

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155374	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
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NAME OF PROVIDER OR SUPPLIER LOGOOTEHEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOGOOTEHE, IN 47553
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K 000 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: 05/28/15</p> <p>Facility Number: 000571 Provider Number: 155374 AIM Number: 100266920</p> <p>At this Life Safety Code survey, Martin County Healthcare and Rehabilitation 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 62 and had a census of 34 at the time of this</p>	K 000	<p>By submitting the following material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective 06/19/2015 to the state findings of the recertification of the life safety survey. I am requesting paper compliance.</p>	

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 048 SS=F Bldg. 01	<p>survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached shed used as an employee only smoke shack.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 34 of 34 residents to accurately address all life safety systems such as staff response to battery operated smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation</p>	K 048	<p>It is the facility's intent to provide a complete written fire safety plan for the protection of residents to accurately address all life safety systems such as staff response to battery operated smoke detectors in resident sleeping rooms.</p> <p>1. Corrective actions accomplished for the residents found to be affected by the alleged deficient practice. a. There were no residents identified by the alleged deficient practice. b. The facility fire plan has been updated to include the procedure for the staff with smoke detectors in resident rooms.</p> <p>2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. There were no residents affected by the alleged deficient</p>	06/19/2015

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K 052 SS=F Bldg. 01	<p>(8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Fire plan on 05/28/15 at 11:55 a.m. with Maintenance man #1 present, the Fire plan did not address staff response to single station smoke alarms (hard wired with battery back ups) in resident sleeping rooms. Based on interview at the time of record review, Maintenance man #1 acknowledged the Fire plan did not include staff response to single station smoke alarms in resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 3 of 5 duct smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires</p>	K 052	<p>practice.</p> <p>3. Measures and systemic changes put into place to ensure that the deficient practice does not re-occur.</p> <p>a. Staff in-serviced on the revised fire plan.</p> <p>b. New employee orientation will include the revised fire plan and discussed during walk through. Then yearly the disaster plan will be in-serviced to the staff which will include the fire plan.</p> <p>4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place.</p> <p>a. Data will be presented to the QA meeting to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.</p> <p>It is the facility's intent to have a fire alarm system installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. 1. Corrective actions accomplished for the</p>	06/19/2015			

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	<p>detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority 		<p>residents found to be affected by the alleged deficient practice. a. There were no residents affected by the alleged deficient practice. b. Following the exit of the surveyor, the facility found the paperwork which showed the duct detector replacement on 04/04/2014 of the failed detectors along with the sensitivity of those. With these supporting documents, the facility is in compliance. c. The Maintenance Director immediately following survey contacted Vanguard (contracted vendor) to schedule the sensitivity testing. The vendor completed the testing on 6/5/13. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. There were no residents affected by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure that the deficient practice does not re-occur. a. The Maintenance Director will review paperwork with contracted vendor to ensure if any discrepancies with equipment. If any discrepancies found, immediate corrective action will be taken to resolve the issue. b. The Maintenance Director will place the sensitivity testing schedule on the Preventative Maintenance program to monitor for compliance of testing date. 4. The corrective action will be monitored to ensure the deficient</p>	

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	<p>having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number of occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records and quarter fire alarm system inspection reports in the Life Safety book on 05/28/15 at 11:50 a.m. with Maintenance man #1 present, the 03/21/14 Vanguard duct smoke detector report indicated three of five duct smoke detectors had failed the sensitivity test. There was no documentation available to show the three duct smoke detectors had been repaired or replaced. This was acknowledged by Maintenance man #1 at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 47 of 52 smoke detectors had been tested for sensitivity within the past 24 months. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72,</p>		<p>practice does not recur and quality assurance measures put into place. a. The Administrator and/or Designee will review inspection report for accuracy. The monitoring will be an ongoing process. b. Data will be presented to the QA meeting to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.</p>				

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	<p>National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity</p>			

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	<p>outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports to be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records and quarter fire alarm system inspection reports in the Life Safety book on 05/28/15 at 11:50 a.m. with Maintenance man #1 present, the most recent sensitivity test documentation available was dated 01/29/13 for 47 of 52 smoke detectors. The four most recent quarterly fire alarm system inspection reports dated 03/09/15, 12/31/14, 09/30/14, and 06/27/14 showed that 52 smoke detectors were inspected and tested for visual/functional condition,</p>			

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K 062 SS=E Bldg. 01	<p>and five duct smoke detectors were tested for sensitivity on 03/21/14. Based on interview at the time of record review, Maintenance man #1 acknowledged 47 of 52 smoke detectors were last tested for sensitivity on 01/29/13.</p> <p>3.1-19(b)</p> <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 observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinet was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect residents, as well as staff and visitors while using the Physical Therapy/Rehab entrance/exit.</p> <p>Findings include:</p> <p>Based on observation on 05/28/15 at 1:00</p>	K 062	<p>It is the facility's intent that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>1. Corrective actions accomplished for the residents found to be affected by alleged deficient practice.</p> <p>a. There were no specific residents identified.</p> <p>b. The Maintenance Director immediately contacted Advantage (contracted vendor) to have 2 spare quick response pendent type in</p>	06/19/2015

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	<p>p.m. during a tour of the facility with Maintenance man #1, the spare sprinkler head cabinet in the Central Mechanical Room had six spare sprinkler heads, however, there were no spare quick response pendent type heads. Quick response sprinkler heads were observed under the overhang outside the Physical Therapy/Rehab entrance/exit. This was acknowledged by Maintenance man #1 at the time of observation; furthermore, Maintenance man #1 said there were no other spare sprinkler heads in the facility that he was aware of.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of over 400 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly staff while in the Central Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation on 05/28/15 at 1:05</p>		<p>house.</p> <p>c. The Maintenance Director immediately contacted Advantage (contracted vendor) for replacement of sprinkler heads with corrosion. Sprinkler head was measured and ordered 06/02/2015. Upon the vendor receiving sprinkler head, they will schedule for service to be completed.</p> <p>d. The Maintenance Director has moved light fixture to prevent any obstruction to the sprinkler head.</p> <p>e. The Maintenance Director immediately contacted Advantage (contracted vendor) for the replacement of sprinkler head that the red dye had faded. Sprinkler head was measured and ordered 06/02/2015. Upon the vendor receiving sprinkler head, they will schedule for service to be completed.</p> <p>2. To identify other residents who have the potential to be affected by the same alleged deficient practice.</p> <p>a. Potentially all residents could be affected by alleged deficient practice.</p> <p>b. 100% audit of the facility sprinkler heads were checked for corrosion. There were no other sprinkler heads identified to be</p>	

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	<p>p.m. during a tour of the facility with Maintenance man #1, the two sprinkler heads in the Central Mechanical Room were covered with green corrosion. This was acknowledged by Maintenance man #1 at the time of observation.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the Central Mechanical Room was free of obstructions to its spray pattern. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect mostly staff while in the Central Mechanical Room, plus any number of residents while in the center east-west corridor which was in the same smoke compartment as the Central Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation on 05/28/15 at 1:05 p.m. during a tour of the facility with Maintenance man #1, the sprinkler head on the east side of the Central Mechanical Room was within two inches of the light fixture which would obstruct sprinkler coverage to the southwest side of the room in the event of a fire. This was acknowledged by Maintenance man #1 at the time of observation.</p>		<p>replaced.</p> <p>3. Measures and systemic changes put into place to ensure that the deficient practice does not re-occur.</p> <p>a. Advantage (contracted vendor) performs quarterly inspections on the sprinkler systems.</p> <p>b. Sprinkler heads have been included on the preventative maintenance schedule for monthly inspection.</p> <p>4. The corrective action will be monitored to ensure the deficient practice does not recur and quality measures put into place are.</p> <p>a. The Maintenance Director will monitor through preventative maintenance program which is an ongoing program. Should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during QA meetings and the plan of action adjusted accordingly if warranted.</p>	

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3.1-19(b)	<p>4. Based on observation and interview, the facility failed to ensure 1 of 6 sprinkler heads under the front entrance carport was continuously maintained to allow the sprinkler head to function to its full capability. 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. This deficient practice could affect any number of residents, staff and visitors while entering and exiting the front entrance/exit door.</p> <p>Findings include:</p> <p>Based on observation on 05/28/15 at 1:20 p.m. during a tour of the facility with Maintenance man #1, one of the six sprinkler heads under the front entrance/exit carport was a clear bulb type sprinkler head. Each of the other five sprinkler heads were red bulb type standard response sprinkler heads. This was acknowledged by Maintenance man #1 at the time of observation.</p> <p>3.1-19(b)</p>			
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K 147 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 1 of 6 smoke compartments. 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, 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 2 residents in room B6.</p> <p>Findings include:</p> <p>Based on observation on 05/28/15 at 12:15 p.m. during a tour of the facility Maintenance man #1, resident room B6 had a small refrigerator plugged into a power strip, furthermore, the power strip was placed on a small table with the refrigerator next to the head of the bed. This was acknowledged by Maintenance man #1 at the time of observation.</p> <p>3.1-19(b)</p>	K 147	<p>It is the practice of this facility to have electrical wiring and equipment in accordance with NFPA 70, National Electrical Code 9.1.2</p> <p>1. Corrective actions accomplished for the residents found to be affected by the alleged deficient practice.</p> <p>a. Room B6 power strip was removed from refrigerator.</p> <p>2. To identify other residents who have the potential to be affected by the same alleged deficient practice.</p> <p>a. There were no residents affected by the alleged deficient practice.</p> <p>3. Measures and systemic changes put into place to ensure that the deficient practice does not re-occur.</p> <p>a. Non-medical equipment such as refrigerators has been included on preventative maintenance schedule to ensure that no power strip plug is being used.</p>	06/19/2015			

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NAME OF PROVIDER OR SUPPLIER LOOGOOTEE HEALTHCARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 POPLAR ST LOOGOOTEE, IN 47553
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(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>4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place.</p> <p>a. The Maintenance Director will check randomly once a week during facility rounds to ensure no improper use of power strip plugs have occurred. Document findings and if noncompliance occurred then immediate corrective action taken. The monitoring will be a ongoing process through the preventative maintenance program.</p> <p>b. Data will be presented at the QA meetings to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.</p>	