

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03 B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2022
NAME OF PROVIDER OR SUPPLIER VERNON HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/08/22 Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660 At this Emergency Preparedness survey, Vernon Health & Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 119 and had a census of 52 at the time of this survey.	E 000			
K 000	Quality Review completed on 09/12/22 INITIAL COMMENTS 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: 09/08/22 Facility Number: 000274 Provider Number: 155810 AIM Number: 100271660 At this Life Safety Code survey, Vernon Health & Rehabilitation was found 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	K 000			

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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K 000	Continued From page 1 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The facility consists of three one story connected buildings separated by a two or three hour fire barrier. (Bldg. 01) consists of the original building which includes the 100 hall, 200 hall, and the kitchen. (Bldg. 02) consists of the service hall and laundry room. (Bldg. 03) consists of the 2003 add on which includes the 300 hall, therapy, and the dining room. All were surveyed with Chapter 19, Existing Health Care Occupancies. (Bldg. 01) was determined to be of Type II (111) construction and was sprinklered. This building has a fire alarm system with smoke detection in corridors and 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 52 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of the detached room housing generator # 1, and a detached storage building used for storage.	K 000			
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