STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 01 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

(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 Short Form 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 Date: 12/10/15 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent Healthcare of Owensville, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building was surveyed with Chapter 19 Existing Health Care Occupancies. 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	K 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 01 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

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	smoke detectors in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 61 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a garage used for maintenance equipment. Quality Review completed on 12/11/15 - DA			
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire	K 0050	K 050 The corrective action taken for those residents found tobe affected by the deficient practice is that allresidents have the potential to be affected by this deficient practice. The facility administration with the supportof the faxed copies of the alarm transmissions is confident that all firedrills were conducted in accordance with the regulation the	12/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 01 B. WING	12/10/2015

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TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

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	Drill book on 12/10/15 at 9:30 a.m. with the Maintenance Supervisor present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters: 1. First shift (day) of the second quarter (April, May, and June), and third quarter (July, August, and September) of 2015 2. Second shift (evening) of the second quarter (April, May, and June), and third quarter (July, August, and September) of 2015 3. Third shift (night) of the second quarter (April, May, and June) of 2015 The facility did produce faxed copies of alarm transmissions to the facility's monitoring company but was unable to verify that fire drills were performed concurrent with those alarm transmissions. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)		facility could notlocate those records which had been completed by the facility's previousmaintenance supervisor. The facility hashired a new maintenance supervisor and he has conducted fire drills on eachshift in accordance with the regulation. The new maintenance supervisor has also been re-inserviced on hisresponsibility for conducting and documenting fire drills on each shift eachquarter. The facility has maintainedcopies of the fire drills which were conducted as part of the facility plan ofcorrection. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that all residents have the potential to be affected bythis deficient practice. The facilityadministration with the support of the faxed copies of the alarm transmissionsis confident that all fire drills were conducted in accordance with theregulation the facility could not locate those records which had been completedby the facility's previous maintenance supervisor. The facility has hired a new maintenancesupervisor and he has conducted fire drills on each shift in accordance withthe regulation. The new maintenancesupervisor has also been re-inserviced on his responsibility for conducting anddocumenting fire drills on each shift each quarter. The facility has maintained copies of thefire drills	

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	155502	A. BUILDING 01 B. WING	12/10/2015

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TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

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			which were conducted as part of the facility plan of correction. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a new maintenance supervisor has been hired. The new maintenance supervisor has beenin-serviced on his responsibility for conducting and maintaining documentationof all fire drills in accordance with State regulations. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool which will monitor the documentation of fire drills toensure that they are being completed quarterly on all shifts in accordance withState regulations. This tool will becompleted by the Executive Director monthly for three months and then quarterlyfor three quarters. The outcome of thistool will be reviewed at the facility's regularly scheduled Quality Assurancemeetings to determine if any additional action is warranted.	
K 0062 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13,			

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	NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of sprinkler system inspection reports on 12/10/15 at 9:50 a.m. with the Maintenance Supervisor present, there was no documentation to show the sprinkler system has had an internal pipe inspection since 04/27/10. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the sprinkler system has not had an internal pipe	K 0062	K 062 The corrective action taken for those residents found tobe affected by the deficient practice is that thedeficient practice could potentially affect all of the facility residents. The automatic sprinkler pipe inspection hadactually already been scheduled by the facility at the time of the Life SafetyCode Survey. The inspection has now beencompleted and the facility maintains documentation of this inspection forreview. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that thedeficient practice could potentially affect all of the facility residents. The automatic sprinkler pipe inspection hadactually already been scheduled by the facility at the time of the Life SafetyCode Survey. The inspection has now beencompleted and the facility maintains documentation of this inspection forreview. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that the facility has hired a new maintenance supervisor. The new maintenance supervisor has beenin-serviced on his responsibility to ensure that the automatic sprinkler pipingsystem is inspected timely every five years. The maintenance supervisor was also instructed on his	12/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	inspection since 04/27/10. 3-1.19(b)		responsibility tomaintain the documentation of the inspection for record keeping and Statereview. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the facility has added the inspection of theautomatic sprinkler piping system to the agenda of the regularly scheduledQuality Assurance meetings by the Executive Director. The purpose of adding this topic to theQuality Assurance meeting agenda is to ensure that the inspection date isreviewed so that timely scheduling of the inspection can be made. This will be an on-going part of thefacility's Quality Assurance meetings.	
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a 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	K 0144	K 144 The corrective action taken for those residents found tobe affected by the deficient practice is that allresidents have the potential to be affected by this deficient practice. The facility has revised the emergencygenerator test log to include documentation related to the required five	12/24/2015

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	110, Standard for Emergency and Standby Power Systems,1999 Edition. 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 Emergency Generator weekly testing log on 12/10/15 at 10:20 a.m. with the Maintenance Supervisor present, the generator log form documented the generator was tested weekly for 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. 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. 3.1-19(b)		minutecool down period after a load test has been completed. The maintenance supervisor has completed atest of the emergency generator utilizing the revised log which includes thefive minute cool down period. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that all residents have the potential to be affected bythis deficient practice. The facilityhas revised the emergency generator test log to include documentation relatedto the required five minute cool down period after a load test has beencompleted. The maintenance supervisorhas completed a test of the emergency generator utilizing the revised log whichincludes the five minute cool down period. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for themaintenance supervisor on the revised emergency generator log with instructionson his responsibility on the completion of this log weekly including thedocumentation related to the five minute cool down period. *The corrective actionwill be monitored to ensure the deficient practice will not recur through*	

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			thequality assurance program by the development and implementation of aQuality Assurance tool which will monitor the documentation of the testing ofthe emergency generator which includes the documentation of the five minutecool down period after completion of a test load. This tool will be completed by the ExecutiveDirector weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of the tool will be reviewed at the facility's regularly scheduledQuality Assurance meeting to determine if any additional action is warranted.	
K 0000 Bldg. 02	A Short Form 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 Date: 12/10/15 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent Healthcare of Owensville, LLC was found not in compliance with Requirements for Participation in	K 0000		

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	Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The 2011 Physical Therapy addition was surveyed with Chapter 18, New Health Care Occupancies. This 2011 addition to the one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and Physical Therapy area. The facility has a capacity of 68 and had a census of 61 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/11/15 - DA			
K 0050 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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			

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	conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 3 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Fire Drill book on 12/10/15 at 9:30 a.m. with the Maintenance Supervisor present, the facility lacked written documentation fire drills were conducted during the following shifts and quarters: 1. First shift (day) of the second quarter (April, May, and June), and third quarter (July, August, and September) of 2015 2. Second shift (evening) of the second quarter (April, May, and June), and third quarter (July, August, and September) of 2015 3. Third shift (night) of the second quarter (April, May, and June) of 2015 The facility did produce faxed copies of alarm transmissions to the facility's monitoring company but was unable to verify that fire drills were performed concurrent with those alarm transmissions. This was confirmed by the Maintenance Supervisor at the time of	K 0050	K 050 The corrective action taken for those residents found tobe affected by the deficient practice is that allresidents have the potential to be affected by this deficient practice. The facility administration with the supportof the faxed copies of the alarm transmissions is confident that all firedrills were conducted in accordance with the regulation the facility could notlocate those records which had been completed by the facility's previousmaintenance supervisor. The facility hashired a new maintenance supervisor and he has conducted fire drills on eachshift in accordance with the regulation. The new maintenance supervisor has also been re-inserviced on hisresponsibility for conducting and documenting fire drills on each shift eachquarter. The facility has maintainedcopies of the fire drills which were conducted as part of the facility plan ofcorrection. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that all residents have the potential to be affected bythis deficient practice. The facilityadministration with the support of the faxed copies of the alarm transmissionsis confident that	12/24/2015

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	record review. 3.1-19(b)		all fire drills were conducted in accordance with theregulation the facility could not locate those records which had been completedby the facility's previous maintenance supervisor. The facility has hired a new maintenancesupervisor and he has conducted fire drills on each shift in accordance withthe regulation. The new maintenancesupervisor has also been re-inserviced on his responsibility for conducting anddocumenting fire drills on each shift each quarter. The facility has maintained copies of thefire drills which were conducted as part of the facility plan of correction. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a new maintenance supervisor has been hired. The new maintenance supervisor has beenin-serviced on his responsibility for conducting and maintaining documentationof all fire drills in accordance with State regulations. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool which will monitor the documentation of fire drills toensure that they are being completed quarterly on all shifts in accordance withState regulations. This tool will	

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			becompleted by the Executive Director monthly for three months and then quarterlyfor three quarters. The outcome of thistool will be reviewed at the facility's regularly scheduled Quality Assurancemeetings to determine if any additional action is warranted.	
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility.	K 0062	K 062 The corrective action taken for those residents found tobe affected by the deficient practice is that thedeficient practice could potentially affect all of the facility residents. The automatic sprinkler pipe inspection hadactually already been scheduled by the facility at the time of the Life SafetyCode Survey. The inspection has now beencompleted and the facility maintains documentation of this inspection forreview. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that thedeficient practice could potentially affect all of the facility residents. The automatic sprinkler pipe inspection hadactually already been scheduled by the facility at the time of the Life	12/24/2015

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	Findings include: Based on review of sprinkler system inspection reports on 12/10/15 at 9:50 a.m. with the Maintenance Supervisor present, there was no documentation to show the sprinkler system has had an internal pipe inspection since 04/27/10. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the sprinkler system has not had an internal pipe inspection since 04/27/10. 3-1.19(b)		SafetyCode Survey. The inspection has now beencompleted and the facility maintains documentation of this inspection forreview. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that the facility has hired a new maintenance supervisor. The new maintenance supervisor has beenin-serviced on his responsibility to ensure that the automatic sprinkler pipingsystem is inspected timely every five years. The maintenance supervisor was also instructed on his responsibility tomaintain the documentation of the inspection for record keeping and Statereview. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the facility has added the inspection of theautomatic sprinkler piping system to the agenda of the regularly scheduledQuality Assurance meetings by the Executive Director. The purpose of adding this topic to theQuality Assurance meeting agenda is to ensure that the inspection date isreviewed so that timely scheduling of the inspection can be made. This will be an on-going part of thefacility's Quality Assurance meetings.	

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TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

(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 0144 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a 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. 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 Emergency Generator weekly testing log on 12/10/15 at 10:20 a.m. with the Maintenance Supervisor present, the generator log form documented the	K 0144	K 144 The corrective action taken for those residents found tobe affected by the deficient practice is that allresidents have the potential to be affected by this deficient practice. The facility has revised the emergencygenerator test log to include documentation related to the required five minutecool down period after a load test has been completed. The maintenance supervisor has completed atest of the emergency generator utilizing the revised log which includes thefive minute cool down period. The corrective action taken for the other residents havingthe potential to be affected by the same deficient practice is that all residents have the potential to be affected bythis deficient practice. The facilityhas revised the emergency generator test log to include documentation relatedto the required five minute cool down period after a load test has beencompleted. The maintenance supervisorhas completed a test of the emergency generator utilizing the revised log whichincludes the five minute cool down period. The measures or systematic changes	12/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 02 B. WING	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	generator was tested weekly for 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. 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. 3.1-19(b)		that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for themaintenance supervisor on the revised emergency generator log with instructionson his responsibility on the completion of this log weekly including thedocumentation related to the five minute cool down period. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool which will monitor the documentation of the testing ofthe emergency generator which includes the documentation of the five minutecool down period after completion of a test load. This tool will be completed by the ExecutiveDirector weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of the tool will be reviewed at the facility's regularly scheduledQuality Assurance meeting to determine if any additional action is warranted.	