall North Canopy on 7/22/15.</p> <p>Sprinkler heads started on 7/21/15 and will be completed in the hall outside of the generator room on</p>	07/24/2015

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K 0062 SS=E Bldg. 01	<p>12:00 p.m., there were two un-sprinklered combustible canopies attached to the building. One was located outside of the 200 hall north exit extending five feet from the building, and the other was located outside of the generator exit extending six feet from the building and attached to the generator room. Based on interview at the time of observation, the Maintenance Director acknowledged there were two combustible canopies extending more than four feet from the building that were not covered by an automatic sprinkler system.</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 and interview, the facility failed to clean and maintain 3 of 3 sprinklers in the clean laundry room and 5 of 6 sprinklers in the attic above the laundry/service hall. LSC 9.7.5 requires all automatic sprinkler systems shall be</p>			K 0062	<p>7/22/15</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The Maintenance Director will complete a monthly inspection of all canopy and overhangs to ensure sprinkler coverage times 6 months and then quarterly times 6 months.</p> <p><b>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Results of the inspection audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months and quarterly thereafter.</p> <p><b>K062=E: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</b></p> <p>This was not in a resident area. No</p>		07/24/2015

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K 0000	<p>inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice was not in a resident area but can affect any staff in the laundry and service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 07/07/15 at 11:45 a.m., three automatic sprinklers in the clean laundry room where completely covered with dust and lint. Also, five automatic sprinklers in the attic above the laundry/service hall were covered with insulation. Based on interview, this was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>resident or staff was affected.</p> <p><b>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>Sprinkler heads checked throughout building and attic to ensure they were free from debris</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The Maintenance Director will complete a monthly inspection of all sprinkler heads to ensure they are free from lint and other debris times 6 months and then quarterly times 6 months.</p> <p><b>How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Results of the inspection audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months and quarterly thereafter</p>		

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Bldg. 03	<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: 07/07/15</p> <p>Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660</p> <p>At this Life Safety Code survey, Vernon Manor Children's Home 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) and 410 IAC 16.2. The new section of the building consisting of Kalor Court, Timm's Trail and Cherry Blossom dining room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This new section consisting of the service hall and the 300 hall of this one story facility was determined to be of Type V (111) construction and sprinklered. The facility has a fire alarm system with smoke detection in corridors and in spaces open to the corridors. Hard wired</p>	K 0000	<p><b>Preparation and/or execution of this plan of correction in general or this corrective action in particular, does not constitute and admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements. Date of compliance is July 24th, 2015.</b></p>	
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	<p>smoke detectors were provided in the resident rooms. The facility has a capacity of 119 and had a census of 75 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services was sprinklered with the exception of the room housing generator # 1, canopies at the 200 north exit and at the generator exit door, and a detached storage building was used for the storage of nursing supplies and was not sprinklered.</p>				