

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2012
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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/26/12</p> <p>Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk-thru survey, Transcendent Healthcare of Boonville, LLC 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>	K0000	<p>Boonville Life Safety POC 2012 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 that the plan of correction be considered our allegation of compliance effective October 24, 2012 to the Life Safety Code Recertification Survey conducted on September 26, 2012.</p>	

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>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered, except the front porch and side porch. The facility has a fire alarm system with smoke detection on in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 88 and had a census of 64 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and was found in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered, except the front porch and side porch. All areas providing facility services were sprinklered, except two detached structures consisting of a garage used as a maintenance shop and maintenance storage, and a small cinder block shed used for facility storage and lawnmower storage.</p>				

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	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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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 record review and interview, the facility failed to provided written documentation 36 of 36 smoke detectors had been tested for sensitivity within the past two years. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be</p>	K0052	<p><b>K052</b> It is the practice of Transcendent Healthcare of Boonville to assure that sensitivity testing for smoke detectors occurs in accordance with the regulation. <b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> There are no specific residents identified. All identified smoke detectors have now had sensitivity testing in accordance with the regulation. Please see under systems implemented to assure compliance with this tag. <b><i>Other residents that have the potential to be affected have been identified by:</i></b> Potentially all residents could be effected. All required</p>	10/24/2012

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	<p>performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</li> <li>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the</p>		<p>smoke detectors have now had sensitivity testing in accordance with the regulation. Please refer to systems implemented to assure compliance with this tag.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>Sensitivity testing has now occurred for each smoke detector as required by the regulation. The sensitivity testing will occur within one year after installation and alternate years thereafter in accordance with the regulation. The sensitivity testing will be included in the preventive maintenance program on an on-going basis. The maintenance Director has been in- serviced related to the following of the preventive maintenance plan</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p> <p>The sensitivity testing of</p>		

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	<p>life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect any of the 64 residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records in the Inspections book on 09/26/12 at 11:30 a.m. with the Maintenance Supervisor present, the most recent sensitivity test documentation was dated 09/18/10. This was confirmed by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>		<p>smoke detectors will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the smoked detectors sensitivity testing is completed in accordance with the schedule. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance.</p> <p><b><i>The date the systemic changes will be completed:</i></b> October 24, 2012</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 2 of 2 areas outside and attached to the building and partially constructed of combustible material. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustible exterior roofs exceeding four feet in width. This deficient practice could affect residents, staff and visitors while using the front porch or side porch to the dining room, which each had at least eight places to sit, plus anyone, entering, or exiting these two areas.</p> <p>Findings include:</p>	K0056	<p><b>K056</b> It is the practice of Transcendent Healthcare of Boonville to assure that all areas are sprinkled in accordance with the regulation. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> There are no specific residents identified. The front and side porches are now sprinkled in accordance with the regulation. Please see under systems implemented to assure compliance with this tag.</p>	10/24/2012			

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	<p>Based on observations on 09/26/12 between 12:00 p.m. and 2:45 p.m. during a tour of the facility with the Maintenance Supervisor, the front porch had a seven foot by forty eight foot overhang attached to the building, and the side porch had a nine foot by fifty five foot overhang attached to the building. Both overhangs and support posts were wrapped with metal, however, they both had wood framed roofs above. There was no sprinkler coverage provided under the overhangs. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p><b>Other residents that have the potential to be affected have been identified by:</b> Potentially all residents could be effected. All porches have been reviewed and are sprinkled in accordance with the regulation. Please refer to systems implemented to assure compliance with this tag.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The sprinklers have been installed on the identified porches. The routine inspections/reviews are now scheduled in accordance with the preventive maintenance schedule to assure that they are maintained in accordance with the regulation. The maintenance Director has been in-serviced related to the preventive maintenance in relation to the sprinklers.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p>				

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			<p>The installed sprinklers as well as all sprinklers are maintained in accordance with the regulation as part of the preventive maintenance program. The preventive maintenance for the sprinklers will be reviewed as part of the QA process at the quarterly meetings. The Maintenance Director, or designee, will be responsible for assuring that sprinklers are maintained appropriately. Any identified issues will be immediately corrected. The Administrator, or designee, will review the preventive maintenance documentation related to facility sprinkler maintenance.</p> <p><b><i>The date the systemic changes will be completed:</i></b> October 24, 2012</p>	

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K0069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, interview and observation; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect mostly kitchen staff.</p> <p>Findings include:</p>	K0069	<p><b>K069</b> <b>It is the practice of Transcendent Healthcare of Boonville to assure that the kitchen exhaust system is cleaned in accordance with the regulation.</b> <b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b> There are no specific residents identified. The kitchen exhaust system has been cleaned. Please see under systems implemented to assure compliance with this tag. <b><i>Other residents that have the potential to be affected have been identified by:</i></b> Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag. <b><i>The measures or systematic changes that have been put into place to ensure that the</i></b></p>	10/24/2012

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	<p>Based on review of the kitchen range inspection reports in the Inspections folder on 09/26/12 at 10:15 a.m. with the Maintenance Supervisor present, there was no documentation to show the kitchen range hood had been cleaned within the past twelve months. This was acknowledged by the Maintenance Supervisor at the time of record review. Based on observation at 12:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was no sticker on the kitchen range hood to indicated the range hood had been cleaned. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>deficient practice does not recur include:</b></p> <p>The kitchen exhaust system has been cleaned in accordance with the regulation. The exhaust system has been placed on the preventive maintenance schedule to assure that it is cleaned semiannually hereafter. The maintenance Director has been in-serviced related to assuring that the kitchen exhaust cleaning is scheduled per the regulation for routine cleaning.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>The cleaning of the kitchen exhaust system will be monitored as part of the preventive maintenance plan. The Maintenance Director, or designee, will be responsible for assuring that kitchen exhaust system is cleaned routinely in accordance with the regulation. Any identified issues will be immediately corrected. The Administrator, or designee, will review the</p>		

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			<p>preventive maintenance documentation as part of the quarterly QA meetings for compliance.</p> <p><b><i>The date the systemic changes will be completed:</i></b> October 24, 2012</p>	