STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING -- B. WING	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 07/25/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 09/05/24 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this PSR to the Emergency Preparedness survey, Transitional Services Sub LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 5. Quality Review completed on 09/06/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 07/25/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/05/24 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bret Beauchamp	Regional Director	09/19/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	At this PSR to the Life Safety Code survey, Transitional Services Sub, LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in all living areas and client sleeping rooms, plus heat detection in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 5 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6. Quality Review completed on 09/06/24			
K S100 Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure 2 of 2 fire extinguishers in the facility were protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants. Findings include:	K S100	KO100 All extinguishers will be mounted in the home Program Director and Program Supervisor will be trained on ensuring that all fire extinguishers will be inspected monthly, mounted properly, and an annual inspection completed All staff will be trained on use of the fire extinguishers in the	10/05/2024

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	Based on observations on 09/05/24 between 1:00 p.m. and 1:30 p.m. during a tour of the facility with the Program Supervisor, there were two fire extinguishers placed on the floor and unsupported. One in the dining room area setting next to the chest freezer, and one in the living room area outside the staff office. Based on interview at the time of each observation, the Program Supervisor agreed the fire extinguishers should not have been setting unsupported on the floor. This finding was reviewed with the Program Supervisor during the exit conference. This deficiency was cited on 07/25/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		home and reporting any issues including if a fire extinguisher is not mounted properly Program Supervisor will monitor at least three times weekly Program Director will monitor during weekly visits in the home Persons Responsible: Program Director, Program Supervisor, Area Director	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system was accurate and complete. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its	K S345	**K0345** -Contractor will be contacted for the results of the smoke detector sensitivity inspection -Program Director and Program Supervisor will be trained on ensuring the fire alarm system is inspected semi-annually and annually. - Program Director and Program Supervisor will ensure Gauge inspections are completed monthly -Program Director and Program Supervisor will ensure the inspections are in the safety book for review -Program Director and Program	10/05/2024

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	listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients and staff. Findings include: Based on record review on 09/05/24 between 1:00 p.m. and 1:30 p.m. with the Program Supervisor present, there were three fire alarm system reports available for review with smoke detector sensitivity test documentation provided. Those reports were dated 05/01/23, 10/26/23, and 04/01/24. All three reports were titled as "Annual" reports, and all three reports presented the question under "System Details" on the cover page, "Was sensitivity performed during the inspection?" And the answer was "Yes" on each report. Furthermore, all three reports did not include the name of the manufacturer's calibrated sensitivity test instrument. Based on interview at the time of record review, the Program Supervisor indicated she did not know which fire alarm		Supervisor will ensure that any recommendations from the inspection are completed -Program Supervisor will monitor at least three times weekly -Program Director will monitor weekly during Site Supervisory visit **Persons Responsible: Program Director, Program Supervisor, Area Director	

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	system report was the actual smoke detector sensitivity test report. This finding was reviewed with the Program Supervisor during the exit conference. This deficiency was cited on 07/25/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure the ceiling in 1 of 3 sprinklered smoke compartments of the facility was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all clients, as well as staff and visitors. Findings include: Based on observations on 09/05/24 between 1:00 p.m. and 1:30 p.m. during a tour of the facility with the Program Supervisor, there was a four inch by two foot gap behind the square HVAC duct which penetrated the ceiling to the attic space in the sprinkler riser room. It appeared the drywall ceiling had been damaged between the HVAC duct and the wall. Based on interview at the time of observation, the Program Supervisor acknowledged the gap in the ceiling behind the HVAC duct and the wall in the sprinkler riser room. This finding was reviewed with the Program Supervisor during the exit conference. This deficiency was cited on 07/25/24. The facility failed to implement a systemic plan of correction	K S353	KO353 Sprinkler System -Contractor will be contacted to repair the gap behind the HVAC duct -All repair invoices will be available for review -Program Director and Program Supervisor will be trained on safety requirements in regards to the sprinkler system and addressing repairs immediately -All staff will be trained on notifying management of any issues with sprinkler system and all repairs needed in the home -Program Supervisor will monitor at least three times weekly in the home -Program Director will monitor weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	10/05/2024

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	to prevent recurrence. NFPA 101 Corridor - Doors			
K S363 Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 4 client bedroom doors would latch into the door frame. This deficient practice could affect four clients. Findings include: Based on observations on 09/05/24 between 1:00 p.m. and 1:30 p.m. during a tour of the facility with the Program Supervisor, the client bedroom door #1 (west hall on left) would not latch into its door frame when tested several times. Based on interview at the time of observation, the Program Supervisor acknowledged that bedroom door #1 would not latch into its door frame. This finding was reviewed with the Program Supervisor during the exit conference. This deficiency was cited on 07/25/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S363	/p> /p> /p> /p> -All staff will be trained on reporting any safety issues in the home -Program Director and Program Supervisor will be trained on ensuring all safety issues are addressed -Program Director will monitor during weekly Site Supervisory visits Persons Responsible: Program Supervisor, Program Director, Area Director	10/05/2024