PRINTED: 05/11/2023

	T OF HEALTH AND HU					FORM APPROVED
	R MEDICARE & MEDIO  NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII TIDI I	E CONSTRUCTION		OMB NO. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			MPLETED
ANDILAN	or connection	15G300	B. WING	· -	<del>-</del> I	24/2023
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP C	OD	
TRANSI	TIONAL SERVICES	S SUB LLC		W PIKE ST RTINSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE	HOULD BE	COMPLETION
TAG	` `	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
E 0000						
Bldg						
		paredness Survey was	E 0000			
	1	ndiana Department of Health in				
	accordance with 42	2 CFR 483.475.				
	Survey Date: 04/2	1/23				
	Survey Date: 04/2	T/ 23				
	Facility Number: (	000819				
	Provider Number:					
	AIM Number: 100	2249100				
		Preparedness Survey,				
		es Sub LLC was found not in				
	-	mergency Preparedness				
	_	Medicare and Medicaid				
	483.475.	ders and Suppliers, 42 CFR				
	483.473.					
	The facility has eig	tht certified beds. At the time				
	of the survey, the c					
	Quality Review con	mpleted on 04/26/23				
E 0039	. , , ,	6.54(d)(2), 418.113(d)(2),				
B		2.15(d)(2), 483.475(d)(2),				
Bldg	, , , ,	.102(d)(2), 485.625(d)(2),				
	, , , ,	.727(d)(2), 485.920(d)(2),				
		1.12(d)(2), 494.62(d)(2)				
	EP Testing Requi	rements	1			

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

\*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)

(2), §491.12(d)(2), §494.62(d)(2).

TITLE (X6) DATE

Regional Director 05/08/2023 **Bret Beauchamp** 

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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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15G300		, ,	UILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 04/24/2023				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  110 W PIKE ST  MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE		
	(2) Testing. The [face exercises to test to annually. The [face following:  (i) Participate in a community-based (A) When a common to accessible, confunctional exercise.  (B) If the [face natural or man-man activation of the exercise is exempt from endercommunity-based functional exercise actual event.  (ii) Conduct an additional exercise is exempt from endercommunity-based functional exercise actual event.  (ii) Conduct an additional exercise (B) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise (B) A facilitator discussion using a clinically-relevant set of problem star messages, or preton challenge an exercises, and emexercises, and emexercises, and emexercises, and emexercises.	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15G300	B. W	ING		04/24	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	3			PIKE ST		
TRANSIT	TIONAL SERVICES	SUBILC			NSVILLE, IN 46151		
	T		-	<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	*[For Hospices at	· · -					
	, ,	spices that provide care in					
		e. The hospice must					
		s to test the emergency					
		ally. The hospice must do					
	the following:	a full-scale exercise that is					
	community based						
	1	nunity based exercise is not					
	` '	ict an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
	. ,	ency that requires activation					
		plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
		ctional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	' '	e year the full-scale or					
	•	e under paragraph (d)(2)(i)					
		conducted, that may					
	include, but is not	limited to the following:					
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise	e; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	mergency plan.					
	(0) = (1)						
	. ,	spices that provide inpatient					
	_	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		15G300	B. WI	NG		04/24/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			PIKE ST		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
	ı			ID	•		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	that is community-			IAG	2-2-1-1-1-1		DATE
		nunity-based exercise is not					
	` '	ct an annual individual					
		ctional exercise; or					
	-	experiences a natural or					
		ency that requires activation					
	_	plan, the hospice is					
		iging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	(ii) Conduct an ac	dditional annual exercise					
	that may include, I	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	_					
	functional exercise						
	(B) A mock disast						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
		rio, and a set of problem					
		ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.	conicolo reconones to and					
		ospice's response to and					
		ntation of all drills, tabletop nergency events and revise					
		ergency events and revise ergency plan, as needed.					
	ine nospice's enie	agonoy pian, as needed.					
	*IFor PRFTs at 84	41.184(d), Hospitals at					
	§482.15(d), CAHs						
	- , ,	PRTF, Hospital, CAH] must					
		to test the emergency					
		ır. The [PRTF, Hospital,					
	CAH] must do the						
	_	ın annual full-scale exercise					
	that is community-						
	_	unity-based exercise is not					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/24/2023		
NAME OF F	PROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZIP COD	)	
	ΓΙΟΝΑL SERVICES			PIKE ST NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL	LD BE ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	· ·	ct an annual individual,				
		ctional exercise; or				
		Hospital, CAH] experiences				
		or man-made emergency				
	-	ation of the emergency is exempt from engaging in				
		ull-scale community based				
	-	ty-based functional exercise				
		et of the emergency event.				
	_	an [additional] annual				
	, ,	at may include, but is not				
	limited to the follo					
		scale exercise that is				
	community-based	or individual, a				
	facility-based fund	ctional exercise; or				
	(B) A mo	ck disaster drill; or				
	(C) A tabletor	exercise or workshop that				
	•	or and includes a group				
	discussion, using					
	•	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er	· ·				
	. , ,	he [facility's] response to				
		umentation of all drills,				
		s, and emergency events				
	needed.	cility's] emergency plan, as				
	*[For PACE at §46	60.84(d):1				
		PACE organization must				
	· ,	to test the emergency				
	plan at least annu					
	organization must	-				
	-	an annual full-scale exercise				
	that is community					
	-	nunity-based exercise is not				
	' '	ct an annual individual,				
	facility-based fund	ctional exercise; or				
	(B) If the PACE ex	xperiences an actual natural				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<del></del>	COMPL	
		15G300	B. W	ING		04/24/	/2023
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		110 W F	PIKE ST		
TRANSIT	FIONAL SERVICES	SUB LLC		MARTIN	NSVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
		ergency that requires					
		mergency plan, the PACE					
	•	gaging in its next required					
		nity based or individual,					
		tional exercise following the					
	onset of the emer	gency event. In additional exercise every					
	` '						
		he year the full-scale or e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited to	-					
		scale exercise that is					
	` '	or individual, a facility					
	based functional						
	(B) A mock disas	•					
	' '	ercise or workshop that is					
		and includes a group					
	discussion, using	<del>-</del> .					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	_	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	*[For LTC Facilitie	- , , -					
		ty] must conduct exercises					
		ency plan at least twice per					
	1 .	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	_					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	•	ct an annual individual,					
	facility-based fund						
	. ,	ility] facility experiences an					
	actual natural or n	nan-made emergency that					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G300		ì	JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 04/24/2023				
	OF PROVIDER OR SUPPLIED SITIONAL SERVICES		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	LTC facility is exerequired a full-scalindividual, facility-following the onset (ii) Conduct an arthat may include, following:  (A) A second full-community-based based functional (B) A mock disas (C) A tabletop exled by a facilitator discussion, using clinically-relevant set of problem staressages, or preto challenge an er (iii) Analyze the [response to and rall drills, tabletop events, and revise emergency plan,  *[For ICF/IIDs at § (2) Testing. The leaver cises to test to twice per year. The following:  (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID of the instruction of the exercise is exempt from er is exempt from er	ster drill; or sercise or workshop that is sincludes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed.  \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the							

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G300		A. BUILDING COMPLETED B. WING 04/24/202					
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD		
TRANSIT	TIONAL SERVICES	SUB LLC			NSVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		ctional exercise following the		IAG			DATE
	onset of the emer	· ·					
		ditional annual exercise					
	that may include,	but is not limited to the					
	following:						
		scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mock disast	er drill; or ercise or workshop that is					
	1 ' '	and includes a group					
	discussion, using	<del>-</del> .					
		emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er						
	1 ' '	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise rgency plan, as needed.					
		rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	1	e HHA must do the					
	following:	£.II I					
		full-scale exercise that is					
	community-based	ommunity-based exercise					
	. ,	conduct an annual					
		based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual, tional exercise following the					
	onset of the emer						
	1	ditional exercise every 2					
	l ` ′	,					1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMP	ESURVEY LETED 1/2023
	PROVIDER OR SUPPLIER		110 V	T ADDRESS, CITY, STATE, ZIP COD V PIKE ST TINSVILLE, IN 46151	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION ID BE OPRIATE	(X5) COMPLETION DATE
	years, opposite the functional exercises of this section is continuous include, but is not (A) A second community-based facility-based facili	e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, tional exercise; or saster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan.  HA's response to and attain of all drills, tabletop mergency events, and revise ency plan, as needed.  36.360]  a OPO must conduct me emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cry scenario, and a set of tts, directed messages, or as designed to challenge an annuale emergency plan, the orm engaging in its next xercise following the onset				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	<del></del>	COMPL	
		15G300	B. W	NG		04/24/	2023
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the [RNHCI's and needed.	OPO's] emergency plan, as					
	exercises to test to RNHCI must do the (i) Conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enter the RNHCI's emel Based on record reversialed to conduct explan at least twice promoted to the following (i) Participate in an is community-based a. When a community-based a. When a community-based function b. If the ICF/IID fact that it is exempt for the interval of the enterval of the enterva	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a relevant emergency et of problem statements, so, or prepared questions enge an emergency plan. NHCI's response to and natation of all tabletop nergency events, and revise regency plan, as needed. View and interview, the facility nercises to test the emergency every ear. The ICF/IID facility ng: annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. Ceility experiences an actual de emergency plan, the ICF/IID form engaging its next required nunity-based or individual, cale functional exercise for 1 conset of the actual event. Ititional exercise that is or an individual, facility-based or individual, facility-based or individual, facility-based or individual, cale exercise that is or an individual, facility-based	E 00	039	- The Program Supervisor and Program Director will be trained complete emergency preparedness exercises that a community based, facility based or table top exercises at least annually ongoing.  -All staff will be trained on Emergency Preparedness Plater - Program Director and Program Supervisor will be trained on documentation of Emergency Preparedness plan and ensuring plan is in the home  -All staff trainings will be availating the home's safety book and employee files  -Documentation of the emergency preparedness exercises will be maintained in the home for immediate review at any time. Persons Responsible: Program Persons Responsible: Persons Responsible: Persons Responsible: Persons Responsible: Persons Responsible: Persons Responsible: Persons Responsibl	ed to are ed  n m able ency e	05/19/2023

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Event ID:

 $\begin{array}{cccc} \text{CNL021} & \text{Facility ID:} & \text{000819} & & \text{If continuation sheet} & \text{Page 10 of 22} \\ \end{array}$ 

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/24/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 110 W PIKE ST MARTINSVILLE, IN 46151				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facilitator that inclu a facilitator, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the IC maintain documenta exercises, and emer ICF/IID facility's er accordance with 42 deficient practice co Findings include:  Based on review of	se or workshop that is led by a des a group discussion led by a narrated, clinically-relevant b, and a set of problem a messages, or prepared to challenge an emergency  F/IID facility's response to and ation of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This buld affect all occupants.  the facility's Emergency on 04/24/23 between 11:30 a.m.			Supervisor, Program Director, Area Director		
	present, the facility preparedness docum incomplete. There is by the facility for a however, the facility documentation of at emergency prepared interview at the time. Supervisor agreed h documentation of at time of the survey.	n the Program Supervisor provided emergency mentation, however it was was documentation provided tornado drill dated 01/10/2023, y was unable to provide n additional exercise to test the dness plan. Based on e of record review, the Program he was unable to provide n additional exercise at the wiewed with the Program he exit conference.					
K 0000							
Bldg. 01	_	Recertification Survey was diana Department of Health in CFR 483.470(j).	K 0	000			

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Event ID:

CNL021 Facility ID: 000819

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED	
		15G300	B. W	ING	_	04/24	/2023	
				STREET A	DDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				PIKE ST			
TRANSIT	TIONAL SERVICES	SUB LLC	MARTINSVILLE, IN 46151					
(X4) ID		STATEMENT OF DEFICIENCIE		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)	TE	COMPLETION	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY		DATE	
	Survey Date: 04/24	1/23						
	Facility Number: 0	00819						
	Provider Number:							
	AIM Number: 1002	249100						
		Code survey, Transitional						
	,	was found not in compliance						
	_	for Participation in Medicaid, 3.470(j), Life Safety from Fire						
	_	n of the National Fire						
		ion (NFPA) 101, Life Safety						
	Code (LSC), Chapter 33, Existing Residential							
	Board and Care Occ	_						
	-	ity with a basement was fully						
	•	cility has a fire alarm system						
		in the attic and smoke						
		els including corridors,						
	-	g areas and the basement. The ty of eight and had a census						
	of eight at the time	· -						
	or orgin at the time (	or and survey.						
	Calculation of the E	Evacuation Difficulty Score						
		PA 101A, Alternative						
	~ ~	Safety, Chapter 6, rated the						
	facility Slow with a	n E-Score of 3.65.						
	Quality Review con	npleted on 04/26/23						
K S100	NFPA 101							
	General Requirem	nents - Other						
Bldg. 01	General Requirem							
_	2012 EXISTING							
	List in the REMAR	RKS section any LSC						
	Section 33.1 or 33	3.2 General Requirements						
		ssed by the provided						
	-	ficient. This information,						
	along with the app	olicable Life Safety Code or						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2023		
	PROVIDER OR SUPPLIEF		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST INSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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
	on Form CMS-256 Based on observation failed to ensure 3 or located in the facility monthly and the institution including the date as performing the inspector of Chapt 4.6.12.3 requires extend the public, such as a maintained or remoster for Portable Fire Extended Fire	on and interview, the facility of 3 portable fire extinguishers by were inspected at least spections were documented and initials of the person section. LSC 33.1.1.3 states the ser 4, General, shall apply. LSC sisting LSC features obvious to fire extinguishers, to be either and NFPA 10, the Standard stringuishers, 2010 Edition, ses fire extinguishers shall be anually or by means of an and device/system at a minimum  Where monthly manual ducted, the date the manual formed and the initials of the sthe inspection shall be sanual inspections are for manual inspections shall label attached to the fire inspection checklist or by an electronic method. pt to demonstrate that at least inspections have been ficient practice could affect all	K S100	The contractor will be contact for annual fire extinguisher inspection -Staff will be retrained on inspecting the portable fire extinguisher each month durit the monthly fire drill test and ensuring they are documenting that they have checked the extinguishers on the affixed inspection and maintenance to the Program Supervisor will be trained on ensuring fire extinguishers checked monthly and annual inspections are conducted by contractor  Responsible parties: Area Director, Program Director, Program Director, Program Director, Program Supervisor	ng g ags. ained are

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G300		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/24/2023	
	PROVIDER OR SUPPLIER		110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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
K S345	interview at the time Supervisor confirmed inspections on the thinspection tags.  This finding was rev Manager during the				
Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.7.5, 9.7.7, 9.7.8, Based on record rev failed to maintain 1	Prompt) m is tested and maintained m an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance adily available.	K S345	Fire Alarm system will be inspected by the contractor -Program Director and Progra	05/19/2023
	Section 9.6. NFPA unless otherwise pe inspections shall be the schedules in Tal required by the auth Table 14.3.1 states visually inspected s a. Control unit troub. Remote annuncia c. Initiating devices	72, Section 14.3.1 states that rmitted by 14.3.2, visual performed in accordance with ole 14.3.1, or more often if nority having jurisdiction. that the following must be emi-annually: ole signals tors  (e.g. duct detectors, manual at detectors, smoke detectors, iances		Supervisor will be trained on ensuring the fire alarm system inspected semi-annually and annually -Program Director and Progra Supervisor will ensure the inspections are in the safety to for review -Program Director and Progra Supervisor will ensure that an recommendations from the inspection are completed -Program Director will monitor weekly during Site Supervisor	n is am pook am ny

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	of Correction identification number 15G300	A. BUILDING B. WING	01	COMPLETED 04/24/2023
	PROVIDER OR SUPPLIER	110 W	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION  This deficient practice could affect all clients and	TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)  Visits	DATE
	staff. Findings include:		Persons Responsible: Area Director, Program Director, Program Supervisor	
K S353 Bldg. 01	Based on record review on 04/24/23 between 11:30 a.m. and 12:58 p.m. with the Program Supervisor present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. The most recent annual fire alarm inspection occured on 04/17/2023. Based on interview at the time of record review, the Program Supervisor confirmed there was no documentation for a semi-annual visual fire alarm system inspection during the past 12 months available for review.  This finding was reviewed with the Program Supervisor at the exit conference.  NFPA 101  Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt)  NFPA 13 and 13R Systems  All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25,		Program Supervisor	
	Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.  NFPA 13D Systems  Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G300		 UILDING	01	COMPI 04/24	LETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD		
TRANSIT	TIONAL SERVICES	SUB LLC		NSVILLE, IN 46151		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	inspected, tested		1710			DATE
	l '	he following requirements of				
	NFPA 25:					
	1. Control valves	s inspected monthly (NFPA				
	25, section 13.3.2	).				
	2. Gauges inspe	ected monthly (NFPA 25,				
	section 13.2.71).					
		s inspected quarterly				
	(NFPA 25, section	•				
		s tested semiannually				
	(NFPA 25, section	•				
	5. Valve supervisory switches tested					
	semiannually (NFPA 25, section 13.3.3.5).					
	6. Visible sprinklers inspected annually					
	((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA					
	25, section 5.2.2).					
	,	angers inspected annually				
	(NFPA 25, section					
	· ·	pected annually prior to				
		for adequate heat for water				
	filled piping (NFPA	A 25, section 5.2.5).				
	10. A representa	ative sample of fast				
		rs are tested at 20 years				
	(NFPA 25, section	,				
		ative sample of dry pendant				
		ed at 10 years (NFPA 25,				
	section 5.3.1.1.15	•				
		olutions are tested annually				
	(NFPA 25, section	es are operated through				
		d returned to normal				
		5, section 13.3.3.1).				
		tems of OS&Y valves are				
		y (NFPA 25, section				
	13.3.4).	- •				
	l '	stems extending into				
	unheated portions	of the building are				
	1	and maintained (NFPA 25,				
	section 13.4.4).					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		15G300	B. W	ING		04/24	/2023
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	· ·		110 W	PIKE ST		
TRANSI	TIONAL SERVICES	S SUB LLC		MARTII	NSVILLE, IN 46151		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	necessary mainte	system last checked and					
	l licocssary mainte	nance provided.					
	B. Show who prov	vided the service.					
	C. Note the source	e of the water supply for the					
	automatic sprinkle	er system.					
	(Provide in REMA	RKS information on					
	`	non-required or partial					
	automatic sprinkle	er system.)					
	33.2.3.5.3, 33.2.3	.5.8, 9.7.5, 9.7.7, 9.7.8,					
	and NFPA 25						
		review and interview, the	KS	353	Contractor will be contacted to		05/19/2023
		ovide written documentation or			inspect and test sprinkler syst	em	
		sprinkler system components			-All inspections in regards to	L.	
	_	and tested for 3 of 4 quarters. res any device, equipment or			safety will be kept in the Safet Book and the office	ıy	
	_	compliance with this Code be			-Program Director and Progra	m	
	1 -	rdance with applicable NFPA			Supervisor will ensure that	1111	
		nkler systems shall be properly			monthly gauge and valve che	cke	
		rdance with NFPA 25, Standard			will be completed	CNS	
		Testing, and Maintenance of			-Program Director and Progra	m	
	_	Protection Systems. NFPA 25,			Supervisor will ensure that all		
		ds shall be made for all			sprinkler heads are clean and		
	_	nd maintenance of the system			of obstruction		
	-	all be made available to the			-Program Director and Progra	m	
	authority having ju	risdiction upon request. 4.3.2			Supervisor will be trained on s		
	requires that record	s shall indicate the procedure			requirements in regards to the	)	
		spection, test, or maintenance),			sprinkler systeme		
	_	at performed the work, the			-All staff will be trained on not		
	· ·	e. NFPA 25, 5.2.5 requires that			management of any issues wi	th	
		evices shall be inspected			sprinkler system		
		they are free of physical			-Program Director and Progra	m	
	_	, 5.3.3.1 requires the mechanical			Supervisor will ensure the		
		evices including, but not limited			inspections are in the safety b	ook	
	_	ngs, shall be tested quarterly.			for review		
	_	ne-type and pressure ow alarm devices shall be			-Program Director and Progra		
		ow alarm devices shall be  7. This deficient practice could			Supervisor will ensure that an	У	
	l resieu seimannuani)	. This deficient practice could	1		recommendations from the		I

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		 JILDING	onstruction 01	(X3) DATE S COMPLI <b>04/24/</b> 2	ETED	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	•	
TRANSIT	ONAL SERVICES	SUB LLC		PIKE ST NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDER'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	affect all clients, sta	aff, and visitors in the facility.		inspection are completed		
	Findings include:			-Program Director will monitor weekly during Site Supervisor visits		
		view on 04/24/23 between 11:30				
	-	. with the Program Supervisor		Persons Responsible: Area		
		rinkler system inspection		Director, Program Director,		
	-	review was dated 04/17/2023.		Program Supervisor		
		urvey, there was no First				
		ebruary, March) of 2023, Third				
		ember) and Fourth (October,				
		per) 2022 quarterly sprinkler				
		eport available for review.  v at the time of record review,				
	the Program Superv					
		inkler system inspection				
	reports were not ava					
	reports were not ave	anasie for feview.				
	2. Based on record	review and interview, the				
	facility failed to ma	intain 1 of 1 automatic sprinkler				
	systems. LSC 9.7.5	requires all sprinkler systems				
	shall be inspected, t	tested, and maintained in				
	accordance with NF	FPA 25, Standard for the				
	Inspection, Testing,	, and Maintenance of				
		Protection Systems. NFPA 25,				
		on 4.1.4.1 states the property				
	· ·	d representative shall correct				
	-	es or impairments that are				
	•	spection, test and maintenance				
		ndard. Corrections and repairs				
	•	by qualified maintenance				
	-	ified contractor. NFPA 25,				
	-	ds shall be made for all naintenance of the system				
	-	all be made available to the				
	•	risdiction upon request. This				
		ould affect all residents, staff				
	and visitors.	outa urioot uri residents, starr				
	and fibroid.					
	Findings include:					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	· /	JILDING	instruction 01	(X3) DATE : COMPL <b>04/24</b> /	ETED
	PROVIDER OR SUPPLIEF			110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	TE	(X5) COMPLETION DATE
	Inspection document 04/24/23 between 1 provided sprinkler information regardisprinkler system states and 'Fail'. The other dated 04/17/23 did result. No document the anti-freeze in the temperature requires and test in the temperature requires and test in the temperature requires and test in the temperature of the facilian inspection documents systems in accordants of the Instantant of Wasystems, 2011 Editing auges on wet pipe inspected monthly to condition and that results in the temperature inspected, tested, and with Chapter 13. Secured with locks with applicable NF permitted to be inspected in the permitted to be inspected and is free of physic practice could affect.	Ithe facility's Sprinkler natation Program Supervisor on 1:30 a.m. and 12:58 p.m., the report dated 01/06/22 included ing the anti-freeze testing in the atting the solution tested 13F or available sprinkler inspection into show an Antifreeze test attation was available indicating in facilities sprinkler system met uirement after the 01/06/22 report.  The view, observation, and the failed to maintain monthly natation for 1 of 1 sprinkler ince with NFPA 25. NFPA 25, spection, Testing, and after-Based Fire Protection ion, Section 5.2.4.1 states sprinkler systems shall be not ensure that they are in good normal water supply pressure in Section 5.1.2 states valves a connections shall be and maintained in accordance ection 13.3.2.1.1 states valves for supervised in accordance ection 13.3.2.1.1 states valves or supervised in accordance PA standards shall be sected monthly. Section 3.3.18 is defined as a visual stem or a portion thereof to set to be in operating condition call damage. This deficient at all clients in the facility.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G300	ì	UILDING	nstruction  01	(X3) DATE COMPL 04/24/	ETED
	PROVIDER OR SUPPLIER			110 W F	DDRESS, CITY, STATE, ZIP COD PIKE ST ISVILLE, IN 46151		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
K S712	Supervisor on 04/24 12:58 p.m., there we monthly gauge and sprinkler system sin observation with the p.m., there were two on the sprinkler rise time of records revi confirmed that mon been documented sin	4/23 between 11:30 a.m. and as no documentation of a valve checks for the home's ace 07/05/2022. Based on a Program Supervisor at 12:59 to gauges and one control valve or. Based on an interview at the ew, the Program Supervisor thly gauge checks have not nnce 07/05/2022.					
Bldg. 01	least quarterly for under varied cond a. Ensure that a trained to perform b. Ensure that a familiar with the usemergency and diprocedures.  2. The facility muse a. Actually evacone drill each year b. Make special evacuation of clier disabilities; c. File a report a d. Investigate all drills, including acaction; and e. During fire drievacuated to a sa	Il personnel on all shifts are assigned tasks; Il personnel on all shifts are se of the facility's saster plans and st: uate clients during at least r on each shift; provisions for the nts with physical and evaluation on each drill; Il problems with evacuation cidents and take corrective area in facilities certified Care Occupancies Chapter					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
		15G300	B. W	B. WING 04/24/2023				
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					PIKE ST			
TRANSIT	TIONAL SERVICES	S SUB LLC		MARTII	NSVILLE, IN 46151			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	3. Facilities must	meet the requirements of						
		and (2) of this section for						
	. •, . ,	lief staff that they utilize.						
	42 CFR 483.470(	_						
		view and interview, the facility	KS	712	All staff will be trained on		05/19/2023	
		vacuation/fire drills at least	K S	/12		ortor	03/19/2023	
					completing fire drills every qua	ırter		
		shift of personnel and under			for each shift			
		for 1 of 12 fire drills. This			-Program Director and Progra	m		
	deficient practice a	ffects all staff and clients.			Supervisor will be trained on			
					ensuring fire drills are complet	:ed		
	Findings include:				every quarter			
					-Program Director and Progra	m		
	Based on records review with the Program Supervisor on 04/24/23 from 11:30 a.m. to 12:58				Supervisor will ensure that dril	ls		
					are placed in the safety book			
	p.m., the third shift	fire drill for the first quarter			-Program Director will monitor			
	_	, March) of 2023 was			through weekly Site Superviso			
		iew. Based on interview at the			Visits			
		ew, the Program Supervisor			-Program Supervisor will moni	tor		
		on of third shift fire drill for the			at least three times weekly du			
		of available for review at the			home visits	"'9		
	time of the survey.				Home visits			
	time of the survey.				Persons Responsible: Prograr	_		
	This finding was re	eviewed with the Program						
	_				Supervisor, Program Director,			
	Supervisor at exit of	conference.			Area Director			
K S762								
Bldg. 01								
	Based on record re	view and interview, the facility	KS	762	Program Supervisor and Prog	ram	05/19/2023	
	failed to maintain s	staffing levels for 1 of 8 clients			Director will ensure drills are			
	in accordance with	33.7.6 which states that staff			completed on all shifts and			
	shall be on duty in	the facility at all times when			monitor evacuation of all			
		evacuation assistance are			individuals			
		eient practice could affect 1			-Program Director and Program	m		
	client.	1			Supervisor will review the scho			
					ensuring that appropriate staff			
	Findings include:				levels are met	i9		
	i manigo meiade.					m		
	Rosed on massards ==	eview with the Program			-Program Director and Program			
		_			Supervisor will monitor emerg	БПСУ		
	Supervisor on 04/2	4/23 at 12:00 p.m., the F-1 forms			drills to ensure that any			

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		X3) DATE SURVEY COMPLETED 04/24/2023			
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				110 W F	ADDRESS, CITY, STATE, ZIP COD PIKE ST NSVILLE, IN 46151		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	needed full assistantevacuate for IV. Nee the F-1 form for the Considerable Attented Response to Instruct the time of record restated the facility is member during over that needs the assist during an evacuation	riewed with the Program			evacuations are completed in timely manner -Program Director will monitor through weekly Site Supervisor Visits  Persons Responsible: Program Supervisor, Program Director, Area Director	or m	

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