STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G300	A. BUILDING 01 B. WING	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	110 W PIKE ST MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 07/18/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/26/24 Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100 At this PSR 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 two story facility with a basement was fully sprinklered. The facility has a fire alarm system with heat detection in the attic and smoke detection on all levels including corridors, bedrooms, all living areas and the basement. The facility has a capacity of eight and had a census of six 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 .24. Quality Review completed on 08/28/24	K 0000		

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

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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K S100 Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to document 1 of 3 portable fire extinguishers located in the facility was subject to maintenance at intervals of not more than one year. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff in the basement. Findings include: Based on observation and interview with the Program Supervisor (PS) at 11:15 a.m. during a Post Survey Revisit on 08/26/24, he stated the portable fire extinguisher located in the basement had not had an annual inspection conducted since the survey on 07/18/24. The affixed maintenance tag indicated the latest annual inspection was done December of 2022. Based on interview at the time of observation, the PS	K S100	Contractor will be contacted for annual fire extinguisher inspection All extinguishers will be inspected in the home Program Director and Program Supervisor will be trained on ensuring that all fire extinguishers will be inspected monthly and an annual inspection completed All staff will be trained on use of the fire extinguishers in the home and reporting any issues including if a fire extinguisher has not been inspected Program Director will monitor fire extinguisher inspections during weekly visits in the home **Persons Responsible: Program Director, Program Supervisor, Area Director	09/26/2024

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	confirmed the fire extinguisher in the basement had its last annual inspection done over one year ago. This deficiency was cited on 07/18/24. The facility failed to implement a systematic plan of correction to prevent reoccurance. This finding was discussed with the Program Supervisor at exit conference.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, except as discussed in 14.2.1.1 and 14.2.1.4, an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review of quarterly sprinkler inspections that were not available for review at the annual survey on 07/18/24 with the Program Supervisor from 11:05 a.m. to 11:45 a.m. during a Post Survey revisit on 08/26/24; 'Deficiency Found 5 year internal' was noted on the 07/08/24	K S353	-Contractor will be contacted for internal pipe inspection -All inspections in regards to safety will be kept in the Safety Book and the office -Completed inspections will be reviewed to ensure the antifreeze has been tested -Program Director and Program Supervisor will ensure the inspections are in the safety book for review -Program Director and Program Supervisor will ensure that any recommendations from the inspection are completed -Program Director will monitor weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	09/26/2024

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	quarterly inspection. Based on interview at the time of record review, the Program Supervisor was not aware of any documentation regarding an internal pipe inspection for the facility's automatic sprinkler system within the most recent five year period. Based on observations at 11:47 a.m. with the Program Supervisor on 08/26/24, automatic sprinkler system piping in the basement was copper. This finding was reviewed with the Program Supervisor during the exit conference.			