

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155124	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2013
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NAME OF PROVIDER OR SUPPLIER VERMILLION CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 S MAIN ST CLINTON, IN 47842
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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: 07/10/13</p> <p>Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Vermillion Convalescent Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors and spaces open to the corridors with battery powered smoke</p>	K010000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>detectors in resident rooms. The facility has the capacity for 119 and had a census of 87 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached garages for maintenance and equipment storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure doors to 1 of 8 hazardous areas could resist the passage of smoke. LSC requires where hazardous areas are protected by the approved automatic fire extinguishing system, the hazardous area is separated from other spaces by smoke resisting partitions and doors. LSC 8.2.4.3.4 requires door clearances shall be in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, 1-11.4 requires clearances under the bottom of doors shall comply with table 1-11.4 which limits the clearance for swinging doors with builders hardware to 3/4 inches between the bottom of the door and floor. This deficient practice could affect any visitors, staff and 10 or more residents in the vicinity of the south nurses' station.</p> <p>Findings include:</p>	K010029	<p>#1. The facility feels it has met this requirement through the following: 1. No residents were harmed. 2. All residents residing within the vicinity of the south station, visitors and staff are at risk. See #3 below for corrective action. 3. the maintenance staff replaced door which now has an 1/2 inch clearance at base of door. 4. In the future any new replacement doors will be measured and we will be secure in the fact that the Door clearance at the base is less than 3/4 inches. The doors will be observed 5 x weekly . All findings will be included in the facility's Quality Assurance Program meetings. 5. The above corrective actions will be completed on or before July 18, 2013 #2 Residents suffered no harm. See #3 below for corrective action. 2. All residents , visitors and staff in facility are at risk, See #3 below</p>	07/19/2013			

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	<p>Based on observation with the maintenance supervisor on 07/10/13 at 1:10 p.m., the self closing door providing access to a storage room located near the south nurses station was undercut by 1 1/2 inches which exceeded the maximum permitted. The maintenance director measured and confirmed the size of the undercut at the time of observation.</p> <p>3-1. 19(b)</p> <p>2. Based on observation and interview, the facility failed to provide a working automatic closer for a door providing access to 1 of 8 hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 6 or more residents with access to the south laundry service corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/10/12 at 1:40 p.m., the self closer on the door to the six by ten foot combustibile storage materials room near the south service corridor exit</p>		<p>for corrective action. 3. self-closure mechanism to arrange automatic closure in the designated area Installed 7/15/13.</p> <p>4. Maintenance will check the functioning of the doors and do routine maintenance As part of the facilities Quality Assurance Program 5. The above corrective action will be completed on or before 07/19/13..</p>		

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	<p>had a self closing device, but it had been dismantled. The maintenance director said at the time of observations, he didn't know the device had been changed to prevent the door from self closing.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit doors on the Expressions unit was clearly recognizable. LSC 7.1 requires compliance with chapter 7. LSC 7.5.2.2 requires exit doors shall be designed and arranged to be clearly recognizable. Nothing can be arranged to conceal or obscure any exit. This deficient practice affects staff, visitors, and 18 residents on the Expressions unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/10/13 at 12:55 p.m., the west exit door from the Expressions unit was painted over with a mural. An exit sign was located above the door but it was not immediately obvious there was a door. The was no latch, knob or other device to indicate it was a door. A push panel which would identify the side the door would open on was painted over as part of the mural. The maintenance director said at the time of observation, the mural was meant to disguise the exit from the unit occupants.</p> <p>3.1-19(b)</p>	K010038	<p>The facility feels it has meet this requirement through the following: 1. Residents suffered no harm, See #3 below corrective action 2. 18 residents and visitors on the Expressions unit were effected See #3 for corrective action 3.A silver 4 x 12 inch door handle applied to door, see exhibit C An additional exit sign posted. As seen in the exhibit C, the second door is clearly visible to outside. 4. Maintenance will inspect the two exit doors every week on the routine maintenance monitoring tool see (attachment D)As part of the facilities Quality Assurance Program5. The above corrective actions will be completed on or before 07/28/13</p>	07/28/2013

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to keep 2 of 2 unattended soiled linen and trash collection receptacles with a capacity of more than 32 gallons within a 64 square foot area, in a room protected as a hazardous area. This deficient affect occupants of the Expressions unit with a census of 19 residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/10/13 at 1:00 p.m., two 32 gallon soiled linen and trash collection receptacles stood side by side in the west exit vestibule of the Expressions unit. The collection receptacles were filled and the carts exceeded the 32 gallon capacity permitted. The carts remained in the corridor vestibule during the survey until the administrator was advised of the issue</p>	K010075	<p>K75 The facility believes it has meet its requirements through the following: 1. Residents remain at the facility and have suffered no immediate negative outcomes. See #3 below corrective action. 2. All residents have the right to be clear and unobstructed exit access. See #3 for corrective action 3. All nursing staff were educated thru in-services on storage of linen carts (Attachment a) and no items are to be stored in cubicle exits.. All charge nurses will monitor at med pass daily to assure egress clear (Attachment b).All findings are included in the facilities QA Program 4. The above corrective action will be completed befor or on July 22, 2013 see attachment a,b</p>	07/26/2013			

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	<p>on 07/10/13 at 1:45 p.m. The maintenance director acknowledged at the time of observation, the carts exceeded the 32 gallon capacity for unattended trash and collection receptacles.</p> <p>3.1-19(b)</p>			