STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155508	A. BUILDING -- B. WING	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/01/24 Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 At this Emergency Preparedness survey, Transcendent Healthcare of Boonville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 52. Quality Review completed on 04/09/24	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective April 26, 2024, to the state findings of the Life Safety Code and Emergency Preparedness survey conducted on April 1, 2024.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/01/24 Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 At this Life Safety Code survey, Transcendent	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective April 26,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin L McCarty	Executive Director	05/01/2024

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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	Healthcare of Boonville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 102 and had a census of 52 at the time of this survey. All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except two detached structures consisting of a garage used as a maintenance shop and maintenance storage, and a small cinder block shed used for facility storage and lawnmower storage. Quality Review completed on 04/09/24		2024, to the state findings of the Life Safety Code and Emergency Preparedness survey conducted on April 1, 2024.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks were readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with	K 0222	K 222 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now placed the appropriate signage on the door leaf adjacent to the release device in the direction of egress on the identified doors located on the north exit door on the Season's unit and the east exit door in the therapy department. The facility has also posted the key pad codes near the keypad of both identified doors. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential	04/26/2024

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	the Maintenance Supervisor, the following exit doors were equipped with magnetic locks with 15 second delayed egress: a. Season's Unit north exit door b. Therapy Unit east exit door These exit doors were not provided with signage that read, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. Furthermore, these exit doors did not have the code posted near the keypad to exit. When tested by the Maintenance Supervisor at the time of each observation, both doors did release from the magnetic holder when pushing on the panic bar and activating the 15 second delayed egress, and by pushing the code. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged these exit doors were not provided with the proper signage or had the code posted near the keypad. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 locked exit doors was readily and easily accessible for residents, staff, and visitors. This deficient practice could affect up to 5 residents, as well as staff and visitors in the Therapy Unit. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the Therapy Unit west exit door to the outside required heavy force		to be affected by this deficient practice. The therapy unit west exit door has now been adjusted and no longer requires heavy force to open the door. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide check of all doors with delayed egress locks were checked to ensure proper signage and key pad codes were posted. The doors were also checked to ensure that the doors opened smoothly with no heavy force required. No other issues were identified during this check of delayed egress locks. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to the use of delayed egress locks, including the use of proper signage and the posting of key pad codes. The staff was also re-educated on their responsibility for checking these doors for proper functioning to ensure they open freely without any heavy force required. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as	

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	to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force to open. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the exit door required heavy force to open. This finding were reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		part of the facility's preventative maintenance program all delayed egress door locks will be checked to ensure proper signage and key pad codes are in place and that the doors are functioning properly and open freely without any heavy force required. These checks will be completed by the maintenance supervisor and/or their designee monthly and documented in the facility's preventative maintenance log. This practice will be on on-going process.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 11 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 20 residents as well as staff and visitors. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the southwest hall	K 0281	K 281 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified all residents, staff and visitors have the potential to be affected by this deficient practice. The double light fixture on the southwest hall side exit door (east exit) has now been repaired and has two light bulbs in the light socket to ensure proper lighting. *The corrective action taken for the other residents that have the*	04/26/2024

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	side exit discharge (east exit) had a double light fixture, however, one of the light bulbs was missing and had a door alarm cord plugged into the empty light socket. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A check of all eleven exit means of egress have now had the lighting fixtures checked to ensure they each have two functioning light bulbs in place to ensure proper lighting. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to the illumination of means of egress. The staff was re-educated on the regulation to ensure they understood that each lighting fixture is required to have two functioning light bulbs in the lighting fixture. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program each exit means of egress will be checked monthly to ensure that both light bulbs in the lighting fixtures are in place and functioning properly. These checks will be completed by the maintenance supervisor and/or their designee monthly and documented in the facility's preventative maintenance log. This practice will be an on-going process.	

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K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 doors to a courtyard could not be mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect mostly staff at the time of the survey because the Season's Unit is currently closed to residents. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the Season's Unit outside door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Supervisor said this door was not a required exit and agreed there should be a "NO EXIT" sign on the door. This finding was reviewed with the Administrator	K 0293	K 293 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all staff have the potential to be affected by this deficient practice. The facility has now placed the appropriate NO EXIT signage at the courtyard door on the Season's Unit. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All doors leading to a courtyard area that are not an exit have now been checked and have the appropriate NO EXIT signage properly posted at the door. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	04/26/2024

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	and Maintenance Supervisor during the exit conference. 3.1-19(b)		been provided for all maintenance staff on the regulation related to exit signage. The staff was re-educated on the requirement related to the posting of NO EXIT signage on all doors leading to a courtyard that are not considered to be a facility exit. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program all none exit doors are checked monthly to ensure the proper NO EXIT signage is in place. These checks will be completed by the maintenance supervisor and/or their designee monthly and documented in the facility's preventative maintenance log. This practice will be an on-going process.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a laundry dryer room door, would close completely and latch automatically. This deficient practice could affect staff while in the laundry room or adjacent service hall rooms. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the laundry dryer room door to the service corridor was provided with a self closing device, however, the door would not close completely and latch automatically when tested several times, furthermore, the door could not be closed fully even with heavy force. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and agreed the laundry dryer room door to the service corridor would not close	K 0321	K 321 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, facility staff members have the potential to be affected by this deficient practice. The identified laundry dryer room door has now been repaired. The laundry dryer room door now closes completely without force and latches automatically into the door frame. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this	04/26/2024

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	completely and latch automatically or with force. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		deficient practice. A housewide check of all hazardous area doors has been completed to ensure that these doors close completely without force and latch automatically into the door frame. No other issues were identified during this check of the hazardous area doors. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to hazardous area enclosures to ensure that the staff is knowledgeable on the requirements to ensure that these doors close completely without force and latch automatically into the door frame. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program all hazardous area door closures will be checked monthly to ensure that the doors close completely without force and latch automatically into the door frame. These checks will be completed by the maintenance supervisor and/or their designee monthly and documented in the facility's preventative maintenance log. This practice will be an on-going process.	

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K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure 1 of 9 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect mostly up to 5 residents and staff while in the Physical Therapy Gym. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was a one and a half foot by one and a half foot plywood attic access panel in the Physical Therapy Gym office. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the plywood attic access panel did not have a flame spread rating as far as he knew.	K 0331	K 331 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents receiving therapy and facility staff have the potential to be affected by this deficient practice. The attic access panel has now been replaced with a ¾ inch fire resistance drywall attic access panel. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide check has been completed on all smoke compartments to ensure that all interior wall and ceiling areas have a flame spread rating of Class A or Class B. No other	04/26/2024

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	This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		issues were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to interior wall and ceiling finish fire rating requirements. The staff was re-educated on the requirements that all interior wall and ceiling areas must have a Class A or Class B fire rating finish. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the interior surfaces of the facility to ensure they meet the required flame spread rating of class A or B. This tool will be completed by the Environmental Services supervisor and/or their designee monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 04/01/24 between 9:00 a.m. and 12:30 p.m. with the Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 05/26/23 by the facility's fire alarm inspection vendor, furthermore, there were quarterly inspections available dated 08/02/23, 11/06/23, and 02/20/24 by the facility's fire alarm inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors and heat detectors. The facility's pull	K 0345	K 345 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility now has documentation on file from the fire alarm inspection vendor that includes the semi-annual visual inspection of the facility's fire alarm devices, including the visual inspection of smoke and heat detectors. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility now has documentation on file from the fire alarm inspection vendor that includes the semi-annual visual inspection of the facility's fire alarm devices, including the visual inspection of smoke and heat detectors. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	04/26/2024

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	stations were tested during each quarterly inspection. Based on interview at the time of record review, the Maintenance Supervisor agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors and heat detectors. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		been provided for all maintenance staff on the regulation related to the testing and maintenance of the facility's fire alarm system. The staff was re-educated on the required documentation of these inspections including the semi-annual visual inspection of the facility's fire alarm devices, such as smoke and heat detectors. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* Executive Director will now be responsible for reviewing the documentation on the semi-annual visual fire alarm system inspection to ensure that all components of the fire alarm system have been inspected and the findings documented in the inspection report. The Executive Director will be responsible for taking immediate action if the inspection report does not meet the requirement.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.			

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	9.6.1.6 Based on record review and interview, the facility failed to provide a complete and accurate written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 04/01/24 between 9:00 a.m. and 12:30 p.m. with the Maintenance Supervisor present, the facility provided fire watch documentation, however, it was incomplete and not accurate. The plan failed to include or was inaccurate with the following information: a. Contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway. b. Indicating the person conducting the fire watch has been properly trained. c. The plan says "If the fire alarm system is out of service for 10 hours in a 24 hour period", when the requirement is 4 hours or more in a 24 hour period. d. The plan still includes contacting the facility's former fire alarm system vendor (Vanguard), which has not been around for over three years, instead of the facility's current fire alarm system vendor. Based on an interview at the time of record review, the Maintenance Supervisor confirmed the fire watch documentation provided lacked, or was inaccurate of the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit	K 0346	K 346 F *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by the deficient practice. The facility has reviewed and revised their fire watch policy and procedure which is now complete and accurate. All staff members have been educated on the revised policy. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has reviewed and revised their fire watch policy and procedure which is now complete and accurate. All staff members have been educated on the revised policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff members on the revised facility fire watch policy. All staff members have been re-educated on their responsibility in conducting a fire watch should the facility's fire alarm system be out of service. *The corrective action taken to*	04/26/2024

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	conference. 3.1-19(b)		*monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for reviewing the Fire Watch policy annually to ensure that all components are complete and accurate and will also be responsible for scheduling a mandatory annual in-service for all staff on the fire watch policy.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 2 of 2 overhang canopies. NFPA 13-2010 Edition,	K 0351	K 351 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no	04/26/2024

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	Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect at least 5 residents, staff, and visitors. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was a 8 foot by 6 foot canvas canopy not sprinkled and attached to the building outside each of the following locations: a. Season's Unit courtyard door b. Therapy Unit east entrance/exit door Based on interview at the time of each observation, the Maintenance Supervisor acknowledged there was no sprinkler coverage under the canvas canopy and further said there was no flame spread documentation for the canvas canopy's that he knew of. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility was able to locate the supportive documentation that the two canopies outside the seasons' unit and the therapy unit were treated with a fire-retardant material prior to installation. That supportive documentation is now on file at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility was able to locate the supportive documentation that the two canopies outside the seasons' unit and the therapy unit were treated with a fire-retardant material prior to installation. That supportive documentation is now on file at the facility. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulations related to sprinkler system installation with a focus on ensuring that all materials utilized meet the necessary fire-retardant guidelines as set forth in the regulation. *The corrective action taken to*	

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			monitor to ensure the deficient practice will not recur is that the Executive Director will now be responsible for reviewing any and all materials utilized in the facility to ensure that they meet or exceed the sprinkler system installation guidelines, including the use of only fire-retardant materials when warranted by the regulation.	
K 0353 SS=F 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 automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 2 of 3 sprinkler system gauges on 1 of 1 sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire	K 0353	K 353 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents,	04/26/2024

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	Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, two of three sprinkler gauges on the sprinkler system riser had a date of 2015 which was four years past due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. Based on interview at the time of the observation, the Maintenance Supervisor confirmed the sprinkler system gauges had not been recalibrated within the most recent five year period and would have the gauges replaced as soon as possible. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure one sprinkler head in 1 of 9 smoke compartments partially covered with corrosion was replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of		staff and visitors have the potential to be affected by this deficient practice. The sprinkler system gauges on the sprinkler system riser have now been repaired and tested by comparison with a calibrated gauge. The documentation of this testing is now on file at the facility. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The corroded sprinkler head identified in the therapy gym shower room has now been replaced and is free of corrosion. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All sprinkler system gauges on the sprinkler system riser have now been calibrated and are in good functioning order. A housewide check of all sprinkler heads has been completed. All sprinkler heads are now in good condition and free of any corrosion. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	

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	the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was one sprinkler head in the Therapy Unit shower room partially covered with green corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the sprinkler head in the Therapy Unit shower room was partially covered with green corrosion and should be replaced. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		been provided for all maintenance staff on the regulation related to the maintenance and testing of the sprinkler system. The staff was re-educated on their responsibility on ensuring that all required maintenance and testing of the sprinkler system and its components is completed in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program, the sprinkler system maintenance checks and testing are being completed as required by the regulation and the findings documented in the preventative maintenance logs. These checks will be completed by the maintenance supervisor and/or their designee weekly. This is an on-going process.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the			

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	building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete and accurate written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 04/01/24 between 9:00 a.m. and 12:30 p.m. with the Maintenance Supervisor present, the facility provided fire watch documentation, however, it was incomplete and not accurate. The plan failed to include or was inaccurate with the following information: a. Contacting the Indiana Department of Health (IDOH) with the web link for contacting the	K 0354	K 354 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by the deficient practice. The facility has reviewed and revised their fire watch policy and procedure which is now complete and accurate. All staff members have been educated on the revised policy. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has reviewed and revised their fire watch policy and procedure which is now complete and accurate. All staff members have been educated on the revised policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff members on the revised facility fire watch policy. All staff members have been re-educated on their	04/26/2024

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	Incident Reporting System located on the IDOH Gateway. b. Indicating the person conducting the fire watch has been properly trained. c. The plan says "If the fire alarm system is out of service for 10 hours in a 24 hour period". The plan did not mention if the sprinkler system is out of service for 10 hours in a 24 hour period. d. The plan still includes contacting the facility's former fire alarm system vendor (Vanguard), which has not been around for over three years, instead of the facility's current sprinkler system vendor. Based on an interview at the time of record review, the Maintenance Supervisor confirmed the fire watch documentation provided lacked, or was inaccurate of the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		responsibility in conducting a fire watch should the facility's sprinkler system be out of service. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for reviewing the Fire Watch policy annually to ensure that all components are complete and accurate and will also be responsible for scheduling a mandatory annual in-service for all staff on the fire watch policy.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure electrical wiring was protected in 1 of 9 smoke compartments. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely	K 0511	K 511 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified	04/26/2024

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	cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect at least 10 residents and staff. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, there was a wall mounted electrical receptacle in the northeast corridor outside resident room 9 that was loose and protruding outward a half inch. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the loose cover from the electrical receptacle on the wall in the northeast corridor and said he would correct it by the end of the day. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a junction box in 1 of 9 smoke compartments was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect mostly staff in the basement. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with		during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The wall mounted electrical receptacle in the northeast corridor outside room 9 is now securely affixed to the wall. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all staff members have the potential to be affected by this deficient practice. The junction box located in the ceiling/floor joist space in the basement now has the appropriate cover in place so that no wiring is exposed. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide check of all electrical receptacles, switches and junction boxes has been conducted. All electrical receptacles, electrical switches and junction boxes are now securely covered to prevent the exposure to any electrical wiring. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to	

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	the Maintenance Supervisor, there was an electrical junction box observed in the ceiling/floor joist space in the basement with no cover plate and several exposed wires. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the junction box with several exposed electrical wires was not provided with a junction box cover. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		utilities, gas and electric. The staff have been re-educated on their responsibility to ensure all electrical receptacles, switches, and junction boxes are properly covered and secured to prevent the possible exposure to any electrical wiring. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the electrical receptacles, switches and junction boxes to ensure that they are securely mounted and properly covered to prevent the possible exposure to the electrical wiring. This tool will be completed by the maintenance supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed by the Executive Director to determine if any additional action is warranted.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected.			

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	* takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure intake combustion air from the outside was provided in 1 of 3 rooms/areas containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for mostly staff in the laundry dryer room, service corridor, and other adjacent rooms. Findings include: Based on observations on 04/01/24 between 12:30 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the the dryer room within the laundry room had two fuel fired dryers that had no fresh air vent for intake combustion air from the outside provided for this enclosed room. Based on interview at the time of observation, the Maintenance Supervisor confirmed there was no fresh air vent in the dryer room. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0522	K 522 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all staff have the potential to be affected by this deficient practice. The facility has now ordered a vent/louver system that will be installed in the laundry room window that will open automatically when the dryers are running. The earliest that this vent louvered system is available from the vendor is 05-03-24. The device will be immediately installed upon receipt from the vendor. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* no residents have the potential to be affected by this deficient practice however, all staff members have the potential to be affected by this deficient practice. The facility has now ordered a vent/louver system that will be installed in the laundry room window that will open automatically when the dryers are running. The earliest that this vent louvered system is available from the vendor is 05-03-24. The device will be immediately installed upon receipt from the vendor.	05/03/2024

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			The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all maintenance staff on the regulation related to HVAC – any heating device. The staff will be educated on the care and maintenance of the vent/ louvered system on 05-03-24 and instructed on their responsibilities to ensure that the device continues to function properly. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program, checks will be made weekly by the maintenance supervisor and/or their designee to ensure that the vent/louvered system in the laundry room is functioning properly. These weekly checks will be recorded in the facility's preventative maintenance log.	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event			

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	of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete and accurate written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:	K 0711	K 711 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire safety plan to include the following; the location of the smoke barriers throughout the facility, how the staff is to respond to activated battery operated smoke alarms, the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, the removal of wheeled equipment from the egress corridors in the event of an emergency and the transmission of the alarm to the fire department. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all	04/26/2024

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Plan on 04/01/24 between 9:00 a.m. and 12:30 p.m. with the Maintenance Supervisor present, the document was a generic plan and did not address the following items: a. The plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility. b. Staff response to battery operated smoke alarms in resident rooms and a few other locations. c. Use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. d. Removal of wheeled equipment from the egress corridors in the event of an emergency. e. The transmission of the alarm to the fire department. Based on interview at the time of record review, the Maintenance Supervisor acknowledged and agreed that the Fire Plan was a generic plan and did not address the previously mentioned items. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire safety plan to include the following; the location of the smoke barriers throughout the facility, how the staff is to respond to activated battery operated smoke alarms, the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, the removal of wheeled equipment from the egress corridors in the event of an emergency and the transmission of the alarm to the fire department. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all facility staff on the revised fire safety plan. The staff members have been educated on the changes/additions to the fire safety plan to ensure their knowledge level and to ensure each member understands their responsibilities in the case of a fire. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program fire drills will be conducted in accordance with the regulations and will monitor the staff knowledge level on how to	

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			properly respond to a fire and/or fire drill. This will be an on-going process.	