STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 01 B. WING	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOOGOOTEE NURSING CENTER	12802 E US HWY 50 LOOGOOTEE, IN 47553

(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
K 0000 Bldg. 01	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). Survey Dates: 03/08/16 Facility Number: 000164 Provider Number: 155263 AIM Number: 100289550 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. 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 and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 34 at the time of this	K 0000	By submitting the following material we are not admittingthe truth or accuracy of any specific findings or allegations. We reserve the right to contest the findingsor allegations as part of any proceedings and submit these responses pursuantto our regulatory obligations. Thefacility requests the plan of correction be considered our allegation ofcompliance effective 03/24/2016 to the state findings of the Life Safety CodeSurvey. We are requesting papercompliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	survey. All areas where the residents have customary access were sprinklered and 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. Quality Review completed on 03/10/16 - DA			
K 0050 SS=C Bldg. 01	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 Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions for 11 of 12 fire drills. This deficient practice could affect all residents in the facility. Findings include:	K 0050	It is the practice of this facility to ensure that FireDrills are held at unexpected times under varying conditions, at leastquarterly on each shift. 1. Corrective actions accomplished for thoseresidents found to be affected by the alleged deficient practice.	03/24/2016

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	Based on review of the facility's fire drills on 03/08/16 at 9:30 a.m. with the Maintenance Supervisor present, eleven of twelve fire drills were conducted during the last three days of the month. During an interview at the time of record review, the Maintenance Supervisor acknowledged that eleven of twelve fire drills were performed during the last three days of the month. 3-1.19(b)		1. There were no residents affected by thealleged deficient practice. 2. Toidentify other residents who have the potential to be affected by the samealleged deficient practice. 1. No residents were harmed by the allegeddeficient practice. 3. Measuresand systemic changes put into place to ensure that the alleged deficientpractice does not recur. 1. A schedule for the year has been developedthat has fire drills occurring on each shift, each quarter at varying times anddays of month. 2.MaintenanceDirector has been in-serviced on fire drills being conducted on each shift,each quarter at varying times and days of month. 4. Thecorrective action will be monitored to ensure the deficient practice does notrecur and quality assurances measures put into place are: 1. The Maintenance Director will provide a copyof the fire drill documentation to the Administrator for review. This is an ongoing program, should non-compliancebe observed, corrective action shall betaken, the observations and any corrective actions taken will be reviewedduring QA meetings and the plan of action adjusted	

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			accordingly if warranted.	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 29 of 29 battery operated smoke alarms in resident rooms to ensure the smoke alarms are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could all residents, as well as staff, and visitors in the facility. Findings include: Based on review of the Smoke Detector Battery Check file on 03/08/16 at 10:45 a.m. with the Maintenance Supervisor present, all 29 resident sleeping rooms have battery operated smoke alarms. There was no documentation available to show any of the battery operated smoke alarms have been inspected/tested monthly over the past twelve months. This was confirmed by the Maintenance Supervisor at the time of record review. Based on observation between 11:15 a.m. and 1:00 p.m. it was confirmed all resident rooms were provided with battery operated smoke alarms.	K 0130	It is the practice of this facility to ensure the propermaintenance of battery operated smoke alarms in resident rooms to ensure thesmoke alarms are continually operable. 1. Corrective actions accomplished for thoseresidents found to be affected by the alleged deficient practice. 1. There were no residents affected by thealleged deficient practice. 2.All29 battery operated smoke detectors have had the battery replaced and tested toensure proper functioning. 3.Documentationhas been completed for the testing and the battery replacement. 2. Toidentify other residents who have the potential to be affected by the samealleged deficient practice. 1. No residents were harmed by the allegeddeficient practice. 3. Measuresand systemic changes put into place to ensure that the alleged deficientpractice does not recur. 1. A preventative maintenance program has beenput into place which includes the documentation of the monthly testing of	03/24/2016

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	3.1-19(b)		eachresident's room battery operated smoke detector. 4. Thecorrective action will be monitored to ensure the deficient practice does notrecur and quality assurances measures put into place are: 1. The Maintenance Director will provide a copyof the monthly documentation to the Administrator for 3 months. 2.Thefindings from these audits and any corrective actions taken will be discussedduring monthly QA meeting and the current plan revised, as warranted.	
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generator was allowed a 5 minute cool down period after each load test, furthermore, the facility failed to provide documentation that the transfer time for the generator was being recorded after each load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,1999 Edition.	K 0144	It is the practice of this facility that generators areinspected weekly and exercised under load for 30 minutes per month inaccordance with NFPA 99 and NFPA 110. 1. Corrective actions accomplished for thoseresidents found to be affected by the alleged deficient practice. 1. There were no residents affected by thealleged deficient practice. 2.ThePreventative Maintenance form has been updated to include the cool down timeand the transfer time to be recorded on	03/24/2016

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	NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's Monthly Generator Log on 03/08/16 at 10:00 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested weekly for over 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test, furthermore, there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Maintenance Supervisor confirmed the monthly generator log did not include documentation of a cool down time being recorded or the generator transfer time being recorded. 3.1-19(b)		the monthly testing. 3.Thefacility has tested the generator and documented the required cool down timeand the transfer time. 2. Toidentify other residents who have the potential to be affected by the samealleged deficient practice. 1. No residents were harmed by the allegeddeficient practice. 3. Measuresand systemic changes put into place to ensure that the alleged deficientpractice does not recur. 1. The Maintenance Director will complete thePreventative Maintenance scheduled monthly testing along with documenting thefindings. Concerns identified will benoted per Maintenance and repairs scheduled. 2.Administratorwill review the monthly Preventative Maintenance log to ensure completion ofthe testing and findings. 4. Thecorrective action will be monitored to ensure the deficient practice does notrecur and quality assurances measures put into place are: 1. The Maintenance Director will monitor thesystem through preventative maintenance program which is an ongoing program. Should non-compliance be observed, correctiveaction shall be taken, the observations	

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			and any corrective actions taken willbe reviewed during QA meetings and the plan of action adjusted accordingly ifwarranted.	