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 10/15/2014

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

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K010000	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). Survey Date: 10/15/14 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 Surveyor: Bridget Brown, Life Safety Code Specialist 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. 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 and battery powered smoke	K010000	Dear Sirs Please find enclosed plan of correction for the survey ending 11/1/14 Due to the low scope and severity of the survey findings, please find enclosed sufficient documentation providing evidence of compliance with plan of correction. The documentation and photos confirm allegation of compliance. Thus, the facility is respectfully requesting paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact Administrator Respectfully Melissa Gum RN, HFA	

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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	detectors in resident rooms. The facility has the capacity for 119 and had a census of 79 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached garages for maintenance and equipment storage which were not sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/20/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			
K010018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the	K010018	Submission of this plan of	10/22/2014

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	facility failed to ensure doors protecting corridor openings in 5 of 10 smoke compartments could automatically latch into the door frame. Manual slide bolt latches are not permitted on corridor doors. This deficient practice affects staff, visitors and 30 or more residents in the South front, South back, North back, North front and Expressions smoke compartments. Findings include: Based on observation with the maintenance director and administrator on 10/15/14 between 11:30 a.m. and 2:25 p.m., the double door sets providing access to linen storage, supply and activities storage closets on the North back (two doors), North front (two doors), South front (two doors), and Expressions unit each required one door to latch into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The in addition, the first door had to be secured by a manual slide bolt latch before the second door with the automatic latch would close securely. The maintenance director acknowledged at the time of observations, one door in each door set included manual slide bolt latches and each door could not latch independently into their door frames.		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. The plan of correction is prepared and submitted because requirement under state and federal law. Please accept plan od correction as our credible allegation of compliance. K018 The facility feels it has met requirements through the following: 1 No residents were negatively impacted by deficient practice 2 All visitors, staff and 30 or more residents within the facility were at risk 3. A door latch was placed on the five double door sets 4. Maintenance staff checked all doors to make sure they latched appropriately, they will check daily on rounds 5 x weekly. Maintenance will report results to QA Committee monthly 5.The above corrective actions will be completed by 10/23/14	

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	3.1-19(b)			
K010025 SS=E	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 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 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers in a janitor's closet was maintained to provide the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or	K010025	K25 The facility has met requirements through the following: 1.No residents were negatively impacted by deficient practice. 2. All visitors, staff and 10 or more residents within the facility were at risk. 3. The smoke barrier in the south janitors closet had a gap ½ inch around a pipe. This was sealed with a material capable of smoke Resistance-Red Devil Heat resistant Caulking	10/22/2014

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	be protected by an approved device designed for the specific purpose. This deficient practice affects visitors, staff and 10 or more residents in the south nurses station smoke compartment. Findings include: Based on observation with the maintenance director and administrator on 10/15/14 at 1:25 p.m., the janitor's closet across from the south nurses station had a laid in ceiling from which four panels were missing. An unsealed half inch annular space surrounding a pipe, four inches in diameter, penetrated the ceiling into the attic space above. An unsealed one inch gap was observed along one side of a device identified by the maintenance director as a heating unit, penetrated the same ceiling. The maintenance director acknowledged at the time of observation, the openings in the ceiling should have been sealed. 3.1-19(b)		See attachment B & C. 4. The maintenance Director or his designee will monitor monthly and presentto QA Committee quarterly 5. The above correctioe action was completed by10/22/2014.	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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	condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure an annual test to check backflow preventers for 1 of 1 sprinkler systems was conducted as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 9-6.2.1 indicates all backflow preventers installed in fire protection system piping shall be tested annually. This deficient practice affects all residents, staff, and visitors. Findings include: Based on review of Sprinkler System test Reports with the maintenance director and administrator on 10/15/14 at 2:00 p.m., no current backflow test was found in inspection records provided. The last record of backflow testing was dated 12/14/12. The maintenance director said at the time of record review, no other backflow test had been done. 3.1-19(b)	K010062	K062 The facility has met this requirement Throughthe following: 1. No Residents were negatively impacted by the deficient practice 2. All visitors,staff and residents within the facility were at risk. 3.Gibson Services was contacted to setup appointment 4. The maintenance Director or his designee will monitor monthly and presentto QA Committee quarterly 5. The above corrective action was completed by 10/30/2014.	10/30/2014

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K010067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure the fire damper in the ductwork serving 2 of 9 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects visitors, staff and 20 or more residents in the North Front and South Front smoke compartments. Findings include:	K010067	K067 The facility has met this requirement Throughthe following: 1. No Residents were negatively impacted by the deficient practice 2. All visitors,staff and 20 or more residents within the facility were at risk. 3. Gibson Electric was notified at 830am 10.22.14 They will schedule a damper inspection within 10/30/14. They inspection every four years were added to audit on monthly rounds. See attachment D. 4. The maintenance Director or his designee will monitor monthly and presentto QA Committee quarterly 5. The above corrective action was completed by 10/30/2014.	10/30/2014

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	The contractor Fire Safety Inspection and Test Report for the fire damper installed in ductwork penetrating the North Front and South Front firewall was reviewed with maintenance director and administrator on 10/15/14 at 2:30. The report was dated 05/27/10. The maintenance director said at the time of review, he had no more recent fire damper inspection and test as it had not been done since May of 2010. 3.1-19(b)			
K010068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 laundry rooms were provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment."	K010068	The facility has meet this requirement through the following- 1 No Residents were negatively impacted by the deficient practice 2 All visitors, staff and 20 or more residents within the facility were at risk. 3. See attachment E A 12-16 inch fresh air intake was added to each laundry room. 4. the Maintenance Director or his designee will monitor monthly and present to QA committee	10/23/2014

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	This deficient practice could affect visitors, staff, and 20 or more residents on the North Front and South Front smoke compartments. Findings include: Based on observation with the maintenance director and administrator on 10/15/14 between 11:30 a.m. and 2:25 p.m., the north and south laundry rooms each had two, gas fueled dryers with no fresh air intake. The maintenance director acknowledged at the time of observations the gas fueled dryers did not have a fresh air intake. 3.1-19(b)		monthly. The above action completed on 10/23/14	
K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (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; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not			

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	permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites were separated from resident areas and ventilated as required. NFPA 99 8-6.2.5.2 requires transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that: (a) Is 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; and (b) The area is mechanically ventilated. This deficient practice affects visitors, staff and 10 or more residents on the South hall.. Findings include: Based on observation with the maintenance director and administrator on 10/15/14 at 1:15 p.m., the oxygen supply storage room opening into the South Hall hall exit corridor was identified by the maintenance director as the site used to fill portable oxygen supply tanks and signs on the door. The four by four foot room was filled to capacity with five liquid oxygen tanks leaving a 12 by 12 inch space for staff to	K010143	K0143 The facility has met this requirement Throughthe following: 1. No Residents were negatively impacted by the deficient practice 2. All visitors,staff and 10 or more residents within the facility were at risk. 3.Additional storage room was prepared that met criteria with one hour fire resistive construction, concrete floor, ventilated, sprinklers. Signs were posted and an inservice was conducted on 'Oxygen transfer' See Attachment 4. The maintenance Director or his designee will monitor monthly and present to QA Committee quarterly 5. The above corrective action was completedby 10/20/14	10/20/2014

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	stand and close the door behind them when transfilling portable oxygen tanks. Nurse #1 was asked at the time of observation, to demonstrate the means by which filling of a portable oxygen tank was done. The nurse opened the door, held it open with her foot, and proceeded to fill the portable oxygen tank. Residents were sitting in the corridor. The nurse acknowledged at that time, this was the way oxygen was usually transfilled into the portable tanks. The maintenance director acknowledged the nurse did not follow the posted procedure requiring the door to be closed during the transfilling and she could not close the door behind her because there were too many tanks stored in the room. 3.1-19(b)			
K010144 SS=F	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. Based on observation and interview, the facility failed to ensure 1 of 1 emergency	K010144	K0144	10/30/2014

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	generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and		The facility has met this requirement Throughthe following: 1. No Residents were negatively impacted by the deficient practice 2. All visitors,staff and residents within the facility were at risk. 3.An ancillary remote alarm annunciator will bemoved to north nurses station. Is presently acrossfrom Director of Nursing office. 4. The maintenance Director or his designee will monitor monthly and presentto QA Committee quarterly 5. The above corrective action was completed by 10/30/2014.	

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	visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation with the maintenance director and administrator on 10/15/14 at 2:10 p.m., an ancillary remote alarm annunciator for the emergency generator was provided in the the corridor across from the DON's office. The location was acknowledged by the the maintenance director at the time of observation, to be at least 80 feet from any nurses station. He said the DON's office was not continuously occupied, the adjacent areas were attended only during business hours. He said agreed the annunciator alarm would not be heard at the nurses stations and the trouble light would not be visible. 3.1-19(b)			

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