

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 12/13/2012
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NAME OF PROVIDER OR SUPPLIER LOGOOTEENURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOGOOTEEN, IN 47553
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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: 12/13/12</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	By submitting the enclosed 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 requests the plan of correction be considered our allegation of compliance.	

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>sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 32 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinkler. All areas providing facility services were sprinklered, except two detached structures; a wood shed containing the facility generator, and a wood framed garage used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/19/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 exits were maintained to provide safe access to the public way in accordance with LSC Section 7.1. LSC Section 7.1.6.3 requires walking surfaces shall be nominally level. This deficient practice could any residents, as well as staff and visitors during an evacuation through the east and west resident sleeping room halls.</p> <p>Findings include:</p> <p>Based on observations on 12/13/12 between 11:45 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, the east and west hall exit discharge areas both had one inch grade changes in the first connecting concrete slab and one inch gaps between the second connecting concrete slab which could create a trip hazard for anyone traversing these areas to evacuate to a public way. This</p>	K0038	The corrective action taken for those residents who have been affected by the deficient practice is that no specific residents were identified during the survey. The corrective action taken; all walkways have been assessed and the concrete slabs will be repaired to have no grade changes or gaps greater than one inch between connecting concrete slabs. The Administrator or designee will monitor all sidewalks on a quarterly basis to assure areas are level and without gaps greater than one inch. The Administrator will report audit results to Quality Assurance Committee quarterly.	01/11/2013			

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	<p>was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>			

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K0048 SS=F	<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</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 32 of 32 residents, including staff response to battery operated smoke detectors in resident rooms or the use of alarms, transmission of the alarm to the fire department, response to the alarm, isolation of the fire, and preparation of the floor and building for evacuation thus 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> <ol style="list-style-type: none"> (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 	K0048	<p>The corrective action taken for those residents who have been affected by the deficient practice is that no specific residents were identified during the survey. The corrective action taken for those residents having the potential to be affected by this deficient practice is the Disaster Plan has been revised to include complete instructions for responding to battery operated smoke detectors which includes use of alarms, transmission of alarms to the fire department, response to the alarm, isolation of the fire, evacuation of immediate area, evacuation of smoke compartment, and preparation of the floor and building for evacuation and extinguishment of fire. All staff will be inserviced on revised Disaster Plan. The Disaster Plan will be reviewed by Quality Assurance Committee quarterly for 6 months and annually thereafter.</p>	01/13/2013

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	<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 facility's written Disaster Plan on 12/13/12 at 9:30 a.m. with the Maintenance Supervisor and Director of Nursing (DON) present, the "Fires" plan did not address staff reaction to resident room battery operated smoke detectors if actuated. Also, other items not addressed within the plan include; use of the alarms, transmission of the alarm to the fire department, response to the alarm, isolation of the fire, and preparation of the floor and building for evacuation. Based on interview at the time of record review, the Maintenance Supervisor and DON acknowledged the fire safety plan was not a complete plan.</p> <p>3.1-19(b)</p>				

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K0050 SS=C	<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>1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company for 12 of 12 drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. 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 Maintenance Book on 12/13/12 at 9:45 a.m. with the Maintenance Supervisor and Director of Nursing (DON) present, question 5 after "Complete after</p>	K0050	The corrective action taken for those residents who have been affected by the deficient practice is that no specific residents were identified during the survey. Maintenance director has been instructed on the need to contact the monitoring company before and after each drill. A faxed copy of the fire drill verification sheet will be requested from the monitoring company after each drill. Maintenance director has been instructed on the federal and state regulations pertaining to conduction of fire drills at various times on each shift. The corrective measure put in place to assure compliance is that the administrator will review the documentation of each fire drill which includes faxed verification from the monitoring company, the name and time of drill, and varied times to ensure that it is complete and accurate with federal and state regulations. A copy of all drills will be kept in the	01/13/2013			

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	<p>the drill" on the current fire drill form used by the facility asked "Did Vanguard (alarm system monitor) received a signal and if so to who at Vanguard (alarm system monitor) confirmed that signal was received and what time was signal verified?" Ten of twelve documented fire drill reports since November of 2011 said only "yes" after the question. They did not include the time the alarm was received or the name of the person who received the alarm. Furthermore, the other two fire drill reports only included the name of the person who received the alarm. During an interview at the time of record review, the Maintenance Supervisor indicated the monitoring company was always contacted before and after a fire drill was conducted during all shifts, but acknowledged all portions of question 5 were not answered on the fire drill reports.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee</p>		<p>administrators office. The administrator will report the results during the quarterly Quality Assurance meeting to determine if further action is required.</p>		

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	<p>shifts during 3 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 Maintenance Book on 12/13/12 at 9:45 a.m. with the Maintenance Supervisor and Director of Nursing (DON) present, three of four second shift (evening) fire drills since November of 2011 were performed between 3:20 p.m. and 4:30 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times of the second shift fire drills were not varied.</p> <p>3-1.19(b)</p>				

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K0052 SS=F	<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>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm control panel on 12/13/12 at 1:25 p.m. during a tour of the facility with the Maintenance Supervisor, there was a yellow trouble light illuminated for the East Wing zone and a yellow trouble light illuminated for the System Trouble. At the time of observation, the fire alarm system was tested from the east wing pull station and the system actuated the audible alarm, however, both trouble lights stayed illuminated when the system was reset. During an interview at the time of</p>	K0052	The corrective action taken for those residents who have been affected by the deficient practice is that no specific residents were identified during the survey. The corrective action taken for those residents having the potential to be affected by this deficient practice is that the fire alarm panel will be replaced to eliminate previous trouble light status. The fire alarm panel and parts have been ordered, and a company is scheduled to install panel on January 15, 2013. The corrective measure to assure compliance is that the fire panel will be monitored weekly for two weeks, then monthly with each fire drill to ensure that it remains in compliance with federal and state regulations.	01/15/2013

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	<p>observation and testing, the Maintenance Supervisor acknowledged the yellow trouble lights were still illuminated after the fire alarm system was reset.</p> <p>3.1-19(b)</p>			

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K0144 SS=C	<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 provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all</p>	K0144	The corrective action taken for those residents who have been affected by the deficient practice is that no specific residents were identified during the survey. The corrective action is the generator log form has been revised to include load percentage, and the maintenance director has been instructed to document this with monthly generator inspections. To assure compliance the generator log will be reviewed by the Administrator monthly for three months, and the results will be reported to the Quality Assurance Committee.	01/13/2013	

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	<p>residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Generator Log on 12/13/12 at 10:05 a.m. with the Maintenance Supervisor and DON present, the generator log form documented the generator was tested monthly under load, however, there was no documentation on the form showing the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes since November of 2011. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include documentation the generator was exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes.</p> <p>3.1-19(b)</p>			