STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155124	A. BUILDING -- B. WING	07/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/11/23 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 At this Emergency Preparedness survey, Vermillion Convalescent Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 119 certified beds. At the time of the survey, the census was 72. Quality Review completed on 07/13/23	E 0000	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. Please accept this plan of correction as our credible allegation of compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/11/23 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 At this Life Safety Code survey, Vermillion	K 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MELISSA GUM	ADMINISTRATOR	07/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Convalescent Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 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 smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 119 and had a census of 72 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has one detached garage used for maintenance and equipment storage which was not sprinklered. Quality Review completed on 07/13/23		Please accept this plan of correction as our credible allegation of compliance.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 1 of 1 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient	K 0291	1. No Resident was affected by the deficient practice. 2. All Residents have the potential to be affected by the deficient practice. 3. All emergency lights were tested on July 19, 2023 for their annual test requirements. All lights tested were found to be in	07/19/2023

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	practice could affect all building occupants when work is needed on the generator. Findings include: Based on an records review with the Maintenance Director on 07/11/23 at 10:40 a.m., documentation of a monthly 30 second test for the battery powered emergency light was not available for review for the months of May and June of 2023. Based on an interview at the time of record review, the Maintenance Director confirmed there is a battery powered light for the generator and stated the 30 second testing for the aforementioned months were not documented. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		compliance with the 90-second requirement. 4. Maintenance supervisor or designee will complete monthly 30-second testing and annual 90-second testing using the attached form (SEE ATTACHMENT A-1) of emergency lights. Maintenance supervisor or designee will present testing and inspection results to the Quality Assurance Committee each month for review. Should any deficient practice be identified, immediate corrections will be made and any re-education provided. 5. Date of completion: July 19, 2023 SEE ATTACHMENT A-1	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure all sprinkler heads in the kitchen were not corroded, loaded, or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 07/11/23 at 11:37 a.m., the sidewall sprinkler head in the kitchen pantry room was loaded with dirt, grease, and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director confirmed the sidewall sprinkler head in the kitchen pantry was loaded with dirt, grease and showed signs of corrosion. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0353	1. No Resident was affected by the deficient practice. 2. All Residents have the potential to be affected by the deficient practice, however none were affected. 3. The sprinkler head was cleaned by the Maintenance Supervisor on 7/19/23. Gardner Fire Protection was contacted and advised the sprinkler head was corroded and needed replaced. Gardner provided a date of inspection/replacement of the sprinkler head 7/28/2023. 4. The Maintenance Supervisor or designee will complete monthly inspections of all sprinkler heads to ensure no head is corroded or soiled. These inspections will continue monthly indefinitely in conjunction with the preventative maintenance schedule. Should any sprinkler head be identified as corroded or soiled, corrective actions will be taken immediately to either clean the sprinkler head or schedule replacement of the identified sprinkler head. Results of these inspections will be submitted to the Quality Assurance Committee monthly for inspection. Should any deficient practice be identified, corrective	07/28/2023

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			actions will be taken immediately. (SEE ATTACHMENT A-2) 5. Date of completion: 7/28/2023	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

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	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 1 residents. Findings include: Based on observation with the Administrator and Maintenance Director on 07/11/23 at 11:50 a.m. during a tour of the facility, the corridor door to Resident Room 251 had an impediment to closing, in that it took considerable force to close and latch into it's frame. When opening, the corridor door to resident room 251 took considerable force to open. Based on interview at the time of observation, the Maintenance Director confirmed the resident room door took considerable force to close and stated it's probably swollen and he would work on the door. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0363	1. No Resident was affected by the deficient practice. 2. All Residents have the potential to be affected by the deficient practice. 3. Room 251's door was adjusted by the Maintenance Supervisor on 7/14/23 and is now closing and latching into the door frame. 4. The Maintenance Supervisor or designee will complete monthly door inspections to ensure all doors are closing and latching into the door frame in conjunction with the preventative maintenance schedule. The inspections will continue indefinitely and be presented to the Quality Assurance Committee. Should any deficient practice be identified, corrective actions will be made immediately. 5. Date of completion: 7/19/2023	07/19/2023
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and			

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	Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 55 of 55 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in	K 0914	1. No Resident was affected by the deficient practice. 2. All Residents have the potential to be affected by the deficient practice. 3. All 55 Resident sleeping room outlets were tested on 7/20/23. Any outlet that failed inspection was replaced immediately. 4. All 55 Resident sleeping room outlets will be tested annually moving forward. The Maintenance Supervisor was re-educated on the annual testing requirement. The Maintenance Supervisor or designee will complete annual	07/20/2023

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	each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/11/23, the facility's resident sleeping rooms contained five to seven non-hospital-grade electrical receptacles. Based on records review at 10:46 a.m., no documentation was available to show the electrical receptacles in resident sleeping rooms were tested within the past 12 months. The most recent receptable retention testing documented as occuring on various dates from January to April 2022. Based on interview at the time of records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated he had not gotten around to performing the annual receptacle retention testing this year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		outlet testing of all 55 Resident sleeping rooms annually. Results of these annual inspections will be presented to the monthly Quality Assurance Committee for review. Should any deficient outlets be identified, same will be replaced immediately. 5. Date of completion: 7/20/2023	