

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

PRINTED: 08/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155263		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/17/2016	
NAME OF PROVIDER OR SUPPLIER LOGOOTE NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOGOOTE, 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
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00202860, IN00203177, and IN00202621 completed on 7/8/16. Complaint IN00202621 - Corrected Complaint IN00203177 - Corrected Complaint IN00202860 - Corrected Survey dates: August 16, 17, 2016 Facility number: 000164 Provider number: 155236 AIM number: 100289550 Census bed type: SNF/NF: 31 Total: 31 Census payor type: Medicare: Medicaid: 28 Other: 3 Total: 31 Sample: 3 Loogoote Nursing Center was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00202860, IN00203177 and IN00202621. Quality review completed by#02748 on August			{F 000}			

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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NAME OF PROVIDER OR SUPPLIER LOOGOOTEE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{F 000}	Continued From page 1 17, 2016.	{F 000}			