

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  03/28/2016
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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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K 0000  Bldg. 01	<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: 03/28/16</p> <p>Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210</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 sprinkled. 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 a capacity of 120 and had a census of 105 at the time of this visit.</p>	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. We respectfully request a desk review in lieu of a facility revisit.	
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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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K 0015 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 04/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 shower rooms was provided with an interior finish with a flame spread rating of Class A, Class B or Class C for a fully sprinkled building. This deficient practice could affect 28 residents who reside on the A Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/28/16 at 11:20 a.m. with the maintenance supervisor, the A Hall shower room west</p>	K 0015	<p>K015 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has ensured that the A hall shower room does have an interior finish with a flame rating spread of Class A, Class B, or Class C. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p>	04/15/2016

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	<p>wall was covered with a fiber board interior wall finish. Furthermore, based on an interview with the maintenance supervisor on 03/28/16 at 11:30 a.m., there was no documentation available to indicated the flame spread rating of the A Hall shower room west wall fiber board interior finish. This was verified by the maintenance supervisor at the time of observation and acknowledged at the exit conference on 03/28/16 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p>All residents have the potential to be affected by the alleged deficient practice. All shower room interior finishes have been examined to ensure they have a flame rating spread of Class A, Class B, or Class C. Any new shower room finish changes in the future will be examined to ensure they have a flame rating spread of Class A, Class B, or Class C. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> Any new shower room finish changes in the future will be examined to ensure they have a flame rating spread of Class A, Class B, or Class C. The Maintenance Supervisor or his designee will maintain a notebook with all flame rating information for the facility. The 'Environmental Safety Survey – Maintenance' audit will be reviewed by the safety committee monthly to ensure compliance. Safety committee meetings minutes will be discussed during the monthly quality assurance program. The Executive Director or their designee will</p>	

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K 0027 SS=E Bldg. 01	<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 1o-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 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 that 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 affects 32 residents who reside on the C Hall and 30 residents who reside on the B Hall.</p> <p>Findings include:  Based on observations on 03/28/16</p>	K 0027	<p>be responsible to ensure any further actions recommended by the quality assurance committee are completed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The B hall and C hall set of smoke barrier doors restrict the movement of smoke for at least 20 minutes. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> All residents have the potential to be affected by the alleged deficient practice. All smoke barrier doors have been examined to ensure they restrict the movement of smoke for at least 20</p>	04/15/2016

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K 0029 SS=E Bldg. 01	<p>during a tour of the facility from 8:30 a.m. to 12:30 p.m. with the maintenance supervisor, the C Hall set of smoke barrier doors and the B Hall set of smoke barrier doors each had a one inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 03/28/16 at 12:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire</p>		<p>minutes.</p> <p>The Maintenance Supervisor or his designee will review fire doors monthly as part of the quality assurance audits to ensure compliance.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Supervisor or his designee will review fire doors monthly as part of the quality assurance program to ensure compliance. The 'Environmental Safety Survey – Maintenance' audit will be reviewed by the safety committee monthly to ensure compliance. Safety committee meetings minutes will be discussed during the monthly quality assurance program. The Executive Director or their designee will be responsible to ensure any further actions recommended by the quality assurance committee are completed.</p>	

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	<p>extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 12 hazardous areas, such as a combustibile storage room over 50 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 32 residents who reside on the D Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/28/16 at 10:50 a.m. with the maintenance supervisor, the D Hall clothing storage room, which measured eighty square feet and stored twelve cardboard boxes of clothing, had a door that lacked a self closing device. This was verified by the maintenance supervisor at the time of observation and acknowledged at the exit conference on 03/28/16 at 12:55 p.m.</p> <p>3.1-19(b)</p>	K 0029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The corridor door on D hall has a self closing device.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the alleged deficient practice. All corridor doors to hazardous areas have been examined by the Maintenance Supervisor or his designee to ensure they have a self closing device.</p> <p>The Maintenance Supervisor or his designee will review doors to hazardous areas monthly as part of the quality assurance audits to ensure compliance.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>	04/15/2016

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K 0062 SS=F Bldg. 01	<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>Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at</p>	K 0062	<p><b>practice does not recur?</b> The Maintenance Supervisor or his designee will review doors to hazardous areas monthly as part of the quality assurance program to ensure compliance. The 'Environmental Safety Survey – Maintenance' audit will be reviewed by the safety committee monthly to ensure compliance. Safety committee meetings minutes will be discussed during the monthly quality assurance program. The Executive Director or their designee will be responsible to ensure any further actions recommended by the quality assurance committee are completed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The private fire hydrant located outside the front entrance is continuously maintained in reliable operating condition and is inspected and tested</p>	04/15/2016

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	<p>Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and patients.</p> <p>Findings include:</p> <p>Based on observation on 03/28/16 at 11:45 a.m. with the maintenance supervisor, the facility had one private fire hydrant located outside the front entrance. Based on an interview with the maintenance supervisor on 03/28/16 at 11:50 a.m., there was no documentation of an annual inspection for the fire hydrant. The lack of an annual inspection for the one fire hydrant located outside the front entrance was verified by the maintenance supervisor at the time of interview and acknowledged at the exit conference on 03/28/16 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p>annually.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the alleged deficient practice. The Maintenance Supervisor or his designee will be responsible to ensure the private fire hydrant is inspected annually. The Maintenance Supervisor or his designee will be responsible to review and report annually to the safety committee that the private fire hydrant is inspected annually.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The 'Environmental Safety Survey – Maintenance' audit will be reviewed by the safety committee monthly to ensure compliance. Safety committee meetings minutes will be discussed during the monthly quality assurance program. The Executive Director or their designee will be responsible to ensure any</p>		

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K 0074 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 61 of 61 resident rooms were flame retardant. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p>	K 0074	<p>further actions recommended by the quality assurance committee are completed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All window curtains in 61 of 61 resident rooms have been removed. <b>How other residents having</b></p>	04/15/2016

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	<p>Based on observations with the maintenance supervisor on 03/28/16 during a tour of the facility from 8:30 a.m. to 12:30 p.m., all sixty one resident rooms in the facility had a set of window curtains and lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the maintenance supervisor, there was no documentation regarding flame retardant window curtains for sixty one resident rooms in the facility. This was acknowledged by the maintenance supervisor at the time of observations and at the exit conference on 03/28/16 at 12:55 p.m.</p> <p>3.1-19(b)</p>		<p><b>the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the alleged deficient practice. Any new window curtain changes in the future will be examined to ensure they have a flame rating spread of Class A, Class B, or Class C. The Maintenance Supervisor or his designee will maintain a notebook with all flame rating information for the facility.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Supervisor or his designee will examine any new window curtain changes in the future to ensure they have a flame rating spread of Class A, Class B, or Class C. The Maintenance Supervisor or his designee will maintain a notebook with all flame rating information for the facility. The Maintenance Supervisor or his designee will discuss any new materials needing flame ratings at the monthly</p>	

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			safety committee meeting. The 'Environmental Safety Survey – Maintenance' audit will be reviewed by the safety committee monthly to ensure compliance. Safety committee meetings minutes will be discussed during the monthly quality assurance program. The Executive Director or their designee will be responsible to ensure any further actions recommended by the quality assurance committee are completed.		