

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 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
--------------------	--	---------------	---	----------------------

K010000	<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: 07/15/14</p> <p>Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</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 Daliha 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.</p>	K010000	<p>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 August 15th, 2014.</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.

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 07/15/2014	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(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			
K010025 SS=D	<p>A service hall and the 300 hall was of Type V (111) construction and was 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 87 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 and a detached storage building used for the storage of nursing supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired</p>						

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 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
	<p>glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/15/14 from 12:38 p.m. to 1:33 p.m., there were unsealed ceiling penetrations in the following locations:</p> <p>a. five unsealed penetrations in the 100 hall mechanical room ceiling ranging in size from one half inch to one fourth inch and there was a ten inch by twelve inch hole in the ceiling near the water heater exhaust vent that was covered with a piece of plastic wall covering,</p> <p>b. three unsealed penetrations measuring in size from two inches to one fourth inch in the ceiling of the furnace room located in the employee's break room,</p>	K010025	<p>K025=D: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</p> <p>This was not in a resident area. No resident was effected.</p> <p>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;</p> <p>This was not a resident area. No other residents had the potential to be affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p> <p>It is the policy of this facility (Vernon Manor) to ensure all smoke barrier walls are sealed after any penetrations. All smoke barrier walls were inspected and the sealing was verified to ensure compliance on 7/15/14. All smoke barrier walls throughout the building are sealed</p>	08/15/2014

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 07/15/2014
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
	<p>c. three unsealed penetrations measuring one inch each in the sprinkler riser room ceiling. Measurements were provided by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>		<p>and comply with state and federal laws.</p> <p>All smoke barrier walls will be inspected monthly x 6 months and quarterly thereafter. Anytime penetration occurs, the Maintenance Director will be informed and contractors will be required to seal these walls. The Maintenance Director will be responsible to monitor these acts and verify continued compliance.</p> <p>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;</p> <p>Results of the rounding audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months and quarterly thereafter.</p> <p>All penetration acts will be documented and sealing will be verified with the Maintenance Director and Executive Director's signature.</p> <p>On an ongoing basis, monthly reports will be provided by facility to regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>		

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 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 9 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the untitled generator log in the TEL's computer program with the Maintenance Director on 07/15/14 at</p>	K010144	<p>K144=F: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</p> <p>This was not in a resident area. No resident was effected.</p> <p>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;</p> <p>Monthly testing with load on the generators will be completed on tels as required. Immediately following completion, a copy will be printed from the tels website and the Maintenance Director and Executive Director will verify all parts of the inspection are entered. Accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection.</p> <p>The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and complete. All further inspections will be placed in a binder and kept for ease of access.</p>	08/15/2014

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 07/15/2014
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
	<p>11:07 a.m., the June and May 2014 documentation for the monthly generator load test did not include the amps for each phase of both generators so the percentage of the load could not be verified. For the months of July through December 2013 and January through February 2014 both generators were documented as operating at 100 percent of the capacity of the generator. The Maintenance Director stated at the time of record review, he was not the Maintenance Director at that time but based on the size of the generators and the size of the facility it wasn't possible for either to run at 100 percent capacity.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p> <p>It is the policy of this facility (Vernon Manor) to continue monthly testing with load on the generators and will be completed on tels as required. Immediately following completion, a copy will be printed from the tels website and the Maintenance Director and Executive Director will verify all parts of the inspection are entered in. Accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection.</p> <p>The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and complete. All further inspections will be placed in a binder and kept for ease of access.</p> <p>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;</p> <p>Completion and accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection. The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and</p>		

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 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
K010147 SS=D	<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>1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord were not used as a substitute for fixed wiring or to provide power to equipment with a high current draw. 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 specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect was not in a resident care area but could affect facility staff.</p>	K010147	<p>complete. All further inspections will be placed in a binder and kept for ease of access.</p> <p>Results of the rounding audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months. On an ongoing basis, monthly reports will be provided by facility to regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p> <p>K147=D: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; This was not in a resident area. No resident was effected. 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; This was not a resident area. No other residents had the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; It is the policy of this</p>	08/15/2014

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 07/15/2014	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(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			
	<p>Findings include:</p> <p>a. Based on an observation with the Maintenance Director on 07/15/14 at 12:50 p.m., two heavy duty extension cords were plugged in and providing power to electrical equipment in the generator room. Based on an interview with the Maintenance Director at the time of observation, he acknowledged one extension cord supplied power to a well pump but was unable to determine what equipment the remaining extension cord was providing power too.</p> <p>b. Based on an observation and interview with the Maintenance Director on 07/15/14 at 1:05 p.m., he acknowledged an extension cord was plugged in and providing power to a dorm size refrigerator in the Activity office closet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the 200 hall housekeeping closet was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area,</p>		<p>facility (Vernon Manor) to ensure no extension cords are used throughout the building and all electric connections are to be inside a junction box. No extension cords are being used in the building at this time 7/28/14. All electrical connections are in a junction box with a metal cover or electrical fixture. Monthly inspections of the entire building by the Maintenance Director will be completed to ensure no extension cords are being used for any reason. Anytime electrical work is to be completed at Vernon Manor, the Maintenance Director is to verify that all electrical connections are in a junction box and are covered with a metal plate or electrical fixture. The Maintenance Director will be responsible to monitor these acts and verify continued compliance. 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; Results of the rounding audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months. All electrical work will be documented and wiring will be verified with the Maintenance Director and Executive Director's signature. On an ongoing basis, monthly reports will be provided by facility to regional Quality Assurance Committees for review</p>				

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 07/15/2014	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(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			
	<p>either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff with access to the 200 hall housekeeping closet.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/15/14 at 1:10 p.m., there was an electrical receptacle on the wall within two feet of a sink in the 200 hall housekeeping closet. The receptacle was not a GFCI receptacle and when the test button was pressed on a GFCI testing device by the Maintenance Director, he acknowledged power was not interrupted at the receptacle.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring connections was maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c)</p>		and recommendation as part of the annual Quality Assurance Program.				

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 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
K030000	<p>requires all junction boxes shall be provided with covers compatible with the box. This deficient practice was not in a resident care area but would affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/15/14 at 1:20 p.m., there was a single light bulb hanging by wires at the ceiling of the water heater room located in the laundry room. The Maintenance Director stated at the time of observation, the wiring needs to be enclosed in a box with a light fixture attached.</p> <p>3.1-19(b)</p> <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: 07/15/14</p> <p>Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660</p> <p>Surveyor: Amy Kelley, Life Safety Code</p>	K030000	<p>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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2014	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(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			
	<p>Specialist</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 smoke detectors were provided in the resident rooms. The facility has a capacity of 119 and had a census of 87 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 and a detached storage building used for the</p>		<p>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 August 15th, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
--------------------	--	---------------	---	----------------------

K030104 SS=E	<p>storage of nursing supplies.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure 1 of 1 ventilation duct penetrations on the 300 hall was provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affect residents in 2 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 07/15/14 at 2:20 p.m., a smoke damper was not installed in the ventilation duct that penetrated the 300 hall smoke barrier wall. This was acknowledged by the Maintenance Director at the time of</p>	K030104	<p>K104=E: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</p> <p>This was not in a resident area. No resident was effected.</p> <p>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;</p> <p>A fire damper has been ordered and has been guaranteed to be installed on or before 8/15/14 by the service provider. Document attached from SafeCare, for verification of this service guaranteed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged</p>	08/15/2014
-----------------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
	observation. 3.1-19(b)		<p>deficient practice does not recur;</p> <p>It is the policy of this facility (Vernon Manor) to ensure all ducts running through smoke barrier walls are equipped with a fire damper. All dampers will be visually inspected monthly in-house by the Maintenance Director and professionally inspected every 4 years according to state and federal law.</p> <p>The Maintenance Director will be responsible to monitor these acts and verify continued compliance.</p> <p>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;</p> <p>Results of the rounding audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months.</p> <p>All damper inspection will be documented and kept on file for reference.</p> <p>On an ongoing basis, monthly reports will be provided by facility to regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
K030144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 9 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the untitled generator log in the TEL's computer program with the Maintenance Director on 07/15/14 at</p>	K030144	<p>K144=F: What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice;</p> <p>This was not in a resident area. No resident was effected.</p> <p>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;</p> <p>Monthly testing with load on the generators will be completed on tels as required. Immediately following completion, a copy will be printed from the tels website and the Maintenance Director and Executive Director will verify all parts of the inspection are entered. Accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection.</p> <p>The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and complete. All further inspections will be placed in a binder and kept for ease of access.</p>	08/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
	<p>11:07 a.m., the June and May 2014 documentation for the monthly generator load test did not include the amps for each phase of both generators so the percentage of the load could not be verified. For the months of July through December 2013 and January through February 2014 both generators were documented as operating at 100 percent of the capacity of the generator. The Maintenance Director stated at the time of record review, based on the size of the generators and the size of the facility it wasn't possible for either to run at 100 percent capacity.</p> <p>3.1-19(b)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p> <p>It is the policy of this facility (Vernon Manor) to continue monthly testing with load on the generators and will be completed on tels as required. Immediately following completion, a copy will be printed from the tels website and the Maintenance Director and Executive Director will verify all parts of the inspection are entered in. Accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection.</p> <p>The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and complete. All further inspections will be placed in a binder and kept for ease of access.</p> <p>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;</p> <p>Completion and accuracy will be verified and the complete formula with variables entered will be placed on EVERY inspection. The Maintenance Director and Executive Director will ensure this and sign off that documentation is correct and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2014
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
			<p>complete. All further inspections will be placed in a binder and kept for ease of access.</p> <p>Results of the rounding audits will be presented to Quality Assurance Committee for review and recommendation monthly for 6 months. On an ongoing basis, monthly reports will be provided by facility to regional Quality Assurance Committees for review and recommendation as part of the annual Quality Assurance Program.</p>		