STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/11/2014

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
K010000	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: 08/11/14 Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210 Surveyor: Mark Bugni, Life Safety Code Specialist 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	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014
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
	a capacity of 120 and had a census of 110 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/14/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010025 SS=E	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 observations and interview, the facility failed to ensure 3 of 8 attic smoke	K010025	Submission of this plan of correction is not a legal admission that a	08/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014
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
	barrier walls were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 25 residents who reside on the A Hall and 15 residents who use the Rehabilitation Hall. Findings include: Based on observations with the maintenance manager on 08/11/14 from 1:50 p.m. to 2:40 p.m., the following attic smoke barrier walls had penetrations which were not fire stopped or missing drywall: a. The West Rehabilitation Hall smoke barrier wall had three, three inch circular areas of drywall missing and a four inch gap around a cable television wire bundle penetration not fire stopped. b. The East Rehabilitation Hall smoke barrier wall had a three foot by two foot square area of drywall missing on the south side of the attic smoke barrier wall. c. The A Hall smoke barrier wall had a ten inch circular area of drywall missing on the east side of the wall and a four inch gap around the sprinkler pipe penetration with no fire stopping material. The West Rehabilitation Hall, East Rehabilitation Hall and A Hall attic smoke barriers missing drywall and penetrations not being fire stopped were verified by the maintenance manager at the time of observations and		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. K 025 1. The identified penetrations in the smoke walls were corrected on 8-15-14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014
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
	acknowledged by the Director of Nursing at the exit conference on 08/11/14 at 2:45 p.m. 3.1-19(b)		2. All facility residents have the potential to be affected by this deficient practice. On 8-15-14, the Maintenance Supervisor and Maintenance Assistant audited the entire facility to identify any smoke barriers with penetrations. No other areas of concern were identified during the audit. 3. The Administrator re-educated the Maintenance Supervisor and Maintenance Assistant regarding Life Safety Code regulation of no penetrations in smoke barrier walls. This education was completed on 8-18-14. 4. The Maintenance Supervisor and/or Maintenance Assistant will audit all smoke barriers to ensure that there are no penetrations four (4) times a month for three (3) months. The findings will be brought to three (3) monthly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director (at least quarterly) and 3 other staff members will determine if further action needs to be taken and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/11/2014
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
			determine the continued time schedule for further monitoring. 5. Date of Compliance: August 19, 2014	
K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observations and interview, the facility failed to ensure 2 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 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 affects 55 residents who reside on the A Hall and C Hall. Findings include:	K010027	K 027 1. The identified gaps where the smoke barrier doors on A Hall and C Hall did not close completely were corrected on 8-15-14. 2. All facility residents that reside on A Hall and C Hall have the potential to be affected by this deficient practice. On 8-15-14, the Maintenance Supervisor and Maintenance Assistant audited the entire facility to identify any sets of smoke barrier doors with greater than a 1/8 inch clearance to restrict the movement of smoke. No other areas of concern were identified during the audit.	08/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014
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
	Based on observations with the maintenance manager on 08/11/14 from 12:55 p.m. to 1:40 p.m., the A Hall and C Hall sets of smoke barrier doors did not close completely, leaving between a two inch gap and a three inch gap where the doors came together. This was verified by the maintenance manager at the time of observations and acknowledged by the Director of Nursing at the exit conference on 08/11/14 at 2:45 p.m. 3.1-19(b)		3. The Administrator re-educated the Maintenance Supervisor and Maintenance Assistant regarding Life Safety Code regulation of 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 education was completed on 8-18-14. 4. The Maintenance Supervisor and/or Maintenance Assistant will audit all sets of smoke barrier doors to ensure that the 1/8 inch requirement is met and the doors close correctly four (4) times a month for three (3) months. The findings will be brought to three (3) monthly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director (at least quarterly) and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring.	

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		08/11/2014

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
			5. Date of Compliance: August 19, 2014	
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 9 of over 300 sprinklers covered in corrosion were replaced. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 15 residents who use the rehabilitation room, located near the Administration Hall exit. Findings include: Based on observation on 08/11/14 at 11:45 a.m. with the maintenance manager, the Administration Hall outside overhang had nine sprinklers completely covered in green corrosion. This was verified by the maintenance manager at the time of observation and	K010062	K 062 1. The facility has received a quote from Tri-State Fire Protection, Inc to replace the identified sprinkler heads with concerns related to corrosion. 2. Facility residents who use the rehabilitation room, located near the Administration Hall exit have the potential to be affected by this deficient practice. On 8-15-14, the Maintenance Supervisor and Maintenance Assistant audited the entire facility to identify any other sprinkler heads with corrosion or issues. None of the other facility sprinkler heads had corrosion or issues identified during the audit. 3. The Administrator re-educated the Maintenance Supervisor and Maintenance Assistant regarding Life Safety Code regulation of maintaining sprinkler heads in operating condition (no corrosion on sprinkler head etc.). This education was completed on 8-18-14. 4. The Maintenance Supervisor and/or Maintenance Assistant will audit all facility sprinkler heads to ensure that they are in operating condition four (4) times a month for three	08/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 08/11/2014
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
	acknowledged by the Director of Nursing at the exit conference on 08/11/14 at 2:45 p.m. 3.1-19(b)		(3) months. The findings will be brought to three (3) monthly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director (at least quarterly) and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring. 5. Date of Compliance: August 19, 2014	