| 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 09/21/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VERMILLION CONVALESCENT CENTER | 1705 S MAIN ST<br>CLINTON, IN 47842 |

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| K 0000<br><br>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).<br><br>Survey date: 09/21/15<br><br>Facility Number: 000052<br>Provider Number: 155124<br>AIM Number: 100290340<br><br>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.<br><br>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 smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in the resident sleeping. The facility has a capacity of 119 and had a census of 75 at | K 0000 | Submission of this plan ofcorrection does not constitute admission or agreement by the provider of thetruth of facts alleged or correction set forth on the statement ofdeficiencies.<br><br>This plan of correction isprepared and submitted because of requirement under state and federal law.<br><br>Please accept this plan ofcorrection as our credible allegation of compliance. | |

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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| | the time of this survey.<br><br>All areas where the residents have customary access were sprinklered except for the south exit overhang which was not sprinklered. The facility has two detached garages used for maintenance and equipment storage which was not sprinklered.<br><br>Quality Review completed 09/23/15 - DA | | | |
| K 0021<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:<br><br>a) the required manual fire alarm system;<br><br>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2<br>Based on observation and interview, the facility failed to ensure 2 of 3 doors to a hazardous area such as the kitchen were not prevented from self closing into its frame to resist the passage of smoke. This deficiency could affect 10 residents observed in the main dining room as well as visitors and staff. | K 0021 | 1 All residents suffered no harm See #3 below for corrective action<br>2. No other resident's residing within thefacility is at risk for the development of Complications.<br>3. All dietary staff were in-serviced on "Common Fire code Violation" | 09/22/2015 |

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| | Findings include:<br><br>Based on observations on 09/21/15 at 2:15 p.m. with the Maintenance Supervisor, the west kitchen door was held open with a food cart and the half kitchen door used to serve food was held open with a large fan. Both doors were equipped with door closing devices and opened into the main dining room. Based on interview on 09/21/15 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen doors were prevented from self closing into the door frame.<br><br>3.1-19(b) | | Dietary Manager will check daily x 5 days, x 4 weeks to ensure compliance andreport results to the QA Committee<br>4. After three months ofcontinued compliance, then be reviewedmonthly as part of the facility's monthly Quality Assurance Program.<br>5. The above corrective actions will becompleted on or before October 1,2015 | |
| K 0056<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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 | | | |

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| | 1. Based on observation and interview, the facility failed to ensure 4 of 8 steel armover sprinkler pipes observed were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.<br><br>Findings include:<br><br>Based on observations on 09/21/15 during the tour between 1:15 p.m. to 3:00 p.m. with the Maintenance Supervisor, the following steel sprinkler pipe armovers were observed:<br>a. 200 hall just outside the riser room measured five feet long and unsupported.<br>b. Expressions unit dining room on 200 hall measured four feet long and unsupported.<br>c. Expressions lounge on 200 hall east and west measured four feet each and were unsupported.<br>Based on interview on 09/21/15 concurrent with the observations with the Maintenance Supervisor it was | K 0056 | 1. 30 residents were affected.<br>2. No residents are at risk.<br>3.<br>Regarding **A.**<br>The facility purchased 14 steel armover sprinkler anchors to be installed by 10/5/15<br>Regarding **B.**<br>**Elwood Fire & Equipment company came to the facility and will install sprinkler system south exit overhang.**<br>Maintenance manager will reviewmonthly the fire concern report as part of the facility's QualityAssurance Program.<br>5. The above corrective actions will becompleted on or before October 5, 2015. | 10/05/2015 |

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| | acknowledged the aforementioned steel sprinkler pipe armovers exceeded twenty four inches in length and were unsupported.<br><br>3.1-19(b)<br><br>2. Based on observations and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 3 exits with outside canopies in accordance with NFPA 13, Standard for the 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 combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 30 residents on 200 wing using the south exit to evacuate as well as staff and visitors.<br><br>Findings include:<br><br>Based on observation on 09/21/15 at 2:01 p.m. with the Maintenance Supervisor, the south exit for 200 wing had an entrance overhang constructed of aluminum material for the ceiling with interior wood construction which connects to the building and extends fifteen feet in width and lacked sprinkler | | | |

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| | protection. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the lack of sprinkler protection by the aforementioned exit overhang and stated it was constructed of aluminum and wood.<br><br>3.1-19(b) | | | |
| K 0070<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8<br>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in the facility. This deficient practice could affect 5 residents in the front lobby as well as visitors and staff.<br><br>Findings include:<br><br>Based on observation on 09/21/15 at 1:30 p.m. with the Maintenance Supervisor, inside the business office next to the front lobby a portable space heater was available for use under an employee's desk, but was not plugged in. Based on interview on 09/21/15 concurrent with | K 0070 | The heater was used in a non-residential area It was removed from the building immediately See attachment B | 09/22/2015 |

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| | the observation, it was acknowledged by the Maintenance Supervisor space heaters were not allowed in the facility which was further verified by the space heater policy.<br><br>3.1-19(b) | | | |
| K 0143<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Transferring of oxygen is:<br><br>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;<br><br>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br><br>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association.<br>8.6.2.5.2<br>1. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transfer occurs had continuously working electrically powered mechanical ventilation. This deficient practice could affect 24 residents on 300 west hall as well as visitors and staff in the area. | K 0143 | This standard was not meet basedon observation vent not working in oxygen room.<br>The facility feels it has metthis requirement through the following:<br>1. No residents were negatively impacted by thedeficient practice.<br>2. No other resident's residing within thefacility is at risk for the development of Complications. | 10/02/2015 |

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| | Findings include:<br><br>Based on observation on 09/21/15 at 2:26 p.m. with the Maintenance Supervisor, the oxygen storage room on 300 west hall used to store and transfer oxygen was provided with an electrically powered mechanical vent, but was not operating at the time of observation. Based on interview on 09/21/15 concurrent with the observation it was acknowledged by the the Maintenance Supervisor this room was used to transfer oxygen and did not have a working electrically powered vent in the room.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire resistive enclosure. This deficient practice could affect 16 residents on 300 south hall as well as visitors and staff near the oxygen storage room.<br><br>Findings include:<br><br>Based on observation on 09/21/15 at 2:23 p.m. with the Maintenance Supervisor, the door to the oxygen transfer room on 300 south hall did not have a manufacturer's tag which could identify it | | 3. maintenance staff moved oxygen to a room with a fire rated door.. Maintenance will check weekly to ensure compliance andreport results to the QA Committee<br>An additional storage area wascreated<br>4. After three months ofcontinued compliance, then be reviewedmonthly as part of the facility's monthly Quality Assurance Program.<br>5. The above corrective actions will becompleted on or before October 1,2015 | |

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| | as a forty five minute fire rated door. Based on interview on 09/21/15 at 2:25 p.m., it was acknowledged by the Maintenance Supervisor oxygen transfer occurs in the Oxygen storage room and the fire rating of the corridor door to the oxygen transfer room was unknown and could not be verified.<br><br>3.1-19(b) | | | |