

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2013
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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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(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
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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: 09/12/13</p> <p>Facility Number: 000274 Provider Number: 15A014 AIM Number: 100271660</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Vernon Manor Childrens 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. Our date of compliance is October 12, 2013</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>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 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 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the room housing generator # 1 and a detached building used for the storage of nursing supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010021 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen corridor doors was held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice was not in a resident area area but could affect any number of facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Maintenance Director on 09/13/13 at 1:25 p.m., he acknowledged the soiled linen corridor door entering the laundry room was equipped with a kick down door stop which would not allow the door to close automatically when in use.</p> <p>3.1-19(b)</p>	K010021	<p>K021What 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; Maintenance director and Laundry staff were educated that doors can not be propped open by ED. On 9/13/13 the kick down door stop was removed from the laundry room door. During rounding on days of work</p>	10/12/2013			

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			Maintenance director and Environmental supervisor will observe laundry door to ensure it is not propped open. Rounding Documentation will be reviewed by ED to ensure 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. 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.		

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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>Based on observation and interview, the facility failed to ensure 2 of 4 shower rooms used for the storage of soiled linen, therefore creating a hazardous area, were provided with a door that would self close and latch into the frame. This deficient practice could affect 3 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/12/13 at 12:10 p.m. and 12:40 p.m., the corridor door to the 100 hall south shower room and the 200 hall south shower room each lacked a self closing device. Each shower room contained a barrel with soiled linen and a barrel for towels. Based on an interview with the Maintenance Director at the time of observations, the soiled linen barrels are stored in the shower</p>	K010029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; . No resident was affected by the alleged practice. 1 resident had the potential to be affected. 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; All other shower areas were observed with no stored items found. 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; The shower rooms on 100 hall south and 200 hall south are not designated storage areas. On 9/13/13 the linen barrels were removed and staff re-educated on proper location of dirty linen barrels by E.D.. During rounding</p>	10/12/2013			

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	rooms until collected by laundry personnel and taken to the laundry room. 3.1-19(b)		on days of work maintenance director and Environmental supervisor will observe shower rooms to ensure they are not being used for storage. Rounding Documentation will be reviewed by ED to ensure 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. 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.		

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K010046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 6 of 6 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director on 09/12/13 during the tour from 12:10 p.m. to 2:40 p.m., a total of six battery operated emergency lights were observed throughout the facility including at both emergency generators. Based on record review and interview with Maintenance Director at 12:00 p.m., documentation could not be found to confirm an annual test had been</p>	K010046	<p>K046What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice 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; All residents residing in the facility had the potential of being 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; The maintenance Director was educated on the need for annual inspections on battery operated emergency lights on 9/18/13. By Joe Garrett Director of Operation. The facility is at full power when emergency back up system is in use. The three (3) battery operated emergency lights located in the facility were removed. An annual test was completed on the three battery operated emergency light located by the two (2) emergency generators and Mechanical room on 9/26/113. Inspection documentation will be enter into tels (the facility documentation program) and reviewed monthly</p>	10/12/2013	

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	conducted for the the six battery operated lights within the last year. 3.1-19(b)		by ED to ensure 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 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.		

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the TELS computer program in the fire drill section with the Maintenance Director on 09/12/13 at 11:30 a.m., there was no record of a third shift fire drill for the first quarter of 2013 or a second shift fire drill for the fourth quarter of 2012. Based on an interview with the Maintenance Director at the time of record review, he missed conducting a third shift drill for the first quarter of 2013 and was not employed with the facility during the fourth quarter of 2012.</p> <p>3.1-19(b)</p>	K010050	<p>K050What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; .No residents were affected by this alleged practice. 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 All residents who reside in the facility could have the potential of being affected by this alleged practice. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; On 9/18/13 the maintenance direct was re-educated on fire drill requirements by Joe Garret, Director of Director Operations Maintenance Director will review with ED the shift rotation for fire drill for each quarter prior to completing them. How the corrective action(s) will be monitored to ensure the alleged</p>	10/12/2013	

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	3.1-51(c)		deficient practice will not recur, i.e., what quality assurance program will be put into place;Results of the review 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.		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 14 manual fire alarm boxes was mounted at the proper height. NFPA 72, National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice affects any number of staff and at least 10 residents in the movie room during movie night.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/12/13 at 1:00</p>	K010051	K051What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice. Resident who attend movie night had the potential to be affected. 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; All manual fire alarm boxes were measured to ensure they were at the correct height. With no findings. No other residents were found to have the potential of being affected. What measures will be put into place or	10/12/2013			

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	p.m., the manual fire alarm box on the wall in the movie room measured sixty inches from the floor level to the bottom of the fire alarm box. Measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b)		what systemic changes will be made to ensure that the alleged deficient practice does not recur; Maintenance director was educated on the correct height of fire alarm pull boxes. by Joe Garrett, Director of Operations. All manual fire alarm boxes were measured to ensure they were at the correct height. On 9/27/13 the manual fire alarm box in the theater room was relocated to the proper height. New manual fire alarm boxes installed will be measured for the correct height by the maintenance director to ensure compliance. Verification of the correct height will be reported to the ED. 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 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.		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 a complete automatic sprinkler system was provided for 1 of 2 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 feet in width. This deficient practice could affect 11 residents in Daliha Lane.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 09/12/13 at 12:15 p.m., there was a unsprinklered canopy of wood construction at the 100</p>	K010056	<p>K056 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice. 11 residents had the potential to be affected. 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 is the only location with a Non attached wood canopy. No other residents have 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; A quote was obtained and sprinkler system installation scheduled for 10/10-11/2013. After installation routine maintenance and inspections will</p>	10/12/2013			

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	<p>hall south (Daliha Lane) exit. The canopy covers the sidewalk and measured 10 feet wide and extends 24 and one half feet from the building. The canopy is not attached to the building but the gap between the canopy and the building is three fourths of an inch. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>be completed per maintenance program. Maintenance director will report results to ED. 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 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>		

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(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	
K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance</p>	K010130	<p>K130What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice. 11 residents had the potential of being affected. 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; All penetration areas in fire barriers were check with no findings. No other residents had the potential of being 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; The unfaced fiberglass insulation was not in an opening but was used for insulating purpose lying against a concrete wall. Unfaced fiberglass insulation is inorganic and is noncombustible. By guidelines of NAIMA unfaced fiberglass is accepted as a fire block. On 9/23/13 the piece of insulation was removed. Maintenance Director will monitor all new penetration area in fire barrier to ensure 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;</p>	10/12/2013	

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	<p>of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 4 residents in Babbling Brook and 7 residents in Dotties Dream.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 09/12/13 at 2:10 p.m., there was fiberglass insulation stuffed in the opening where the fire wall meets the corrugated roof decking above the lay in ceiling at the fire door at the Persimmons dining room. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>Results of the 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>		

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K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 90 of 90 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and</p>	K010154	K154 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice 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; All residents who reside in the facility had the potential of being 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; Maintenance director was educated on the required for a Fire Watch Policy by Joe Garrett, Director of Operations on 9/18/13. A new policy was put into place to include the designated person shall be trained in the duties and responsibilities of conducting the fire watch and the contact phone number for the Indiana State department of health. Managers and Charge nurse were educated in the duties and responsibilities	10/12/2013			

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	<p>lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Watch Policy and Procedure" documentation with the Maintenance Director on 09/12/13 at 11:40 a.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not include:</p> <p>a. the designated person(s) shall be trained in the duties and responsibilities for conducting the fire watch.</p> <p>b. the policy did not include the the contact phone number for the Indiana State Department of Health.</p> <p>Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>of conducting a fire watch on 9/27/13. Staff interviews will be conducted weekly for 6 weeks and randomly thereafter to ensure understanding of the Fire Watch Policy and procedure 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 interviews 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>		

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 90 of 90 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K010155	<p>K155 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice. 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; All residents who reside in the facility have 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; Maintenance director was educated on the required for a Fire Watch Policy by Joe Garrett, Director of Operations on 9/18/13. A new policy was put into place to include the designated person shall be trained in the duties and responsibilities of conducting the fire watch and the contact phone number for the Indiana State department of health. Managers and Charge nurse were educated in the duties and responsibilities of conducting a fire watch on</p>	10/12/2013

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	<p>Findings include:</p> <p>Based on review of the "Fire Watch Policy and Procedure" documentation with the Maintenance Director on 09/12/13 at 11:40 a.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not include:</p> <p>a. the designated person(s) shall be trained in the duties and responsibilities for conducting the fire watch.</p> <p>b. the policy did not include the the contact phone number for the Indiana State Department of Health.</p> <p>Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>9/27/13. Staff interviews will be conducted weekly for 6 weeks and randomly thereafter to ensure understanding of the Fire Watch Policy and procedure 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 interviews 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>		

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K030000	<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: 09/12/13</p> <p>Facility Number: 000274 Provider Number: 15A014 AIM Number: 100271660</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Vernon Manor Childrens 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 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 was of</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 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. Our date of compliance is October 12, 2013</p>	
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	<p>Type V (111) construction and was 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 90 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the room housing generator # 1 and a detached building used for the storage of nursing supplies.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K030046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation, record review and interview; the facility failed to ensure 6 of 6 emergency light fixtures of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director on 09/12/13 during the tour from 12:10 p.m. to 2:40 p.m., a total of six battery operated emergency lights were observed throughout the facility including at both emergency generators. Based on record review and interview with Maintenance Director at 12:00 p.m., documentation could not be found to confirm an annual test had been</p>	K030046	<p>K046What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice 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; All residents residing in the facility had the potential of being 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; The maintenance Director was educated on the need for annual inspections on battery operated emergency lights on 9/18/13. By Joe Garrett Director of Operation. The facility is at full power when emergency back up system is in use. The three (3) battery operated emergency lights located in the facility were removed. An annual test was completed on the three battery operated emergency light located by the two (2) emergency generators and Mechanical room on 9/26/113. Inspection documentation will be enter into tels (the facility documentation program) and reviewed monthly</p>	10/12/2013			

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	conducted for the the six battery operated lights within the last year. 3.1-19(b)		by ED to ensure 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 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.		

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K030050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the TELS computer program in the fire drill section with the Maintenance Director on 09/12/13 at 11:30 a.m., there was no record of a third shift fire drill for the first quarter of 2013 or a second shift fire drill for the fourth quarter of 2012. Based on an interview with the Maintenance Director at the time of record review, he missed conducting a third shift drill for the first quarter of 2013 and was not employed with the facility during the fourth quarter of 2012.</p> <p>3.1-19(b)</p>	K030050	<p>K050What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; .No residents were affected by this alleged practice. 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 All residents who reside in the facility could have the potential of being affected by this alleged practice. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur; On 9/18/13 the maintenance direct was re-educated on fire drill requirements by Joe Garret, Director of Director Operations Maintenance Director will review with ED the shift rotation for fire drill for each quarter prior to completing them. How the corrective action(s) will be monitored to ensure the alleged</p>	10/12/2013			

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	3.1-51(c)		deficient practice will not recur, i.e., what quality assurance program will be put into place;Results of the review 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.		

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K030154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 90 of 90 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and</p>	K030154	K154 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice 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; All residents who reside in the facility had the potential of being 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; Maintenance director was educated on the required for a Fire Watch Policy by Joe Garrett, Director of Operations on 9/18/13. A new policy was put into place to include the designated person shall be trained in the duties and responsibilities of conducting the fire watch and the contact phone number for the Indiana State department of health. Managers and Charge nurse were educated in the duties and responsibilities	10/12/2013			

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	<p>lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Watch Policy and Procedure" documentation with the Maintenance Director on 09/12/13 at 11:40 a.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not include:</p> <p>a. the designated person(s) shall be trained in the duties and responsibilities for conducting the fire watch.</p> <p>b. the policy did not include the the contact phone number for the Indiana State Department of Health.</p> <p>Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>of conducting a fire watch on 9/27/13. Staff interviews will be conducted weekly for 6 weeks and randomly thereafter to ensure understanding of the Fire Watch Policy and procedure 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 interviews 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>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A014		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 09/12/2013	
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K030155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 90 of 90 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.</p>	K030155	<p>K155 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were affected by this alleged practice. 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; All residents who reside in the facility have 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; Maintenance director was educated on the required for a Fire Watch Policy by Joe Garrett, Director of Operations on 9/18/13. A new policy was put into place to include the designated person shall be trained in the duties and responsibilities of conducting the fire watch and the contact phone number for the Indiana State department of health. Managers and Charge nurse were educated in the duties and responsibilities of conducting a fire watch on</p>	10/12/2013			

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