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	07/27/2022

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: 07/27/22 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 63. Quality Review completed on 07/29/22	E 0000	K0000 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. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Community's allegation of compliance. Thus, the community respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	
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).	K 0000	K0000 Submission of this Plan of Correction does not constitute admission or agreement by the	

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	Survey Date: 07/27/22 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 At this Life Safety Code survey, Vermillion Convalescent Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 63 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 07/29/22		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 of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Community's allegation of compliance. Thus, the community respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	
K 0353 SS=F 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	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 coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Housekeeping Supervisor on 07/27/22 during a tour of the facility from 12:05 p.m. to 1:18 p.m., the spare sprinkler	K 0353	K0353 K0353 requires the facility maintain, in a cabinet, a supply of spare sprinklers that correspond to the types and temperature ratings of the sprinklers on the property 1. No residents or staff were harmed. The cabinet has been replenished with appropriate sprinkler heads (See Attached A) The sprinkler located in the soiled utility room next to the entrance to Expressions Hall has been replaced (See Attached B) The sidewall sprinkler located in the walk-in refrigerator in the kitchen was cleaned with compressed air as recommended immediately prior to survey exit (See Attached C) 2. All residents have the potential to be affected, thus the following corrective measures have been taken; 3. As means of ongoing compliance Elwood Fire	08/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	cabinet in the riser room did not contain any sidewall sprinkler heads. Based on observation with the Housekeeping Supervisor, the facility had sidewall sprinklers in shower rooms and resident rooms. Based on interview at the time of observation, the Housekeeping Supervisor agreed the spare sprinkler cabinet did not contain sidewall sprinkler heads. 2. Based on observation, and interview; the facility failed to ensure all loaded sprinklers were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect at least 5 residents and staff in the vicinity of the south soiled utility room and the kitchen. Findings include:		Equipment Co. will continue routine inspections and pertinent staff has been educated (See Attached D) 1. As a means of quality assurance, the Administrator or designee will monitor sprinkler head inspections on scheduled days of work for 4 weeks, then weekly for 4 weeks, then monthly until compliance is maintained for 2 consecutive months. The results of the audits will be reviewed as part of the regularly scheduled quality assurance committee meetings with the plan of action adjusted accordingly, as warranted. 4. The above corrective action will be completed on or before 08/08/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:05 p.m. to 1:18 p.m. on 07/27/22, the sidewall sprinkler located in the soiled utility room next to the entrance to Expressions Hall showed signs of green corrosion. Additionally, the sidewall sprinkler located in the walkin refrigerator in the kitchen was covered with dirt and lint. Based on interview at the time of observation, the Housekeeping Supervisor agreed the aforementioned automatic sprinklers were loaded. These findings were reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 23 portable fire extinguishers was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the	K 0355	K0355 K0355 requires the facility to ensure fire extinguishers are inspected at least monthly 1. No residents were harmed. The fire extinguisher located in the north laundry room has been replaced (See Attached E and F) 2. Staff in the North laundry room had the potential to be affected, thus the following corrective measures have been taken; 3. As a means of ongoing compliance, pertinent staff was	08/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in north laundry. Findings include: Based on observations with the Housekeeping Supervisor during a tour of the facility from 12:05 p.m. to 1:18 p.m. on 07/27/22, the ABC type portable fire extinguisher located in the north laundry room next to room 328 had an affixed maintenance tag indicating the annual inspection for the extinguishers was performed by the inspection contractor in February 2022. The affixed maintenance tag for the fire extinguisher was missing a documented monthly inspection for the months of March, April, May 2022. Based on interview at the time of the observation, the Housekeeping Supervisor agreed portable fire extinguisher documentation for the aforementioned three month period was not available for review. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		educated (See Attached D) Routine inspections will be performed by Elwood Fire Equipment Co. 4. As a means of quality assurance, the Administrator or designee will monitor fire extinguisher inspections on scheduled days of work for 4 weeks, then weekly for 4 weeks, then monthly until compliance is maintained for 2 consecutive months. The results of the audits will be reviewed as part of the regularly scheduled quality assurance committee meetings with the plan of action adjusted accordingly, as warranted. 5. The above corrective measures will be completed on or before 8/11/2022	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents and staff in two smoke compartments. Findings include: Based on observation with the Housekeeping Supervisor during a tour of the facility from 12:05 p.m. to 1:18 p.m. on 07/27/22, the smoke barrier door set to the North back hall in the corridor by Resident Rooms 312 and 314 failed to fully self close when tested to close multiple times. The two doors in the door set each swing in the same direction and was equipped with a door closing coordinator affixed to the top of the door frame near the center of the door frame. The coordinator failed to operate correctly and propped the doors	K 0374	K0374 K0374 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. 1. No residents were harmed. The door closing coordinator has been replaced to the North back hall. 2. All residents have the potential to be affected, thus the following corrective measures have been taken; 3. As a means of ongoing compliance, pertinent staff was educated (See Attached D) 4. As a means of quality assurance, the Administrator or designee will monitor fire extinguisher inspections on scheduled days of work for 4 weeks, then weekly for 4 weeks, then monthly until compliance is	08/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	open with a four to five inch gap in between the meeting edges of the door set. Each door in the door set was held in the fully open position with magnetic holding devices set to release each door to close with fire alarm system activation. Based on interview at the time of the observation, the Housekeeping Supervisor agreed the smoke barrier door set failed to fully self close to restrict the passage of smoke due to the closing coordinator not functioning correctly. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		maintained for 2 consecutive months. The results of the audits will be reviewed as part of the regularly scheduled quality assurance committee meetings with the plan of action adjusted accordingly, as warranted. 5. The above corrective measures will be completed on or before 8/11/2022	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 boiler rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could affect staff in the mechanical room. Findings include:	K 0522	K0522 K0522 requires the boiler room to be provided with intake combustion air from the outside 1. No residents or staff were harmed. The intake vents were cleaned immediately prior to survey exit (See Attached H and I).	08/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 01 B. WING	07/27/2022

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
	Based on observation during a tour of the facility with the Housekeeping Supervisor on 07/27/22 at 12:40 p.m., the mechanical room, located across the corridor from the contained fuel-fired water heaters, did have a fresh air intake, but the two screens over the intakes were completely covered and clogged with dirt, dust and debris. This condition did not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Housekeeping Supervisor stated the intakes were covered with lint and dirt and would need to be cleaned. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		2. All residents have the potential to be affected, thus the following corrective measures have been taken; 3. As a means of ongoing compliance, pertinent staff was educated (See Attached D) 4. As a means of quality assurance, the Administrator or designee will monitor fire extinguisher inspections on scheduled days of work for 4 weeks, then weekly for 4 weeks, then monthly until compliance is maintained for 2 consecutive months. The results of the audits will be reviewed as part of the regularly scheduled quality assurance committee meetings with the plan of action adjusted accordingly, as warranted. 5. The above corrective measures will be completed on or before 8/11/2022	