

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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
F000000	<p>This visit was for the Investigation of Complaints IN00149178 and IN00149006.</p> <p>Complaint IN00149178 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00149006 - Substantiated. Federal/state deficiencies related to the allegations are cited at F371.</p> <p>Survey dates: May 19, 2014 and May 20, 2014</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey team: Jennifer Carr, RN - TC Julie Dover, RN Angela Halcomb, RN</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 9 Medicaid: 70 Other: 26 Total: 105</p>	F000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
--	---

(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
--------------------	--	---------------	---	----------------------

F000371 SS=E	<p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 28, 2014, by Brenda Meredith, R.N.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper sanitation and food handling practices related to, a sticky floor, handwashing and improperly stored Styrofoam cups during 2 of 4 kitchen observations.</p> <p>Findings include:</p>	F000371	Preparation and/or execution of this poc does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed to continue compliance with State and Federal regulations.1. Cups are no longer stored on the bottom shelf without protection. The cups are in a container with sides to prevent falling and touching the floor. The	06/09/2014
-----------------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2014
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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	
	<p>The facility kitchen was toured with the contracted interim Corporate Dietary Manager on 5/19/14 at 9:45 a.m. The kitchen floor was observed to be sticky throughout. The bottom shelf of a food preparation table located in front of the walk-in freezer was observed to have a single column of Styrofoam cups, in an open plastic bag, hanging over the edge of the shelf with a Styrofoam cup touching the floor.</p> <p>On 5/20/2014 at 9:44 a.m., the Corporate Dietitian was observed entering the kitchen while pushing her hair under the hair net on her head. She then picked up a Styrofoam cup off the bottom of the ice cart and scooped ice with the ice scooper from the ice machine into the cup. She did not wash her hands at any time during the continuous observation.</p> <p>A copy of the policy "Handwashing - Dietary Guidelines" was provided by the Staff Coordinator on 5/19/2014 and reviewed on 5/20/2014 at 10:30 a.m. The policy included, but was not limited to, "Follow established handwashing policy per Infection Control guidelines. Wash hands: 1. Immediately before work....3. After coughing, blowing nose, sneezing,</p>		<p>floors are cleaned per policy. Handwashing is monitored by the dietary manager.2. No residents were actually effected by this deficiency. In-services were completed for the kitchen staff on 5-28-14. 3. In-services were completed per the Dietary manager for sanitation and infection control, cleaning procedures and cleaning matrix, safe food handling, including hand washing. 4. The dietary manager will monitor storage, hand washing, and cleanliness of the floor. The dietary manager will audit storage, cleaning procedures, and handwashing practices 5 days per week x 4 weeks. The dietary manager will report results to the QAPI team during their monthly meeting. The team will review the results, and decide on any further action to be taken, and how long audits will continue after the monthly review.5. June 9, 2014.We respectfully request a desk review for this deficiency. All in-services are completed. The cups are stored appropriately. The floors are cleaned appropriately, and the tour indicated was at 9:45 a.m. This would normally be a time of day that clean up would be happening after breakfast, yet not complete. The Corporate dietician is well educated on kitchen procedures and food handling, and is now even more aware after this event.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2014
NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
(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	
	<p>touching hair, mouth or cigarette...6. Before touching food, clean dishes or silverware...."</p> <p>The Corporate Dietitian was interviewed regarding her expectations on handwashing in the kitchen on 5/20/2014 at 12:12 p.m. She indicated, "Before they start any food production, they should wash their hands....If they touch their hair, they should wash their hands."</p> <p>This federal tag relates to Complaint IN00149006.</p> <p>3.1-21(i)(2)</p>				