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	04/19/2017

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: 04/19/17 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 2012 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 alarms in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 36 at the time of this	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 05/10/17 to the state findings of the Life Safety Code Survey. We respectfully request paper compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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 04/20/17 - DA			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested monthly for 30 seconds and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall	K 0291	It is the practice of this facility to ensure emergency lighting during power outages and testing of emergency battery lighting. 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. No residents were harmed by the alleged deficient practice. 3. Measures and systemic	04/28/2017

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	be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 04/19/17 at 11:17 a.m. with the Maintenance Supervisor present, the "Monthly maintenance" form for "Emergency Battery lights/replace as needed" for 2016 and 2017 only indicated the battery operated emergency light at the generator was tested once a month. The form did not specify the light was tested for at least 30 seconds. Furthermore, there was no documentation to show the battery operated emergency light was tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Supervisor said there was no other documentation available to show the battery operated emergency light was tested for at least 30 seconds monthly, plus there was no documentation to show a 90 minute annual test was performed during the past twelve months.		changes put into place to ensure that the alleged deficient practice does not recur. a. A preventative maintenance program has been put into place which includes the documentation of 30 second monthly and 90 minute annual testing of emergency battery lighting. b. Maintenance Director has been in-serviced on the completion of the emergency battery lighting log on 04/26/17. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place are: a. Maintenance Director will provide copy of emergency battery lighting test log to the administrator for review. This is an ongoing program, should non-compliance be observed, corrective action shall be taken. The observations and corrective actions taken will be reviewed during Q/A meetings and the plan of action adjusted if warranted. Completion date 04/28/2017.	

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	3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING 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 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 60 doors to the corridor would close completely and latch into the door frame. This deficient practice could affect over 19 residents, as well as staff and visitors in the East Hall. Findings include: Based on observation on 04/19/17 at 11:45 a.m. during a tour of the facility with the Maintenance Supervisor, the corridor door to room 24 in the East Hall did not close completely and latch into the door frame when tested several times. The bottom of the door was becoming wedged to the floor and threshold to this room. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the flooring and threshold was recently installed. 3.1-19(b)	K 0363	It is the practice of this facility to ensure doors are provided with a means suitable for keeping doors closed. 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. b. Door has been adjusted to completely close and latch on 04/20/17. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents were harmed by the alleged deficient practice. b. A review of all resident's rooms corridor doors was completed on 04/20/17, no further doors identified. 3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. A preventative maintenance	05/05/2017

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			program has been put into place which includes documentation of the testing of 1 resident's room corridor door on each wing weekly. 4. The corrective action will be monitored to ensure the deficient practice does not recur and quality assurance measures put into place are: a. Maintenance Director will provide a copy of the documentation to the Administrator for review monthly. This is an ongoing program, should non-compliance be observed, corrective action shall be taken. Any corrective actions taken will be reviewed during Q/A meetings and current plan revised as warranted. Completion date 05/05/2017.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA	K 0500	It is the practice of this facility to ensure water heater are in safe operating condition. 1. Corrective Actions	05/10/2017

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	101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 04/19/17 between 11:30 a.m. to 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, the three fuel fired water heaters in the facility had expiration dates of 01/24/17. Based on interview at 12:10 p.m., the Maintenance Supervisor acknowledged the expiration dates of the three fuel fired water heaters was 01/24/17, furthermore, the Maintenance Supervisor said he was not aware of the water heaters being inspected since the 01/24/17 expiration date. 3.1-19(b)		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. No residents were harmed by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. An inspection of the water heaters has been scheduled for May 10, 2017. b. A preventative maintenance program has been put into place which includes documentation of monthly inspection of the certificates expiration date. 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 monthly documentation to the Administrator	

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			for review. This program is an ongoing program, should non-compliance be observed, corrective action shall be taken. The corrective actions will be reviewed during Q/A meetings and the plan of action adjusted accordingly if warranted. Completion date 05/10/2017.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements.			

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	Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation, record review, and interview; the facility failed to ensure 1 of 1 emergency generator and associated equipment was in proper operating condition. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation on 04/19/17 at 12:35 p.m. during a tour of the facility with the Maintenance Supervisor, when the Maintenance Supervisor attempted to start the generator at the generator it did not start, and when the Maintenance Supervisor attempted to start the generator at the transfer switch it also did not start. Furthermore, during observation, the generator's annunciator panel located at the Nurses' Station did not illuminate when tested. when asked, the Maintenance Supervisor said the facility does not have any residents relying on life support equipment. Based on review of the generator testing reports between 9:00 a.m. and 11:30 a.m. the	K 0918	It is the practice of this facility to ensure the emergency generator is in proper working condition. 1. Corrective actions accomplished for those residents found to be affected by the allege deficient practice. a. There were no residents affected by the alleged deficient practice. b. A new battery was installed on 04/19/17, tested and functioned properly. c. Generator was tested and functioned properly on 04/19/17, 04/20/17 and 04/21/17. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents were harmed by the alleged deficient practice. 3. Measures and systemic changes put into place to ensure	05/05/2017

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	most recent weekly testing report was dated 04/18/17. This was verified by the Maintenance Supervisor at the time of record review. 3.1-19(b)		that the alleged deficient practice does not recur. a. Maintenance Director will, in addition to weekly generator test, randomly start generator 1 time per week for 12 weeks and document test results. Concerns identified will be immediately noted per Maintenance and repairs schedule. 4. The corrective action will be monitored to ensure deficient practice does not recur and quality assurance measures put into place are: a. Maintenance Director will provide a copy of the random test weekly for 12 week to the Administrator to review. Any corrective actions taken will be reviewed during the Q/A meeting. Completion date 05/05/2017.	