

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 05/28/2013
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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K010000	<p>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).</p> <p>Survey Date: 05/28/13</p> <p>Facility Number: 011096 Provider Number: 155665 AIM Number: 200232210</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has</p>	K010000	The submission of this plan of correction does not constitute an admission of agreement to any findings listed on the 2567. We respectfully submit this plan of correction to provide proof of our continued compliance with state and federal regulations.	

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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	<p>a capacity of 120 and had a census of 108 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010027 SS=E	<p>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 observation and interview, the facility failed to ensure 1 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 could affect 28 residents who reside on the A Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/28/13 at 12:10 p.m., the A Hall set of smoke barrier doors did not close completely, leaving a one inch gap where the doors came together. This was verified by the</p>	K010027	<p>1. The doors were adjusted to meet standards 5-28-13. 2. 100% audit of all doors completed, and no other issues identified.3. The doors will be checked 5 days per week during maintenance rounds. 4. The results will be reviewed quarterly in QA meeting with the interdisciplinary team.5. June 27, 2013</p>	06/27/2013			

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	<p>maintenance director at the time of observation and confirmed by the administrator at the exit conference on 05/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>				

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K010050 SS=F	<p>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 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</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on each shift for 3 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance director on 05/28/13 at 9:40 a.m., there were no records of a fire drill for the first quarter of the year 2013 on second shift and third shift, the fourth quarter of the year 2012 on first shift, or the third quarter of the year 2012 on second shift and third shift. Additionally, based on an interview with the administrator during the exit conference on 05/28/13 at 1:40 p.m., there was no other documentation available for review to verify the missed fire drills were conducted. This was confirmed by</p>	K010050	<p>1. TELS system audited, and all fire drills found as complete. Print offs of previous fire drills were added to the life safety compliance book/paperwork. 2. All residents have potential to be effected, however, this was a file error, and fire drills were actually completed.3. Fire drills will continue within regulatory guidelines, and will be filed appropriately, electronically, with copies filed in life safety compliance book.4. The Life Safety compliance book will be reviewed quarterly in QA committee to ensure compliance.5. June 27, 2013.</p>	06/27/2013			

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	the administrator at the exit conference on 05/28/13 at 1:40 p.m. 3.1-19(b) 3.1-51(c)				

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K010062 SS=F	<p>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</p> <p>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping systems which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 05/28/13 at 9:40 a.m., the most recent Internal Inspection of the Sprinkler System Piping from Tri-State Fire Protection Inc. was dated 04/15/13. Furthermore, the results of the</p>	K010062	<p>1. The first proposal for flushing the system has been sent to corp. office for review. 42 ft. of piping replaced 6-7-13. Air and water gauges replaced and dated 5-29-13.2. All residents have the potential to be effected. The system will be flushed per regulatory guidelines.3. The maintenance supervisor will keep the records of the completion of flushing the system in the life safety compliance book. This will have the date of completion, and will guide the maintenance supervisor to schedule flushing the sprinkler system within the regulatory guidelines.4. The life safety compliance book will be reviewed during quarterly QA meetings for compliance.5. We respectfully request a temporary waiver for K62. The cost for the system flush will present a hardship for this facility, and must be reviewed per corp. offices for approval. We have been in contact with VP of safety for at least a second quote, and we will need additional time to review quotes and finish the project. Please see attached waiver.</p>	06/27/2013			

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	<p>inspection indicated "Scale and Silt inside the sprinkler system piping was found recommending the sprinkler system be flushed."</p> <p>Based on an interview with the administrator on 05/28/13 at 10:10 a.m., when asked if the sprinkler system flushing was scheduled as a follow up action to the Internal Inspection of the Sprinkler System Piping report dated 04/15/13, the administrator stated the bid was sent to the corporate office with no action taken as of today's date. The lack of recommended follow up action taken after the Internal Inspection of the Sprinkler System Piping inspection was conducted was acknowledged by the administrator at the exit conference on 05/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the</p>						

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	<p>facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Sprinkler System Reports of Inspection on 05/28/13 from 9:40 a.m. to 10:20 a.m. with the maintenance director, the reports dating from 02/14/2006 through 05/10/2013 did not indicate the three sprinkler system riser gauges were replaced.</p> <p>Based on observation of the sprinkler riser on 05/28/13 at 1:00 p.m. with the maintenance director, the three sprinkler gauges on the riser did not have a date of replacement on each gauge or a manufacture date printed on each gauge indicating the year the gauges were made.</p> <p>The lack of the three sprinkler system gauges being replaced within five years was verified by the maintenance director at the time of record review and observation of the sprinkler gauges, and confirmed by the administrator at the exit conference on 05/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>				

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K010067 SS=F	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 40 of 40 fire dampers 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 in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/28/13 during a tour of the facility with the maintenance director from 11:00 a.m. to 1:19 p.m., the maintenance director verified the location of forty fire dampers located in the return air ducts in each smoke compartment</p>	K010067	<p>1. Proposal obtained for inspection and replacement of fire links. The initial visit will include all fire dampers. 2. All residents have the potential to be effected, and inspections will be scheduled to meet regulatory guidelines.3. 25% of the dampers will be inspected every year, rotating over a 4 year period, to ensure that all dampers are inspected at least every 4 years. 4. Records will be kept per maintenace supervisor and vendor, to use as guide to schedule necessary inspections in a timely manner. These records will be reviewed quarterly in the QA committee.5. June 27, 2013</p>	06/27/2013			

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	<p>corridor, in resident rooms, and in common areas throughout the facility. Based on an interview with the maintenance director on 05/28/13 at 1:25 p.m., the forty fire dampers have not had a four year inspection conducted but a bid was acquired and sent to the corporate office. The corporate office had not taken action as of today's date to schedule the fire damper inspections. The lack of four year fire damper inspections on forty fire dampers was acknowledged by the administrator at the exit conference on 05/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>				

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to exercise the generator for 3 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p>	K010144	<p>1. The generator load test will be conducted per the vendor, VanGaurd, to check the system.2. All residents have potential to be effected, and generator tests will be completed within regulatory guidelines.3. Maintenance Supervisor will continue monthly tests for 30 minutes to 30 %. These records will be kept in the Life Safety compliance book. 4. The Life Safety compliance book will be reviewed in quarterly QA meetings with the interdisciplinary team. 5. June 27, 2013.</p>	06/27/2013			

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	<p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Tels Emergency Generator Monthly Load Testing Reports with the maintenance director on 05/28/13 at 10:25 a.m., the report dated 03/25/13 indicated a twenty five percent load test was conducted, the report dated 04/29/13 indicated a twenty eight percent load test was conducted and the report dated 05/27/13 indicated a twenty seven percent load test was conducted, which fell below the requirement of not less than thirty percent of the emergency power system's capability. The lack of a thirty percent load test monthly over the past three months was verified by the maintenance director at the time of record review and confirmed by the administrator at the exit conference on 05/28/13 at 1:40 p.m.</p> <p>3.1-19(b)</p>				