STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155665		06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENNINGS HEALTHCARE CENTER	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
K 0000 Bldg. 01	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: 06/26/15 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 At this Life Safety Code survey, Jennings Healthcare 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 V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 101 at the time of this visit.	K 0000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals, who draft or may be discussed in this response of this plan of correction.In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.The facility respectfully requests a desk review.	

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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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.			
K 0018 SS=E Bldg. 01	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 facility failed to ensure 1 of 75 doors protecting corridor openings was provided with a means suitable for keeping the door closed that was acceptable to the authority having jurisdiction. This deficient practice could affect approximately ten residents, staff and visitors. Findings include: Based on observation on 06/26/15 at 11:30 a.m. with the Executive Director,	K 0018	1. The identified door was corrected on 7/7/15.2. One Resident had the potential to be affected by this citation. Maintenance staff audited all Resident Doors to ensure that they latched appropriately. No other areas of concern were identified during the audit.3. The administrator in-serviced Maintenance staff related to citation and Life Safety Code regulation of a means sutiable for keeping the door closed. This in-service was conducted on 7/7/15.4. Maintenance staff will audit all doors for proper closure	07/26/2015

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	the door to resident room C101 did not latch when the door was closed. Based on interview during the time of observation with the Executive Director, it was acknowledged the door did not latch. 3.1-19(b)		weekly x 3 weeks, monthly x 4 months. The findings will be brought to monthly Quality Assurance Performance Improvement Committee meetings.	
K 0025 SS=E Bldg. 01	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 openings through 1 of 8 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect at least 15 residents, staff and visitors near the main entrance smoke barrier. Findings include: Based on observation with the Executive Director, at 12:15 p.m. on 06/26/15, there	K 0025	1. The identified penetrations was fixed on 7/7/15. 2. All Residents have the potential to be affected by these citations. Maintenance staff audited the entire facility to identify any smoke barriers with penetratons.3. The Administrator in-serviced Maintenance staff related to citation and Life Safety Code regulation related to penetrations through smoke barriers on 7/7/15. 4. Maintenace staff will audit all smoke barrier walls to ensure that there are no penetrations weekly x 3 months and then monthly x 4 months.	07/26/2015

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	were two penetrations above the ceiling tiles of the main entrance smoke barrier that were sealed with expandable foam. Based on interview at the time of the observation, the Executive Director stated documentation of the fire resistance rating of the expandable foam was not available for review and acknowledged the aforementioned openings in the smoke barrier wall above the suspended ceiling failed to maintain the smoke resistance of the smoke barrier. 3.1-19(b)		The findings will be brought to monthly Quality Assurance Performance Imporvement Committee meetings.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the	K 0038	The C Hall exit door does not have capability of being magnetically locked and key pad does not serve function. Door is locked from outside but can be opened from inside by pushing on opening device. Door is equipped with audible alarm. Door is not a public access door, it is used for emergency exit only. Reason for IDR, Plant Ops Director was not in facility at time of Life Safety Survey, ED rounded with Surveyor. ED provided wrong information to Surveyor at the time of Survey.	07/26/2015

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	clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects at least 15 residents and visitors on C Hall. Findings include: Based on observation with the Executive Director on 06/26/15 at 11:25 a.m., the C Hall exit door had the capability of being magnetically locked and could be opened by entering a four digit code. The C Hall exit door did not have a code to open the exit door posted. Based on interview at the time of observation, the Executive Director indicated residents on C Hall lack a clinical diagnosis to be in a secure building. Any resident without a clinical diagnosis requiring specialized security measures or any visitor would have to ask a staff member to let them out of the exit doors if they did not know the code. 3.1-19(b)			
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified			

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	to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions in 6 of 12 fire drills. This deficient practice affects all residents in the facility including staff. Findings include: Based on review of monthly fire drill report documentation with the Executive Director on 06/26/15 at 9:45 a.m., fire drills were conducted at or near the end of the month on 04/30/14, 05/31/14, 08/29/14, 10/30/14, 11/30/14 and 12/31/14. Based on interview at the time of review, the dates of when fire drills were conducted were acknowledged by the Executive Director. 3.1-19(b) 3.1-51(c)	K 0050	1. No Residents Identified.2. All Residents have the potential to be affected by this citation. 3. The Administrator in-serviced Maintenance staff related to citation and Life Safety Code regulating Fire drills being held at random times. This in-service was conducted on 7/7/15.4. Maintenance will audit fire drills to ensure that they are held at random times and random days of the month monthly x 6 months. The findings will be brought to monthly Quality Assurance Performance Improvement Committee meetings.	07/26/2015
K 0067 SS=F Bldg. 01	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 observation and interview, the facility failed to ensure at least 15 of 15	K 0067	1. All Residents have the potential to be affected by this Citation.2. The administrator in-serviced	07/26/2015

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	fire dampers in the ductwork were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) 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 all residents, staff and visitors. Findings include: Based on observation on 06/26/15 during the tour from 10:45 a.m. to 12:30 p.m. with the Executive Director, the facility had at least 15 fire dampers located in the HVAC supply and return air ducts located throughout the facility in the corridors and support rooms. Additionally, based on interview with the Executive Director, during the time of observation, there was no documentation to indicate maintenance on the fire dampers had been provided within the		Maintenance staff related to citation and Life Safety Code related to maintenance of Fire Dampers.This inservice was conducted on 7/7/15.3. All fire dampers will be inspected, cleand and verified that they are in proper working order.3, Maintenance will audit all fire dampers monthly x 6 months to monitor proper functioning. Findings will be brought to Quality Assurance Performance Improvement Committee meetings.	

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	past four years. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 pieces of high current draw electrical devices in the Therapy Rehab office were not plugged into a powers strip as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 10 residents as well as staff and visitors in Therapy. Findings include: Based on observation with the Executive Director at 11:00 a.m. during a tour of the facility on 06/25/15, a refrigerator and coffee pot were plugged into a power strip in the therapy rehab office. Based on interview at the time of observation,	K 0147	1. The Citation was corrected on 7/7/15.2. The administrator in-serviced maintenance staff related to citation and Life Safety Code regarding High current draw electrical devices plugged into power surge instead of fixed wiring, this in-service was conducted on 7/7/15.3. Maintenance will audit entire building for High Current draw electrical devices plugged into power surge instead of fixed wiring.4. Maintenance will audit for high current flow to be plugged into power surges weekly x 3 weeks, monthly x 6 months. Findings will be brought to Quality Assurance Performance Improvement Committee meetings.	07/26/2015

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	the Executive Director acknowledged the aforementioned condition. 3.1-19(b)			