

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 02/03/2015
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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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K010000	<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: 02/03/15</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 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> <p>This one story facility with a basement 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</p>	K010000	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 request the plan of correction be considered our allegation of compliance effective 02-06-15 to the state findings of the Life Safety Code Recertification and State Licensure Survey conducted on 02-03-15.	

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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K010029 SS=B	<p>corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 88 and had a census of 65 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, and 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> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/06/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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</p>						

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	<p>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 1 of 10 hazardous area room doors, such as a laundry dryer room door, was equipped with a properly operating self closing door. This deficient practice could affect mostly staff and vendors while in the service hall.</p> <p>Findings include:</p> <p>Based on observation on 02/03/15 at 10:50 a.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1, the door to the laundry dryer room from the service hall was heavily damaged and splitting apart. The door was equipped with a self closing device, however, it would not self close on its own and stayed open two inches. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010029	<p>K 029</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the identified laundry room door has been repaired by welding the seams. A new door closure device has also been installed and is functioning properly. No specific residents were identified in the survey as this is a service area only.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that no residents would be affected as these are secured areas for facility staff usage only. A house wide audit of all hazardous doors was completed. All doors were found to be in good condition and the door closures functioned properly.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the</p>	02/06/2015	

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K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD		<p>deficient practicedoes not recur is that amandatory in-service was provided for the Maintenance Director/ housekeepingand laundry staff which was conducted by the Executive Director and FacilityOwner on the revised facility preventative maintenance program which includes the checking of the condition of all hazardous doors to ensure they are in goodcondition and that the door closures function properly.</p> <p><i>The corrective action taken to monitor to assureperformance to assure compliance through quality assurance is a Quality Assurance tool has been developed andimplemented to monitor the condition and proper closure of all hazardous doorsin the facility. This tool will becompleted by the Maintenance Director and/or his designee weekly for fourweeks, then monthly for three months and then quarterly for threequarters. The outcomes will be reviewedat the facility's Quality Assurance meetings to determine if any additionalaction is warranted.</i></p>		

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	<p>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 insure 2 of 7 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect up to 5 residents in the Seasons Unit, and up to 15 residents in the northeast corridor, as well as staff and visitors in both areas.</p> <p>Findings include:</p> <p>Based on observations on 02/03/15 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1, there were three sprinkler heads within four feet of each other in the Seasons Unit Nursing Office, furthermore, there were two</p>	K010056	<p>K 056</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the sprinkler heads that were within four feet of each other identified on the Season's unit, potentially affecting 5 residents and the sprinkler heads potentially affecting 15 residents as well as staff and visitors on the northeast corridor have been capped.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all sprinkler heads has been completed which has the potential to affect all</i></p>	02/06/2015

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	<p>sprinkler heads within four feet of each other in the Orientation Room. This was acknowledged by the Maintenance Supervisor and Maintenance Assistant #1 at the time of each observation.</p> <p>3.1-19(b)</p>		<p>residents, staff and visitors. All sprinkler heads were found to be installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for the Maintenance Director/ housekeeping and laundry staff which was conducted by the Executive Director and Facility Owner on the revised facility preventative maintenance program which includes the checking of sprinkler heads to ensure they are installed in accordance with the regulation meaning that all sprinkler heads are located no closer than six feet measured on center from one another.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the location of sprinkler</i></p>	

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 50 of 50 battery operated smoke detectors in resident rooms to ensure the smoke detectors 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 affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the monthly battery operated Smoke Detector Audit testing records on 02/03/15 at 12:30 p.m. with</p>	K010130	<p>heads to ensure they are no closer than six feet measured on center of one another. This tool will be completed by the Maintenance Director and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</p> <p>1. The corrective action taken for those residents found to be affected by the deficient practice is that all 50 smoke detectors that were identified have had new batteries installed which had the potential to affect all residents, staff and visitors.</p> <p>2. The corrective action taken for those residents found to be affected by the deficient practice is that upon the facility contacting the facility boiler inspectors they provided</p>	02/06/2015

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	<p>the Maintenance Supervisor present, all 50 resident room battery operated smoke detectors have not had batteries replaced during the past twelve months. Documentation showed the last time batteries were changed was 07/22/13. Based on interview at the time of record review, the Maintenance Supervisor acknowledged all 50 resident room battery operated smoke detectors have not had batteries replaced within the past twelve months. Based on observations between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant #1, battery operated smoke detectors were observed in all resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 fuel fired boilers had inspection certificates that were current to ensure the boilers were in safe operating condition. NFPA 101 in 19.1.1.3 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 staff and vendors while in the service hall.</p>		<p>the facility with a copy of the last boiler inspection which was conducted in July 2013. The facility was in compliance with the required boiler inspections however did not have a copy of the document on the premises at the time of the survey.</p> <p>1. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit was conducted on all smoke detectors. Batteries were replaced on all smoke detectors and each smoke detector was in proper functioning order.</i></p> <p>1. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that upon the facility contacting the facility boiler inspectors they provided the facility with a copy of the last boiler inspection which was conducted in July 2013. The facility was in compliance with the required boiler inspections however did not have a copy of the document on the premises at the time of the</p>	

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	<p>Findings include:</p> <p>Based on observation on 02/03/15 at 1:45 p.m. during a tour of the facility with Maintenance Supervisor, the inspection certificates for the two fuel fired boilers had expiration dates of 06/04/14. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the two boilers have not been inspected since the 06/04/14 expiration date.</p> <p>3.1-19(b)</p>		<p>survey.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for the Maintenance Director/ housekeeping and laundry staff which was conducted by the Executive Director and Facility Owner on the revised facility preventative maintenance program which includes the monthly inspection of all smoke detectors and the annual replacement of batteries. The preventative maintenance program also includes an annual assessment of all boilers which includes the verification of the appropriate documentation of timely inspections on file at the facility.</p> <p><i>The corrective action taken to</i></p>		

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			<p><i>monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the proper maintenance of smoke detectors including the annual replacement of batteries. The tool also monitors the documentation of the annual assessment of the boilers by the maintenance department as well as the verification of the documented inspections on file at the facility. This tool will be completed by the Maintenance Director and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.</i></p>	