

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 07/18/2016
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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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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: 07/18/16</p> <p>Facility Number: 000571 Provider Number: 155374 AIM Number: 100266920</p> <p>At this Life Safety Code survey, Loogootee 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 35 at the time of this</p>	K 0000	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 requests the plan of correction be considered our allegation of compliance effective 08/17/2016 to the state findings of the Life Safety Code Survey. We are requesting paper compliance.	
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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 0018 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>Quality Review completed on 07/19/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure there were no</p>	K 0018	It is the practice of this facility to ensure there are no impediments to closing of doors.	08/17/2016

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	<p>impediments to closing 16 of 32 resident room corridor doors. This deficient practice could affect all residents, as well as staff and visitors while in all resident sleeping room corridors.</p> <p>Findings includes:</p> <p>Based on observations on 07/18/16 between 10:35 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, there were small trash cans holding the following resident room doors wide open: A5, A6, B1, B2, B3, B5, B6, C3, C4, E1, E2, E4, E5, E8, F3, and F6. The placement of these small trash cans would not allow the previously mentioned resident room doors to close easily in the event of a fire emergency. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>1. Corrective actions accomplished for the residents found to be affected by the alleged deficient practice. a. There were no residents affected by the alleged deficient practice.</p> <p>2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. The small trash cans have been moved from holding resident room door open. A small magnetic door stop has been placed on the door to hold open door which is easily released when slightly pulled.</p> <p>3. Measures and systemic changes put into place to ensure that the deficient practice does not reoccur. a. All staff will be in-serviced 08/12/2016 on items not allowed to hold the resident room door open. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place. a. The Maintenance Director will check randomly once a week during facility rounds to ensure doors are not being held open by trash cans. The monitoring will be ongoing process and if non-compliance is observed, corrective action will be taken immediately. b. Data will be presented at the next two quarterly QA meetings to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.</p>		

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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 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 2 of 10 hazardous area doors, such as storage room doors, latched into their door frames. Doors to hazardous areas are required to automatically latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect all residents, as well as staff and visitors while in the Dining Room.</p> <p>Findings include:</p> <p>Based on observation on 07/18/16 at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor, the two side by side storage rooms adjacent to the Dining Room were provided with self-closing devices, however, neither door latched into their frames when closed fully. This was acknowledged by the Maintenance Supervisor at the time of</p>	K 0029	<p>It is the practice of this facility to provide doors with means suitable for keeping the door closed. 1. Corrective actions accomplished for theresidents found to be affected by the alleged deficient practice. a. There were no residents affected by the alleged deficient practice. 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 reoccur. a. The Maintenance Director made adjustments to the door closure on the two storage rooms adjacent to the Dining Room to ensure proper latching into the door frames. b. TheMaintenance Director will check randomly once a week during facility rounds to ensure doors are properly closing with self-closure device.</p>	08/17/2016			

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K 0038 SS=E Bldg. 01	<p>observations.</p> <p>3-1.19(b)</p> <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 Based on observation and interview, the facility failed to ensure exit egress for 1 of 10 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires that walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect up to</p>	K 0038	<p>4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place. a. The Maintenance Director will check randomly once a week during facility rounds to ensure doors are properly closing with self-closure device. The monitoring will be ongoing process and if non-compliance be observed, corrective action will be taken immediately. b. Data will be presented at the quarterly QA meetings to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.</p> <p>It is the practice of this facility to have exit access arranged so that exits are readily accessible at all times. 1. Corrective actions accomplished for the residents found to be affected by the alleged deficient practice. a. There were no residents affected from alleged deficient practice. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. The facility will complete necessary repairs of the sidewalk outside of B Hall. This work will be completed by 08/17/2016. 3. Measures and systemic changes put into place</p>	08/17/2016

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K 0050 SS=F Bldg. 01	<p>9 residents, as well as staff and visitor in the B Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/18/16 at 10:45 a.m. during a tour of the facility with the Maintenance Supervisor, the side walk four feet outside the B Hall exit door had a one half inch to one inch grade change. The grade change could create a tripping hazard. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the one half inch to one inch grade change in the sidewalk that could be a tripping hazard.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview,</p>	K 0050	<p>to ensure that the deficient practice does not reoccur. a. The Maintenance Director will check randomly the sidewalks once a week during facility rounds for uneven surfaces and repair as needed. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place are. a. The Maintenance Director will check randomly once a week during facility rounds and document findings. b. Data will be presented at the next two quarterly QA meetings to determine trends, patterns, and effectiveness of facility plan. The process will be updated as needed.</p> <p>It is the practice of this facility to ensure that Fire Drills are held at</p>	08/17/2016

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	<p>the facility failed to provide quarterly fire drill documentation for 1 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 on 07/18/16 at 9:30 a.m. with the Maintenance Supervisor present, the facility performed twelve fire drills during the past twelve months, however, the facility lacked fire drill documentation for the first shift (day) of the second quarter (April, May and June) of 2016. This was confirmed by the Maintenance Supervisor 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 conduct fire drills at unexpected times under varying conditions for 9 of 12 fire drills. 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 on 07/18/16 at 9:30 a.m. with the Maintenance Supervisor present, nine of</p>		<p>unexpected times under varying conditions, at least quarterly on each shift. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. There were no residents affected by the alleged deficient practice. 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 alleged deficient practice does not recur. a. A schedule for the year has been developed that has fire drills occurring on each shift, each quarter at varying times and days of month. b. Maintenance Director has been in-serviced on fire drills being conducted on each shift, each quarter at varying times and days of month. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place are: a. The Maintenance Director will provide a copy of the fire drill documentation to the Administrator for review. This 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 the next two quarterly QA meetings and the</p>	

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K 0062 SS=E Bldg. 01	<p>twelve fire drills performed during the past twelve months were conducted during the last four days of the month. During an interview at the time of record review, the Maintenance Supervisor acknowledged that nine of twelve fire drills were performed during the last four days of the month.</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>Based on observation and interview, the facility failed to ensure 3 of over 500 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 kitchen, plus residents, staff and visitors while entering and exiting the Rehab/Therapy section from the outside.</p> <p>Findings include:</p>	K 0062	<p>plan of action adjusted accordingly if warranted.</p> <p>It is the practice of this facility that the automatic sprinkler system be continuously maintained in reliable operating condition and are inspected and tested periodically. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. There were no residents identified. b. The Maintenance Director contacted Advantage(contractd vendor) immediately following survey for replacement of sprinkler heads with corrosion. Sprinkler heads have been measured and ordered 07/20/2016. Upon the vendor receiving sprinkler heads, they will schedule for service to be completed. 2. To identify other residents who have the potential</p>	08/17/2016

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K 0147 SS=D Bldg. 01	<p>Based on observations on 07/18/16 between 10:35 a.m. and 11:45 a.m. during a tour of the facility with Maintenance Supervisor, the following was noted:</p> <p>a. 2 of 2 sprinkler heads in the kitchen dishwashing room were covered corrosion.</p> <p>b. 1 of 2 sprinkler heads under the Physical Therapy/Rehab entrance/exit overhang was covered with corrosion. This was acknowledged by Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure power strips were</p>	K 0147	<p>to be affected by the same alleged deficient practice. a. Potentially all residents could be affected by alleged deficient practice. b. 100% audit of the facility sprinkler heads were checked for corrosion. There were no other sprinkler heads identified to be replaced.</p> <p>3. Measures and systemic changes put into place to ensure that the deficient practice does not re-occur. a. Sprinkler heads have been included on the preventative maintenance schedule for monthly inspection. b. Any sprinkler head found with corrosion will be replaced.</p> <p>4. The corrective action will be monitored to ensure the deficient practice does not recur and quality measures put into place are. 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 the next two quarterly QA meetings and the plan of action adjusted accordingly if warranted.</p> <p>It is the practice of this facility to have and equipment in</p>	08/17/2016

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	<p>not used as a substitute for fixed wiring in 1 of 32 resident sleeping rooms. 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 1 resident in resident room E4.</p> <p>Findings include:</p> <p>Based on observation on 07/18/16 at 11:25 a.m. during a tour of the facility with the Maintenance Supervisor, resident room E4 had an electric bed plugged into a power strip. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>accordance with NFPA 7, National Electrical Code 9.1.2</p> <p>1. Corrective actions accomplished for the residents found to be affected by the alleged deficient practice. a. Room E4 electric bed was removed from powerstrip plug. Maintenance Director was able to rearrange and plug directly into a wall outlet. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. There were no other 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. Electric beds will be checked randomly during facility rounds to ensure that no power strip plug is being used. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place. 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 action taken. The monitoring will be an ongoing process. b. Data will be presented at the next two quarterly QA meetings to determine trends, patterns, and effectiveness of plan. The process will be updated as</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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