STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155502	A. BUILDING -- B. WING	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	7336 W STATE ROAD 165 OWENSVILLE, IN 47665

(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: 04/30/24 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Emergency Preparedness survey, Transcendent Healthcare of Owensville was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. At the time of the survey, the census was 50. Quality Review completed on 05/03/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	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 05/16/2024 to the state findings of the Life Safety Code Recertification, State Licensure and Emergency Preparedness survey conducted on April 30, 2024.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melinda Preusz	Executive Director	05/20/2024

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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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review was 2021 (no exact date provided). Based on interview at the time of review, the Maintenance Assistant confirmed the Emergency Preparedness plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.	E 0004	E 004 *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 reviewed and updated the facility's emergency preparedness plan. The facility will continue to review and update the emergency preparedness plan at least annually and more often if warranted. *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 now reviewed and updated the facility's emergency preparedness plan. The facility will continue to review and update the emergency preparedness plan at least annually and more often if warranted. *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 the Executive Director and the maintenance supervisor on the requirement of reviewing and updating the	05/16/2024

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			emergency preparedness plan at least annually and more often if warranted. The staff was also re-educated on their responsibility to ensure that all staff members are in-serviced on any and all changes in the facility's emergency preparedness plan. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the environmental supervisor to ensure that the facility's emergency plan has been reviewed and updated at least annually. The review will be documented with the Executive Director's and maintenance supervisor's signatures and the date of when the review was conducted.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)			

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	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk			

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	assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a)(1) and 42 CFR 483.73(a)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, facility-based and community-based risk hazards were addressed in the plan, however, there was no facility-based and community-based risk assessment utilizing an all-hazards approach	E 0006	E 006 *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 conducted a facility based and community based risk assessment utilizing an all hazards approach, including missing clients and including strategies for addressing emergency events identified by the risk assessment. *The corrective action taken for the other residents that have the potential to be affected by the*	05/16/2024

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	available for review. Based on interview at the time of record review, the Maintenance Assistant agreed the facility-based and community-based risk assessment utilizing an all-hazards approach was not available for review. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.		*same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a facility based and community based risk assessment utilizing an all hazards approach, including missing clients and including strategies for addressing emergency events identified by the risk assessment. *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 the Executive Director and the maintenance supervisor on the regulation requiring that the facility conduct a facility based and community based risk assessment utilizing an all hazards approach. The Executive Director and the maintenance supervisor will be responsible for the completing this assessment and then maintaining a complete emergency preparedness plan based on the results of this assessment. The Executive Director and the maintenance supervisor were instructed on their responsibility to ensure the plan is reviewed at least annually to ensure that all identified hazards have appropriately been addressed. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an	

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			audit will be conducted quarterly by the Executive Director and the environmental supervisor to ensure all risk hazards have been identified and that there are strategies developed and implemented for addressing all emergency events identified in the risk assessment. The review will be documented with the Executive Director's and maintenance supervisor's signatures and the date of when the review was conducted.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies			

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	and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 2021 (no exact date provided). Based on interview at the time of review, the Maintenance Supervisor confirmed the policies and procedures within the Emergency Preparedness plan have not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.	E 0013	E 013 *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. All emergency preparedness policies and procedures have now been reviewed and revised if warranted. The emergency preparedness policies and procedures will now be reviewed and revised at least annually by the Executive Director and the facility's management team. *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 emergency preparedness policies and procedures have now been reviewed and revised if warranted. The emergency preparedness policies and procedures will now be reviewed and revised at least annually by the Executive Director	05/16/2024

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			and the facility's management team. *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 the Executive Director and the maintenance supervisor on the requirement to review and revise if warranted all policies and procedures related to the facility's emergency preparedness plan. The E.D. and maintenance supervisor will now annually review all emergency preparedness policies and procedures and update those policies as warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the environmental supervisor to ensure that the emergency preparedness policies and procedures are current and have been reviewed at least annually. The review will be documented with the Executive Director's and maintenance supervisor's signatures and the date of when the review was conducted.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan			

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	§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility's Emergency Preparedness plan did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 2021 (no exact date provided). Based on interview at the time of review, the Maintenance Assistant confirmed the Communication Plan within the Emergency Preparedness plan has not been reviewed and updated within the past twelve month period.	E 0029	E - 029 *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's emergency preparedness communication plan has now been reviewed and updated as warranted. The communication plan will be reviewed at least annually by the facility's Executive Director and the maintenance supervisor. *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's emergency preparedness communication plan has now been reviewed and updated as	05/16/2024

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	This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.		warranted. The communication plan will be reviewed at least annually by the facility's Executive Director and the maintenance supervisor. *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 the Executive Director and the maintenance supervisor on the requirement to review and update the facility's communication plan at least annually. The Executive Director and the maintenance supervisor were instructed on their responsibility to review the facility's communication plan at least annually and revise the communication plan when warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the environmental supervisor to ensure that the facility's emergency preparedness communication plan is current. Updates to the plan will be made when warranted. The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	
E 0036 SS=F	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d),			

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	155502	A. BUILDING -- B. WING	04/30/2024

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Bldg. --	484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program			

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	must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include:	E 0036	E 036 *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	05/16/2024

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	Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 2021 (no exact date provided). Based on interview at the time of review, the Maintenance Assistant confirmed the training and testing policy and procedure within the Emergency Preparedness plan has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.		practice. The facility's emergency preparedness training and testing program has now been reviewed and revised as warranted. *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's emergency preparedness training and testing program has now been reviewed and revised as warranted. *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 the Executive Director and the maintenance supervisor on the requirement to conduct an annual review of the facility's emergency preparedness training and testing program. The Executive Director and maintenance supervisor was re-educated on their responsibility for ensuring that the facility's emergency preparedness training and testing program is complete and addresses the responsibilities of each staff member during any emergency event. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the maintenance supervisor on the review of the facility's emergency	

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			preparedness training and testing program to ensure that the program is current and complete. The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §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). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required			

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	community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based			

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	functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or			

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	(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a			

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	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

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	(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and			

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	maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility.	E 0039	E 039 *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 conducted a table top exercise to test the facility's emergency preparedness plan. *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 now conducted a table top exercise to test the facility's emergency preparedness plan. *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 the Executive Director and the maintenance supervisor on the requirement to conduct a testing of the facility's emergency preparedness plan at least twice annually. The Executive Director and the maintenance supervisor have been re-educated on their responsibility to conduct the testing of the facility's emergency preparedness	05/16/2024

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	155502	A. BUILDING -- B. WING	04/30/2024

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	Findings include: Based on review of the Emergency Preparedness plan on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility was able to provide documentation of an actual event involving a tornado warning on 04/02/24, however, the facility was unable to provide documentation of a second exercise conducted during the past 12 month period. Based on interview at the time of record review, the Maintenance Assistant confirmed there was no documentation of a second exercise conducted during the past 12 month period. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.		plan at least twice a year and document the testing as well as the outcome of these testings. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the maintenance supervisor on the required documentation of the exercises conducted at least twice annually of the testing of the facility's emergency preparedness plan. The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with			

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	the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of			

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	this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system	E 0041	E 041 *The corrective action taken for*	05/16/2024

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	inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. Based on interview at the time of record review, the Maintenance Assistant said the generator did run for more than four hours under load during a long power outage at the facility during the past 12 month period, however, it was not documented. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference.		*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 successfully conducted the required four hour load test of the emergency power generator. *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 now successfully conducted the required four hour load test of the emergency power generator. *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 the Executive Director and the maintenance supervisor on the required inspections, testing and maintenance requirements of the facility's emergency power system. The Executive Director and the maintenance supervisor have been re-educated on their responsibilities related to this requirement as well as their responsibility to ensure that complete and accurate documentation of all inspections, testing and maintenance of the	

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			facility's emergency power system is maintained in the emergency preparedness binder for inspection by the authorities. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the maintenance supervisor of the required documentation of the inspections, testing and maintenance of the facility's emergency power system to ensure all required documents are completed timely and available for inspection by the authorities. The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	
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: 04/30/24 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent Healthcare of Owensville was found not in compliance with Requirements for Participation in	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 05/16/2024 to the state findings of the Life Safety Code Recertification, State	

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	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 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 68 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/03/24		Licensure and Emergency Preparedness survey conducted on April 30, 2024.	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			

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	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing system would provide complete coverage over the entire cooking area. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice could affect mostly kitchen staff, plus all residents while in the dining room which was adjacent to and in the same smoke compartment as the kitchen. Findings include: Based on observations on 04/30/24 between 1:45 p.m. and 3:00 p.m. during a tour of the kitchen with the Maintenance Assistant and Dietary Manager, the five extinguishing nozzles under the kitchen range hood were all pointed to the wall behind the cook top stove, grill, and deep fryer and not pointed directly to the cooking appliances. Based on interview at the time of observation, the Maintenance Assistant and Dietary Manager agreed the range hood extinguishing nozzles were not pointed to the kitchen appliances. Furthermore, the Dietary Manager called the range hood inspection vendor and said they would be in the facility the next day to correct the issue.	K 0324	K 324 *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 and staff in the dining area plus all dietary staff have the potential to be affected by this deficient practice. The kitchen range hood has now been repaired and the range hood extinguishing nozzles are now pointed to the cooking appliances. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff in the dining area plus all dietary staff have the potential to be affected by this deficient practice. The kitchen range hood has now been repaired and the range hood extinguishing nozzles are now pointed to the cooking appliances. *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 the maintenance supervisor and all dietary staff on requirements of the kitchen's	05/16/2024

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	This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b)		range hood extinguishing system. The staff was re-educated on the need for kitchen range hood nozzles to be pointed to the entire cooking surface to provide complete coverage. *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 kitchen range hood extinguishing system will be inspected monthly by the maintenance supervisor and/or their designee to ensure that the device is functioning properly and is providing complete coverage of the cooking area. The documentation of these monthly inspections will be maintained in the preventative maintenance binder for inspection by the authorities.	
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, 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 1. Based on record review and interview, the facility failed to ensure the annual testing of all devices connected to 1 of 1 fire alarm system was	K 0345	K 345 *1.) The corrective action taken for those residents found to have*	05/16/2024

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	performed. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device		*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's fire alarm system vendor has now completed an annual inspection of the facility's fire alarm system in accordance with the regulation. This inspection includes a visual inspection and functional testing of all devices connected to the fire alarm system. Documentation of this inspection is now on file in the facility's preventative maintenance binder for review by the authorities. *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 facility fire alarm system vendor has now completed a semi-annual visual inspection of all smoke detectors 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's fire alarm system vendor has now conducted an annual visual	

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	abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility did have quarterly fire alarm system inspections documentation from its fire alarm system vendor which were performed on 07/05/23, 09/15/23, and 04/24/24. These inspections were listed as quarterly inspections of the fire alarm system. There was no annual fire alarm system inspection documentation available for review which included a visual inspection and functional test of all devices connected to the fire alarm system. Based on interview at the time of record review, this was confirmed by the Maintenance Assistant. Furthermore, after calling the facility's fire alarm system vendor, the Maintenance Assistant was notified that the annual fire alarm system inspection/test was supposed to be performed in December 2023, but was never performed. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b) 2. 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		inspection and functional testing of all devices connected to the facility's fire alarm system. This inspection included the visual inspection and testing of all smoke detectors and heat detectors. Documentation of this inspection is now on file in the facility's preventative maintenance binder for review by the authorities. *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 the maintenance supervisor on the required testing and maintenance of the facility's fire alarm system. The supervisor was re-educated on all components of the required visual inspections and testing of all components/devices that are connected to the facility's fire alarm system. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted by the Executive Director and the maintenance supervisor on the documentation of the inspections, testing and maintenance of the fire alarm system. These quarterly audits will be conducted to ensure that all the required visual inspections, testing of all devices connected to the fire alarm system and maintenance of the fire alarm system are documented in accordance with the regulation.	

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	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 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, there was documentation provided regarding quarterly fire alarm system inspections dated 07/05/23, 09/15/23, and 04/24/24 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 stations were tested during each quarterly inspection. Based on interview at the time of record review, the Maintenance Assistant 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, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b)		The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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	155502	A. BUILDING 01 B. WING	04/30/2024

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Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants.	K 0353	K 353 *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 appropriate FDC signage has now been placed on the front of the facility and on the east side of the facility to ensure the fire department prompt access to the fire department connection. *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	05/16/2024

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	Findings include: Based on observations on 04/30/24 between 1:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Assistant, the facility's fire department connection (FDC) was located on the east side of the facility. There was no FDC signage provided at the fire department connection, furthermore, there was no FDC signage at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Assistant who agreed there should be FDC signage at the FDC and the front of the facility. This finding was reviewed with the Administrator, Maintenance Assistant and six staff members during the exit conference. 3.1-19(b)		deficient practice. The appropriate FDC signage has now been placed on the front of the facility and on the east side of the facility to ensure the fire department prompt access to the fire department connection. *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 the maintenance supervisor on the required signage to ensure the fire department prompt access to the facility's fire department connection. The maintenance supervisor was re-educated on their responsibility to ensure that the FDC connection signage remain clearly visible on the facility for the responding fire department to give immediate access to the fire department connection. *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 maintenance supervisor and/or their designee will visually inspect the FDC signage monthly to ensure it remains clearly visible to any responding fire department for immediate access to the fire department connection. These visual inspections will be documented in the facility's preventative maintenance binder monthly for inspection by the	

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K 0761 SS=F Bldg. 01	Based on record review, observation and interview, the facility failed to maintain 2 of 2 rolling fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants while in the dining room. Findings include: Based on record review on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the annual rolling fire door inspection dated 07/05/23 indicated both rolling fire doors between the kitchen and dining room failed the inspection. The Maintenance Assistant was able to provide a vendor report dated 08/23/23 indicating two new rolling fire doors have been ordered to replace the current rolling fire doors. Based on interview at the time or record review, the Maintenance Assistant said the new rolling fire doors have been on back order but was told by the vendor that a June 2024 date was expected for the rolling fire doors to be delivered to the	K 0761	authorities. K 761 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no residents were identified during the survey, all occupants in the dining room have the potential to be affected by this deficient practice. The facility has now secured the two rolling fire doors between the kitchen and the dining room so that they can no longer be utilized. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all occupants in the dining room have the potential to be affected by this deficient practice. The facility has now secured the two rolling fire doors between the kitchen and the dining room so that they can no longer be utilized. *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 the maintenance supervisor and the dietary staff on the modification of the two rolling fire doors between the dining room and the kitchen. The two rolling fire doors have now been secured and the staff will no longer be able	05/16/2024

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	facility. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b)		to utilize these rolling fire doors. *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 maintenance supervisor and/or their designee will check the two rolling fire doors between the kitchen and the dining room monthly to ensure that the doors remain securely closed and can no longer be utilized. These checks will be documented in the facility's preventative maintenance binder for review by the authorities.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

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	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/30/24 between 9:45 a.m. and 1:45 p.m. with the Maintenance Assistant present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past	K 0918	K 918 *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 successfully conducted the required four hour load test of the emergency power generator. *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 now successfully conducted the required four hour load test of the emergency power generator. *The measures that have been put into place to ensure that the*	05/16/2024

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	36 month period. Based on interview at the time of record review, the Maintenance Assistant said the generator did run for more than four hours under load during a long power outage at the facility during the past 12 month period, however, it was not documented. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b)		*deficient practice does not recur is that* a mandatory in-service has been provided for the Executive Director and the maintenance supervisor on the required inspections, testing and maintenance requirements of the facility's emergency power system. The Executive Director and the maintenance supervisor have been re-educated on their responsibilities related to this requirement as well as their responsibility to ensure that complete and accurate documentation of all inspections, testing and maintenance of the facility's emergency power system is maintained in the emergency preparedness binder for inspection by the authorities. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* an audit will be conducted quarterly by the Executive Director and the maintenance supervisor of the required documentation of the inspections, testing and maintenance of the facility's emergency power system to ensure all required documents are completed timely and available for inspection by the authorities. The review will be documented with the Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	

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K 0923 SS=F Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage and transfilling room was separated from adjoining areas by a minimum of 1-hour fire resistance rating. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(4) states storage of positive-pressure gases, if indoors, shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceiling, and doors are of a minimum 1-hour fire resistance rating requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect all residents, staff, and visitors while in the dining room which was adjacent to and in the same smoke compartment as the oxygen storage/transfilling room. Findings include: Based on observations on 04/30/24 between 1:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Assistant, there was a one inch diameter gap around the sprinkler head, which penetrated the ceiling of the oxygen storage/transfilling room, making the ceiling less than a 1-hour fire rated ceiling assembly. Based on interview at the time of the observation, the Maintenance Assistant agreed there was a one inch diameter gap around the sprinkler head in the oxygen storage/transfilling room which did not	K 0923	K 923 *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 in the dining room and in the same smoke compartment have the potential to be affected by this deficient practice. The gap in the ceiling around the sprinkler head in the oxygen storage room has now been repaired and there is no longer a breach in the fire resistance rating. *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 audit of all sprinkler heads has now been conducted and no additional gaps in the ceiling area around the sprinkler heads have been 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 the maintenance supervisor on the regulation related to the proper storage of	05/16/2024

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	maintain a minimum 1-hour fire resistance rating. This finding was reviewed with the Administrator, Maintenance Assistant, and six staff members during the exit conference. 3.1-19(b)		gas equipment. The maintenance supervisor was re-educated on ensuring that the oxygen storage area meets all storage requirements including maintaining the appropriate fire resistance rating of the storage area. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the preventative maintenance program, the maintenance supervisor and/or their designee will inspect monthly the ceiling area around all sprinkler heads to ensure there is no breach in the fire resistance ratings. These checks will be documented in the facility's preventative maintenance binder for review by the authorities.	