PRINTED: 04/20/2017 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND LAN	OF CORRECTION	155502	B. W.		01		COMPLETED 02/01/2017	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RECTIVE ACTION SHOULD BE COMERENCED TO THE APPROPRIATE		
K 0000	REGULATORTOR	LESC IDENTIFICATION OR OR OR OTHER PROPERTY.		mo			DATE	
Bldg. 01	State Licensure the Indiana State	ode Recertification and survey was conducted by Department of Health in 42 CFR 483.70(a).	K 0	000				
	Survey Date: 02/01/17							
	Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960							
	LLC was found Requirements for Medicare/Medic 483.70(a), Life S 2012 edition of the Protection Associately Code (LS	ealthcare of Owensville, not in compliance with r Participation in aid, 42 CFR Subpart Safety from Fire and the						
	be of Type V (00 fully sprinklered alarm system wi detectors in the of to the corridors, smoke alarms in	acility was determined to 00) construction and was a fire the hard wired smoke corridors and spaces open plus battery operated all resident sleeping lity has a capacity of 68						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	ľ í	JILDING	onstruction 01	(X3) DATE : COMPL 02/01 /	ETED
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE		HWY 16	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0291 SS=C Bldg. 01	All areas where to customary access all areas providing sprinklered. Quality Review of DA NFPA 101 Emergency Lighting Emergency Lighting Emergency Lighting duration is provided accordance with 718.2.9.1, 19.2.9.1 Based on record the facility failed backup lights we seconds and annual during 10 of the the light would provided. LSC 11 emergency lighting accordance with 7.9.3.1.1 (1) requisions and the conduction of 3 with 5 weeks between 30 seconds, (3) Figure 1.1.	g of at least 1-1/2-hour and automatically in .9. review and interview, I to ensure 2 of 2 battery are tested monthly for 30 and ly for 90 minutes past 12 months to ensure provide lighting during a outages and a written anspections and tests was	K 0	291	By submitting the enclose material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to conte the findings or allegations as part of any proceeding and submit these responses pursuant to our egulatory obligations. To facility request the plan of correction be considered our allegation of compliance effective 02-20-17 to state findings of the Life Safety Code Survey	Ve st s gs ur he f	02/20/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			Î ´	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPLETED
		155502	B. W	ING		02/01/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
TD 4 1 10 0		0.455.05.00/51/01/11/5			65 W PO BOX 369	
TRANSCENDENT HEALTHCARE OF OWENSVILLE				OWENSVILLE, IN 47665		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		e emergency lighting			conducted on February 1 2017.	,
	'	powered and (5) Written			2017.	
		inspections and tests				
		the owner for inspection				
		having jurisdiction. This			K 291	
	deficient practice					
	residents in the f	acility.				
	Finding since 1				The second (' ' ' '	
	Findings include): 			The corrective action take	
	D 1 1	. 02/01/17			for those residents found	
	Based on record review on 02/01/17 at				have been affected by the	
		the Maintenance			deficient practice is that r	10
		ent, the Battery Operated			specific residents were	
		t Test Log for 2016 and			identified during the surve	·
		he battery operated			however all residents have	
		s were only tested in			the potential to be affecte	
	January and Feb				by the deficient practice. of the facility battery	All
	· · · · · · · · · · · · · · · · · · ·	ere was no documentation			operated back up lights	
		ery operated emergency			have been visually	
		d annually for 90			inspected and have been	
		on an interview at the			tested for 90 minutes and	
		eview, the Maintenance			were found to be	'
	-	there was no other			functioning properly. This	2
		vailable to show the			inspection and testing ha	
		emergency lights were			been documented in the	
		y other months except			facility maintenance files	
	January and Feb	•			and will remain on file for	
		ere was no documentation			future inspections.	
		nute annual test was				
	performed during	g the past twelve months.				
	2.1.10/1-)					
	3.1-19(b)					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155502	A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/01/2017
	ROVIDER OR SUPPLIE	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY OF	ALSO IDENTIFY TING INFORMATION)	IAU	The corrective action take for the other residents having the potential to be affected by the same deficient practice is thata residents have the potent to be affected by this deficient practice. All of the facility battery operated back up lights have been visually inspected and has been tested for 90 minute and were found to be functioning properly. This inspection and testing has been documented in the facility maintenance files and will remain on file for future inspections.	en II tial he ve es s s
				practice does not recur is that the facility is currently recruiting for a new Maintenance Supervisor.	y

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/01/2017
TRANSC	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Upon hire that individual be thoroughly trained on required visual checking and testing of the battery operated back up lights. Until such time the company area Maintenar Supervisor will be responsible to ensure that the battery operated back up lights are visually checked and the required testing has been complete and documented in accordance with life safe codes.	the nce at k
				The corrective action take to monitor to assure compliance is that the facility has adopted the practice that the Maintenance supervisor submit to the Executive Director monthly the documents supporting the the appropriate testing of the battery operated backup lights has been completed. The Executive Director will review and	will at F

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	of correction identification number: 155502	A. BUILDING B. WING	01	COMPLETED 02/01/2017
	PROVIDER OR SUPPLIER SENDENT HEALTHCARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial		initial the documents validating that the supportive documentatio on file in accordance with life safety code. If there any concerns identified by the Executive Director at the time of this review, the will be immediately addressed and corrected addressed and corrected the safety and corrected a	n are y ey

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W		<u>01</u>	02/01/2017	
		155502	D. W.	_		02/01/	/2017
NAME OF I	PROVIDER OR SUPPLIER	Ł			ADDRESS, CITY, STATE, ZIP CODE		
TDANCO					65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWEN	ISVILLE, IN 47665		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	automatic sprinkle		+	TAG	BELLEE.(C.)		DATE
	9.7.5, 9.7.7, 9.7.8,						
		ord review, observation	K 0	353	K 353		02/20/2017
		ne facility failed to					
	•	eler system inspections in					
	_	NFPA 25 for 1 of 1			The corrective action tak	en	
		. NFPA 25, Standard for			for those residents found	l to	
		Testing, and Maintenance			have been affected by the	e	
	_	Fire Protection Systems,			deficient practice is that	าด	
		ection 5.2.4.2 states			specific residents were		
	-	pe sprinkler systems			identified as having beer	1	
	shall be inspected weekly to ensure that				affected by this deficient		
	-	vater pressures are being			practice however all		
		tion 5.1.2 states valves			residents, staff and visito	rs	
		ent connections shall be			have the potential to be		
	_	, and maintained in			affected by this deficient		
		Chapter 13. Section			practice. The facility has	;	
		able 13.1.1.2 shall be			conducted a thorough		
		ection, testing and			sprinkler system inspecti		
	_	valves, valve components			which included all sprink	ler	
		n 4.3.1 states records			heads, all gauges and		
		r all inspections, tests,			control valves. The fire		
		e of the system and its			department connections		
		shall be made available			have been inspected and		
	_	naving jurisdiction upon			tested including the valve		
	1	ficient practice could			valve components and tr	im.	
	-	its, staff, and visitors in			All sprinkler heads have		
	the facility.	, 50011, 0110 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			been inspected and are		
					free of any paint or debri	S.	
	Findings include	··			All components of the		
		·-			facility sprinkler system		
	Based on record	review on 02/01/17 at			were found to be in good		
		the Maintenance			condition and in proper		
	Supervisor prese				functioning order. This	d in	
	Supervisor prese	in, more was			inspection is documented	J III	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	<u></u>			COMPLETED	
		155502	B. W	ING		02/01/2017	
NAME OF I	DDOWIDED OD CHIDDI IEI	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	K		HWY 10	65 W PO BOX 369		
	ENDENT HEALTH	CARE OF OWENSVILLE		OWENS	SVILLE, IN 47665		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	ĺ .
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	,	DATE	
		available from Tri State			the facility sprinkler syste		
		that quarterly sprinkler			inspection log and is bein	·	
	_	e performed on 03/30/16,			maintained in accordance	9	
	06/01/16, 09/23	/16 and 12/28/16.			with life safety code.		
	Weekly dry spri	nkler system gauge					
	inspection docu	mentation for 48 weeks					
	of the most rece	nt 52 week period was			The corrective action take	en	
	not available for	r review. Furthermore,			for the other residents		
	monthly inspect	ion documentation for all					
	sprinkler system	n control valves for 8			having the potential to be		
	months of the m	nost recent 12 month			affected by the same	.,,	
	period was also	not available for review.			deficient practice is that a		
	_	iew at the time of record			residents, staff and visito	rs	
		ntenance Supervisor			have the potential to be		
		cility performs regular			affect by this deficient		
		system inspections but			practice. The facility has		
	•	ent sprinkler system			conducted a thorough		
		m control valves			sprinkler system inspection		
		acknowledged sprinkler			which included all sprinkle	er	
	system gauge ar				heads, all gauges and		
		mentation for the			control valves. The fire		
	_	weekly and monthly			department connections		
					have been inspected and		
	_	available for review.			tested including the valve	es,	
	Based on observ				valve components and		
		rector during a tour of the			trim. All components of the	ne	
	_	:15 p.m. to 2:30 p.m. the			facility sprinkler system		
	1	al of three pressure			were found to be in good		
	gauges at the sp	rinkler riser.			condition and in proper		
					functioning order. This		
	3.1-19(b)				inspection is documented		
					the facility sprinkler syste		
	2. Based on obs	servation and interview,			inspection log and is bein	~	
	the facility faile	d to ensure 1 of over 400			maintained in accordance	9	
	sprinkler heads	in the facility were free of			with life safety code.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED				
AND FLAN	OF CORRECTION	155502	B. WING 02/01/2017			
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIEI				65 W PO BOX 369	
		CARE OF OWENSVILLE			SVILLE, IN 47665	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	paint. NFPA 25 Inspection, Test Water-Based Fir 5.2.1.1.1 require paint and corros any sprinkler that corrosion shall be deficient practic staff while in the any other reside in the front entra Findings include Based on observe p.m. during a too Maintenance Su sprinkler head in with paint cover portion of the sp acknowledged be	ing, and Maintenance of the Protection Systems at the sprinklers to be free of the ion. 5.2.1.1.2 requires at shows signs of paint or the replaced. This the could affect mostly the time clock room, plus the interpretation of the protection of the protection of the ion.		TAG	The measures that have been put into place to ensure that the deficient practice does not recur is that the facility is currently recruiting for a new Maintenance Supervisor. Upon hire that individual be thoroughly trained on required on the facilities weekly sprinkler system inspection and testing process. Until such time to company area Maintenar Supervisor will be responsible to ensure that the facility sprinkler system is inspected and tested in accordance with life safer code and facility practices.	bate By will the the nce at at am at ty

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502	A. BUILDING B. WING	01	COMPLETED 02/01/2017
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165	DRESS, CITY, STATE, ZIP CODE W PO BOX 369 VILLE, IN 47665	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		The corrective action take to monitor to assure compliance is that has adopted the practice that the Maintenance supervisivill submit to the Executi Director monthly the documents supporting the appropriate weekly a monthly inspections and testing of the facility sprinkler system have be completed in accordance with life safety code and facility practices. The Executive Director will review and initial the documents validating that the supportive documentation is on file if accordance with life safety code. If there are any concerns identified by the Executive Director at the time of this review, they we be immediately addressed and corrected.	sor ve at at at ad een een ty

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G <u>01</u>	COMPLETED		
		155502	B. WING		02/01/2017		
NAME OF P	PROVIDER OR SUPPLIE	R	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	•		
			HWY 165 W PO BOX 369				
TRANSC	ENDENT HEALTH	ICARE OF OWENSVILLE	OW	/ENSVILLE, IN 47665			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	, ,	ILDING	ONSTRUCTION 01	(X3) DATE COMPI 02/01 .	ETED
	PROVIDER OR SUPPLIEF	CARE OF OWENSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extil 18.3.5.12, 19.3.5. Based on observ	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 ration and interview, the	K 03	355	K 355		02/20/2017
	fire extinguisher month. NFPA 1 Fire Extinguisher fire extinguisher either manually electronic device 30-day intervals periodic inspecti monitoring of fir include a check items: (1) Location in (2) No obstruction	re extinguishers shall of at least the following			The corrective action take for those residents found have been affected by the deficient practice is that portable fire extinguisher located by the beauty shand in the therapy department have now be inspected and are in good condition and proper functioning order.	of to ne the rs op	
	the operable range (4) Fullness detecting for self extinguishers, care extinguishers, are (5) Condition of hose, and nozzle extinguishers (6) Indicator for	ge or position ermined by weighing or expelling-type artridge-operated and pump tanks tires, wheels, carriage,			The corrective action take for the other residents having the potential to be affected by the same deficient practice is that housewide inspection of portable fire extinguished has been conducted and portable fire extinguished are in good condition and proper functioning order.	e a all s l all	

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	OF CORRECTION OF CORRECTION 155502	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/01/2017
	PROVIDER OR SUPPLIER CENDENT HEALTHCARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could residents, as well as staff and visitors while in the Physical Therapy area and the Beauty Shop. Findings include: Based on observations on 02/01/17 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the monthly inspection tag on the fire extinguisher located in the Beauty Shop lacked documentation of monthly inspections for July through December of 2016. Furthermore, the monthly inspection tag	IAU	The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has adopt a practice whereby upon completion of the monthly fire extinguisher inspection in addition to the maintenance supervisor marking the fire extinguisher tag upon inspection, the maintenance supervisor maintain a fire extinguish log documenting the date the inspection, any corrective action required and their initials. The maintenance supervisor be required to maintain these documents in their records for at least 12 months.	ed y on will er e of

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		A. BUILDING <u>01</u> COMPLETED B. WING 02/01/2017			
		100002			02/01/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369	
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		SVILLE, IN 47665	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		guisher located in the	TAG	Dia relation (DATE
	· · · · · · · · · · · · · · · · · · ·	set in the Physical			
		ked documentation of			
		ons for July through			
		16, and January of 2017.			
	This was acknow	•			
		pervisor at the time of			
	each observation	l.			
	3.1-19(b)				
				The corrective action take	en
				to monitor to assure	
				compliance is that the	
				maintenance supervisor	
				submit the completed fire	!
				extinguisher log to the	do c
				Executive Director month for review. The Executive	·
				Director will review and	;
				initial the documents	
				validating that the	
				supportive documentation	n is
				on file in accordance with	
				life safety code. If there	
				any concerns identified b	у
				the Executive Director at	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 02/01/2017			
	PROVIDER OR SUPPLIED	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0361 SS=E	NFPA 101 Corridors - Areas	•		the time of this review, th will be immediately addressed and corrected	
Bldg. 01	treatment rooms a waiting areas, nur and cooking facili are in accordance 18.3.6.1 and 19.3 18.3.6.1, 19.3.6.1	an patient sleeping rooms, and hazardous areas), rse's stations, gift shops, ties, open to the corridor with the criteria under .6.1.	K 0361	K 361	02/20/2017
	to the corridor we corridor by a particular by an exception per 19.3.6.1(7) states patient sleeping and hazardous a corridor and unlesspace opens onto compartment are electrically super detection system 19.3.4, and (b) If an automatic spin space does not to	ensure 1 of 2 areas open vas separated from the ritition capable of sage of smoke as rinklered building, or met r 19.3.6.1(7). LSC is that spaces other than rooms, treatment rooms, treas shall be open to the imited in area, provided: ad corridors which the orin the same smoke reprotected by an ervised automatic smoke in accordance with each space is protected by rinklers, and (c) The original obstruct access to This deficient practice		The corrective action take for those residents found have been affected by the deficient practice is that it is specific residents were identified during the survey however staff, visitors and up to 22 residents have to potential to be affected by this deficient practice. An electrically supervised smoke detector has been installed in the southwest lounge area outside the beauty shop and is functioning properly.	to e no ey d he y n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/01/2017	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	staff and visitors compartment. Findings include Based on observed 12:40 p.m. during with the Mainter southwest loung Shop was open to Furthermore, LS met because the the Beauty Shop electrically super detection systems.	ation on 02/01/17 at g a tour of the facility nance Supervisor, the e outside the Beauty of the corridor. C 19.3.6.1(7) was not southwest lounge outside was not protected by an rivised automatic smoke a. Based on interview at rivation, the Maintenance owledged the		The corrective action talk for the other residents having the potential to be affected by the same deficient practice is that housewide assessment completed to ensure that spaces open to the corriare protected by an electrically supervised smoke detector. All area were found to be protect by an electrically supervised smoke detector which all areas open to the corridor are being monitored monthly by the maintenance supervisor part of the preventative maintenance program to ensure that these areas that open into the corridor are being monitored by a electrically supervised smoke detector which is functioning properly. The	e a was t all dor as ed tor.

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/01/2017
	ROVIDER OR SUPPLIER ENDENT HEALTHCARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			monitoring will be documented in the smok detector monitoring log weekly by the maintenan supervisor.	
			The corrective action take to monitor to assure compliance is that the maintenance supervisor submit the completed smoke detector monitoring to the Executive Director monthly for reviet to ensure that all areas open to the corridors are being monitored by an	will ng ew

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COM		COMPL	ETED	
		155502	B. WIN	G		02/01/	2017
		1	- Т	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE			SVILLE, IN 47665		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROUBERG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					electrically supervised		
					smoke detector that is		
					functioning properly.		
					If there are any concerns		
					identified by the Executiv		
					Director at the time of this	3	
					review, they will be		
					immediately addressed a	nd	
					corrected.		
K 0372	NFPA 101						
SS=F		ilding Spaces - Smoke					
Bldg. 01	Barrie	ilding Spaces - Smoke					
	Barrier Constructi	- -					
	2012 EXISTING	0.1					
	Smoke barriers sl	nall be constructed to a					
	1/2-hour fire resis	tance rating per 8.5.					
		hall be permitted to					
		rium wall. Smoke dampers					
	•	n duct penetrations in fully					
		tems where an approved					
		s installed for smoke jacent to the smoke					
	barrier.	gassin to the emone					
	19.3.7.3, 8.6.7.1(1)					
	Describe any med	chanical smoke control					
	system in REMAF				1/0-0		
		vation and interview, the	K 037	72	K372		02/20/2017
	facility failed to	ensure the penetrations					
	caused by the pa	assage of electrical wire					
			1				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	<u>v.</u>			COMPL	
155502			B. W	ING		02/01/	2017
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER				65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENS	SVILLE, IN 47665		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e through 2 of 2 smoke			The corrective action take		
		re protected to maintain			for those residents found		
		ance of each smoke			have been affected by the		
	barrier. LSC Sec	etion 19.3.7.5 requires			deficient practice is that n	0	
	smoke barriers to	be constructed in			specific residents were		
	accordance with	LSC Section 8.5 and			identified during the surve	•	
	shall have a min	imum ½ hour fire			however all residents, sta	ff	
	resistive rating.	This deficient practice			and visitors have the		
		esidents, as well as staff			potential to be affected by		
	and visitors in th	e facility.			this deficient practice. Th	ie	
		,			four inch gap around the		
	Findings include		four inch sprinkler pipe in				
					the east side smoke barri	er	
	Based on observ	ations on 02/01/17			wall has been properly		
		n. and 2:15 p.m. during a			sealed to prevent the		
	_	ry with the Maintenance			spread of smoke/fire. The	e	
		following unsealed			one foot by one and a hal	f	
	-	-			foot hole through the wall		
	penetrations wer				which insulated wrapped		
	,	p around a four inch			electrical wire running		
		the east side smoke			through the hole in the wa	all	
	barrier wall	1 1 100 11 1			plus the three inch gap		
	,	one and a half foot hole			around a four inch sprinkl	er	
	_	with insulated wrapped			pipe which was penetratir	ng	
		nning through the hole			the wall has been properl	_	
	in the wall, plus	a three inch gap around a			sealed to prevent the	, l	
	four inch sprinkl	er pipe penetrating the			spread of smoke/fire.		
	wall				'		
	Based on intervi	ew at the time of					
	observations, the	Maintenance Supervisor					
	acknowledged ea	ach aforementioned			The corrective action take	en	
	condition.				for the other residents		
					having the potential to be		
	3.1-19(b)				affected by the same		
	, ,				deficient practice is that a		
			1				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 02/01/2017
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				housewide inspection hat been completed of all smoke barrier walls and other holes/gaps were identified.	
				The measures that have been put into place to ensure that the deficient practice does not recur it that the facility has adop the practice that all smol barrier walls will be inspected monthly by the maintenance supervisor ensure there are no holes/gaps.	ted Ke
				Any identified breaches the smoke barrier walls was be repaired immediately upon identification. This inspection will be documented monthly by maintenance supervisor.	will

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	OF CORRECTION	IDENTIFICATION NUMBER: 155502	A. BUILDING B. WING	<u>01</u>	COMPLETED 02/01/2017
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	alarm signal and s fire conditions. Fir unexpected times at least quarterly of	the transmission of a fire simulation of emergency re drills are held at under varying conditions, on each shift. The staff is edures and is aware that		The corrective action take to monitor to assure compliance is that the maintenance supervisor wall inspection to the Executive Director month for his review. If there are any concerns identified by the Executive Director at the time of this review, the will be immediately addressed and corrected.	will lly e y ey

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		r í	JILDING	nstruction 01	(X3) DATE COMPL 02/01 /	ETED	
TRANSC		CARE OF OWENSVILLE		HWY 16	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	drills is assigned of who are qualified who are qualified to Where drills are completed in the period of the facility failed were held at varient employee shifts. This deficient provides a seed on review on 02/01/17 at 1 Maintenance Supfour third shift (performed between p.m. During an record review, the Supervisor acknowledge who are the provided to the provided the	planning and conducting only to competent persons to exercise leadership. Onducted between 9:00 a coded announcement and of audible alarms. 8.7.1.7, 19.7.1.4 through review and interview, It to ensure fire drills addring 3 of 4 quarters. actice could affect all accility. I to ensure fire drills are times for 1 of 3 during 3 of 4 quarters. actice could affect all accility. I to ensure fire drills accility. I to ensure fire drills active could affect all accility.	K 0	712	The corrective action take for those residents found have been affected by the deficient practice is that it specific residents were identified during the surve however all residents, sta and visitors could potentially be affected by this deficient practice. Find drills have been conducted on all three shifts at varies times to establish a baseline. The corrective action take for the other residents having the potential to be affected by the same deficient practice is that a residents have the potential to be affected by this deficient practice. Fire driver in the deficient practice. Fire driver in the deficient practice.	to e no ey uff re ed d	02/20/2017

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/01/2017
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				have been conducted or three shifts at varied time to establish a baseline.	
				The measures that have been put into place to ensure that the deficient practice does not recur it that the facility has developed a practice that fire drills will be conducted on each shift each quart. The fire drills will occur out least a two hour difference time schedule than from the previous findrill conducted on that she	s t ed er. on
				The corrective action take to monitor to assure compliance is that the maintenance supervisor submit the fire drill sched to the Executive Director monthly for review to ensure that fire drills are being held at varied time accordance with the faci practice. If there are any concerns identified by the Executive Director at the	will dule s in lity

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	OF CORRECTION	IDENTIFICATION NUMBER: 155502	A. BUILDING 01 B. WING		COMPLETED 02/01/2017
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 16	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				time of this review, they we be immediately addressed and corrected.	l l
K 0912 SS=D Bldg. 01	capable of maintai resistance with its locations, receptade bathrooms, play recother than nurserie tamper-resistant of lf used in patient coircuit interrupters 6.3.2.2.6.2 (F), 6.3 Based on observational facility failed to a location resident	- Receptacles have at least one, ependable grounding pole ning low-contact mating plug. In pediatric cles in patient rooms, soms, and activity rooms, es, are listed r employ a listed cover. are room, ground-fault (GFCI) are listed. 1.2.4.2 (NFPA 99) ation and interview, the	K 0912	K 912 The corrective action take	02/20/2017 en

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	· /	ILDING	nstruction 01	(X3) DATE S COMPLI 02/01/3	ETED
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	(GFCI) protection NFPA 70, Article Facilities, define care areas that an conditions while These include state or drenching of the which condition or staff. NFPA 71 Locations, require fixed equipment wet location to hinterrupter (GFC) Moisture can reduce resistance of the insulation is more deficient practice. DNS office. Findings include Based on observation between 12:15 per a tour of the facing Maintenance Suphad two electric feet of a sink with interrupter on the was confirmed we testing device. The by the Maintenance time of observation of the facing device. The protection of the facing device of the maintenance for the maintenance of observation of the facing device. The maintenance of observation of the facing device of the maintenance of observation of the facing device. The maintenance of observation of the facing device of the maintenance of observation of the facing device of the maintenance of observation of the facing device of the maintenance of the main	on against electric shock. e 517, Health Care s wet locations as patient re subject to wet patients are present. anding fluids on the floor the work area, either of is intimate to the patient 70, 517-20 Wet res all receptacles and within the area of the ave ground-fault circuit (I) protection. Note: luce the contact body, and electrical re subject to failure. This re could affect staff in the ation on 02/01/17 r.m. and 2:30 p.m. during lity with the pervisor, the DNS Office receptacles within four the no ground fault circuit re electric outlets. This when testing with a GFCI This was acknowledged ince Supervisor at the			for those residents found have been affected by the deficient practice is that it specific residents were identified during the surve however the staff in the DNS office could potential be affected by this deficie practice. The facility has covered the identified electrical receptacle in the DNS office with a flat plat cover to prevent exposure/access to the electrical outlet. The corrective action take for the other residents having the potential to be affected by the same deficient practice is that a housewide inspection of a electrical receptacles, located in what is defined as a wet location to ensurt that they have a ground fault circuit interrupter to protect against electric shock has been complete. No other receptacles were identified during this inspection	e d. ey ally ent ee	
	3.1-19(b)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155502	A. BUILDING B. WING	Onstruction 01	COMPLETED 02/01/2017		
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				The measures that have been put into place to ensure that the deficient practice does not recur that the facility has implemented the practice as part of the preventation maintenance program the amonthly inspection of electrical receptacles with conducted by the maintenance supervisor ensure that the receptactidentified as being in a volocation are provided with ground fault circuit interrupter to protect against electric shock on they are covered with a plate cover to prevent exposure/access to the electrical outlet.	t is e ve nat II be to cles vet th a		

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	E OF PROVIDER OR SUPPLII INSCENDENT HEALTI	ER HCARE OF OWENSVILLE	HWY	165 W PO BOX 369 NSVILLE, IN 47665		
(X4) I PREF TAG	IX (EACH DEFICIE	STATEMENT OF DEFICIENCIES CNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
				The corrective action take to monitor to assure compliance is that the maintenance supervisor provide the Executive Director with the monthly electrical receptacle inspection report for his review. If there are any concerns identified by the Executive Director at the time of this review, they be immediately addressed and corrected.	will e e e will	

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