

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155263	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2011
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NAME OF PROVIDER OR SUPPLIER  LOOGOOTE NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOOGOOTE, IN47553
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K0000	<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 Dates: 10/11/11</p> <p>Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Loogootee Nursing 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</p>	K0000	<p>K0000This plan of correction is prepared and executed because the provisions of State and Federal law require it and not because Loogootee Nursing Center agrees with the allegations and citations listed. Loogootee Nursing Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such a character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies cited have been or will be corrected by the (dates) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction.</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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K0048 SS=F	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 55 and had a census of 39 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 39 of 39 residents in the event of an emergency 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:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire</p>	K0048	<p>K0048 1. The fire and safety plan was reviewed and the following was added; evacuation of the smoke compartment, use of ABC type fire extinguishers, and the use of the K class extinguisher located in the kitchen area. 2. The fire safety plan was reviewed and the following was added; evacuation of the smoke compartment, use of the ABC type fire extinguishers, and the use of the K class extinguisher located in the kitchen area. 3. The fire safety plan will be reviewed on an monthly basis concurrent with the scheduled fire drill. Plant Manager and/or Administrator will in-service all staff on changes to the evacuation plan and use of all</p>	11/10/2011

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	<p>(5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (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 facility's written fire safety plan labeled "Disaster Preparedness Policy and Procedure" on 10/11/11 at 9:45 a.m. with the Administrator present, the fire safety plan did not address evacuation of the smoke compartment, or the use of the ABC type fire extinguishers located throughout the building or the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Administrator acknowledged the written fire safety plan did not address evacuation of the smoke compartment, or the use of the ABC type fire extinguishers or the</p>		<p>facility fire extinguishers. 4. Plant Manager and/or Administrator will conduct an audit monthly times 6 months concurrent with fire drills to ensure staff compliance. 100% compliance to be achieved. 5. Date of compliance 11/10/2011</p>				

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K0050 SS=F	<p>kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>3.1-19(b)</p> <p>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 provide complete fire drill documentation for 2 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the "LNC Life Safety Fire Drill Etc." book on 10/11/11 at 9:35 a.m. with the Administrator present, the facility conducted twelve fire drills during the past twelve months, however,</p>	K0050	<p>K0050 1. All Fire Drill forms have been reviewed and updated as necessary to ensure compliance. 2. All Fire Drill forms have been reviewed and updated as necessary to ensure compliance. 3. Fire Drill form has been updated, Plant Manager will be in-serviced by Administrator to the changes and will review each form post fire drill to ensure compliance. 4. A Fire Drill Audit form will be completed by the Administrator and/or designee monthly times 6 months to ensure compliance. 100% compliance to be achieved. 5. Date of Compliance 11/10/2011</p>	11/10/2011	

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K0062 SS=E	<p>the drill forms for the second (evening) shift and third (night) shift drills of the second quarter (April, May, and June) of 2011 were not complete. The fire drill dated 05/31/11 had a time of 8:01, with no a.m. or p.m. included, or details of the drill. The fire drill dated 06/29/11 had a time of 11:25, with no a.m. or p.m. included. This was acknowledged by the Administrator at the time of record review.</p> <p>3.1-19(b)</p> <p>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 record review, observation, and interview, the facility failed to ensure 15 of over 300 sprinkler heads in the facility were free of paint and 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</p>	K0062	<p>K0062 1. The sprinkler heads identified have been cleaned and/or replaced and exhibit no signs of rust or corrosion. 2. All sprinkler heads in the facility were checked and cleaned and/or replaced as needed. 3. A sprinkler head inspection will be added to the monthly preventative maintenance program to identify any signs of corrosion or rust. Administrator and/or designee will in-service plant manager on need to identify rusty or corrosive sprinkler heads. 4. Plant</p>	11/10/2011	

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	<p>sprinkler shall be replaced that is painted or corroded. This deficient practice could affect any of the 39 residents, as well as staff and visitors while in the vicinity of the front porch and entrance foyer.</p> <p>Findings include:</p> <p>Based on record review on 10/11/11 at 12:00 p.m. with the Administrator in Training (AIT) present, the most recent quarterly sprinkler inspection report dated 09/15/11 stated "corrosion on sprinkler heads located on porch". Based on observations on 10/11/11 at 12:05 p.m. and again at 12:10 p.m. during a tour of the facility with the Administrator and the Administrator in Training (AIT), all fourteen sprinkler heads over the front porch were covered with corrosion, furthermore, one sprinkler head in the front entrance foyer was covered with tape and white paint. This was acknowledged by the AIT at the time of each observation.</p> <p>3.1 – 19(b)</p>		<p>Manager and/or designee will conduct an audit weekly times 8 weeks and monthly times 4 months. 100% compliance to be achieved. 5. Date of compliance 11/10/2011</p>		

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K0064 SS=B	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any</p>	K0064	<p>K00641. A sign has been put into place to alert staff that the "K" extinguisher in the kitchen is to be utilized once the fixed system has been activated.2. A sign has been put into place to alert staff that the "K" extinguisher in the kitchen is to be utilized once the fixed system has been activated. 3. Administrator and/or designee will in-service the kitchen staff and Plant Manager on the proper usage of the "K" class extinguisher.4. An audit will be conducted to ensure that a place card is present and in place weekly times 8 weeks and monthly times 4 months. 100% compliance to be achieved. 5. Date of compliance 11/10/2011</p>	11/10/2011	

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K0067 SS=F	<p>residents, as well as staff and visitors using the dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 10/11/11 at 11:30 a.m. with the Administrator and Administrator in Training (AIT) during a tour of the facility, there was a Class K portable fire extinguisher in the kitchen which lacked a placard. Based on interview at the time of observation, the Administrator acknowledged the Class K portable fire extinguisher lacked a placard.</p> <p>3.1-19(b)</p> <p>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 3 of 3 egress corridors were not used as a portion of a return air system serving adjoining area rooms. Heating, ventilation and air conditioning (HVAC) ducting shall be installed in</p>	K0067	K0067A waiver dated October 11, 2011 has been submitted for this citation. Quotes are being obtained to complete the work on the HVAC system. The current system does have dampers and smoke detectors in place to ensure that smoke is not transferred to other compartments once that alarm	11/10/2011	

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	<p>accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 10/11/11 between 11:00 a.m. and 12:15 p.m. during a tour of the facility with the Administrator and the Administrator in Training, all resident rooms and support rooms were using the three egress corridors as a return air system. Based on an interview with the Administrator at 12:15 p.m., there is a direct connection to the fire alarm system for the supply air fans so supply air shuts off when the fire alarm is activated; the supply air duct work had smoke detectors installed downstream of the air filters, and, when activated it shut off air supply fans; and HVAC ducts which penetrate</p>		has been activated.		

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K0143 SS=E	<p>smoke barrier walls have smoke dampers installed to prevent the transfer of smoke from one smoke compartment to another.</p> <p>3.1-19(b)</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to the oxygen storage room where oxygen transferring takes place was provided with a properly operating self closing device. This deficient practice could affect up to 20 residents, as well as staff and visitors in the East Hall.</p> <p>Findings include:</p>	K0143	<p>K0143 1. The door identified was repaired so that it closes. 2. Both doors leading into the Oxygen Room were checked to ensure that they function properly and close as identified. 3. Administrator and/or designee inserviced Plant Manager on proper closing of doors leading into the Oxygen Room. 4. Plant Manager and/or designee will conduct audits on Oxygen Room doors weekly times 8 weeks and monthly times 4 months. 100% compliance to be achieved . 5. Date of comliance 11/10/2011</p>	11/10/2011

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K0144 SS=F	<p>Based on observation on 10/11/11 at 11:12 a.m. during a tour of the facility with the Administrator and Administrator in Training (AIT), the right side oxygen storage/transfer room door was provided with a spring loaded self closing hinge, however, the door did not close and latch when tested. The door stayed in the wide open position. This was acknowledged by the Administrator and the AIT at the time of observation, furthermore, the Administrator indicated oxygen transferring takes place in the oxygen storage/transfer room.</p> <p>3.1-19(b)</p> <p>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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110,</p>	K0144	<p>K01441. A remote shut-off for the generator will be installed per regulation.2. A remote shut-off for the generator will be installed per regulation.3. Plant Manager will in-service staff on the use of the remote shut-off for the generator and the procedure will be added to the Disaster Manual.4. Plant Manager and/or designee will conduct an audit concurrent with the monthly fire drill times 4 months. 100%</p>	11/10/2011			

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	<p>Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observation on 10/11/11 between 11:00 a.m. and 12:15 p.m. during a tour of the facility with the Administrator and the Administrator in Training (AIT), a remote shut off device was not found for the generator. Based on interview at 12:20 p.m., the Administrator indicated the generator was over 100</p>		<p>compliance to be achieved.5. Date of Compliance 11/10/2011</p>		

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	horsepower, and further indicated there was no remote shut off device for the generator.  3.1-19(b)				