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

	PLAN OF CORRECTION IDENTIFICATION NUMBER A.			JILDING	ONSTRUCTION	(X3) DATE COMPL 04/30/	ETED
	PROVIDER OR SUPPLIER ENDENT HEALTH(CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg							
	conducted by the In accordance with 42 Survey Date: 04/30 Facility Number: 0 Provider Number: 1002 At this Emergency 1 Transcendent Healtifound not in compli Preparedness Requi Medicaid Participat CFR 483.73 The facility has 68 of the survey, the cension Quality Review consideration of the survey of the	00328 155502 287960 Preparedness survey, hcare of Owensville was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 50. Inpleted on 05/03/24	E 00	000	By submitting the enclosed materials, we are not admittin truth or accuracy of any spec findings or allegations. We reserve the right to contest th findings or allegations as part any proceedings and submit responses pursuant to our regulatory obligations. The farequests the plan of correctio considered our allegation of compliance effective 05/16/20 the state findings of the Life S Code Recertification, State Licensure and Emergency Preparedness survey conduction April 30, 2024.	fic e of these acility n be 24 to safety	
E 0004 SS=F Bldg	SS=F 441.184(a), 482.15(a), 483.475(a), 483.73(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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		ľ	UILDING	NSTRUCTION	COMPL 04/30/	ETED	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Federal, State and preparedness required must develop estate comprehensive errogram that mee section. The emer program must include the following elem (a) Emergency Pladevelop and main preparedness planand updated at least must do all of the "For hospitals at §485.625(a):] Emergency Plane (CAH) must comprehensive errogram that mee section, utilizing a "For LTC Facilities Emergency Plane develop and main preparedness planand updated at least "For ESRD Facil Emergency Plane develop and main	uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ments: an. The [facility] must tain an emergency that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital hely with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency that must be [evaluated], that must be [evaluated],					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2024		
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to develop an preparedness plan that least annually in 483.73(a). This defines residents in the facing residents in the	the Emergency Preparedness stween 9:45 a.m. and 1:45 p.m. ce Assistant present, the an emergency preparedness thas not been reviewed and past twelve months. The most w was 2021 (no exact date n interview at the time of nance Assistant confirmed the dness plan has not been ed within the past twelve	E 00	004	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 identificating 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 will continue to revand update the emergency preparedness plan at least annually and more often if warranted. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now reviewed and updated the facility's emergency prepared plan. The facility will continue review and update the emergency preparedness plan at least annually and more often if warranted. The measures that have been into place to ensure that the deficient practice does not rect that a mandatory in-service had been provided for the Executive Director and the maintenance supervisor on the requirement reviewing and updating the	ed s, ential lity's n. iew r the all ve this has eness to ency put ur is as ve	05/16/2024

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Event ID:

9SL421

Facility ID: 000328

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	JRVEY	
	(x3) date survey completed 04/30/2024	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	(X5) COMPLETION DATE	
### EDOCATOR OR LSC IDENTIFYING INFORMATION #### I 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. ###################################	DATE	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155502			JILDING	INSTRUCTION	COMP	E SURVEY PLETED 0/2024	
	STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION
	[(a) Emergency P develop and main preparedness pla and updated at le must do the follow (1) Be based on a facility-based and assessment, utiliz approach.* (2) Include strategemergency event assessment. * [For Hospices at Plan. The Hospice maintain an emerthat must be reviewery 2 years. Th following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategemergency event assessment, include strategemergency event assessment, include the consequences disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main preparedness pla and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following: (1) Be based on a great plan and updated at le do the following:	lan. The [facility] must atain an emergency in that must be reviewed, ast every 2 years. The plan wing:] and include a documented, community-based risk ring an all-hazards gies for addressing is identified by the risk replan must develop and gency preparedness plan rewed, and updated at least replan must do the remainded and include a documented, community-based risk ring an all-hazards gies for addressing is identified by the risk ring an all-hazards gies for addressing is identified by the risk ring an all-hazards gies for power failures, natural risk remergencies that would risk sability to provide care.		TAG			DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/30/2024	
	PROVIDER OR SUPPLIEF	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 ISVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. Based on record revialed to maintain a preparedness plan to includes a documer community-based remergency events in assessment in accord (1) and 42 CFR 483 practice could affect Findings include: Based on review of plan on 04/30/24 be with the Maintenant facility-based and covere addressed in the second second stratege in the second	ing an all-hazards and missing residents. It is given for addressing is identified by the risk identified by the risk identified by the risk identified by the risk identified at least every 2 must do the following: Ind include a documented, community-based risk ing an all-hazards ing missing clients. It is for addressing is identified by the risk identified by the	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 potent 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 brisk assessment. The corrective action taken for other residents that have the	ed s, ential d	

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assessment utilizing an all-hazards approach

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potential to be affected by the

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	OF CORRECTION	IDENTIFICATION NUMBER 155502	A. BUILDING B. WING		COMPLETED 04/30/2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	time of record revie agreed the facility-b risk assessment utili was not available fo This finding was rev	viewed with the Administrator, ant, and six staff members		same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility 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 trisk assessment. The measures that have been into place to ensure that the deficient practice does not rethat a mandatory in-service he been provided for the Execut Director and the maintenance supervisor on the regulation requiring that the facility conditacility based and community based risk assessment utilizing an all hazards approach. The Executive Director and the maintenance supervisor will be responsible for the completing assessment and then maintain a complete emergency preparedness plan based on results of this assessment. The Executive Director and the maintenance supervisor were instructed on their responsible ensure the plan is reviewed a least annually to ensure that a identified hazards have appropriately been addressed. The corrective action taken to monitor to ensure the deficient practice will not recur is that a series of the confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice will not recur is that a confliction of the ensure the deficient practice.	ave y this y has ed by the n put cur is as ive e d duct a ng e oe g this ining the che che d d d d d d d d d d d d d

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 0/2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZII V STATE ROAD 165 SVILLE, IN 47665	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and proper and imples preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies reviewed and usears.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),		audit will be conduct by the Executive Dire environmental super all risk hazards have identified and that the strategies developed implemented for add emergency events ic risk assessment. The be documented with Director's and mainted supervisor's signatured date of when the revision conducted.	ector and the visor to ensure been ere are I and lessing all lentified in the ereview will the Executive enance res and the	

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULT A. BUILD B. WING		NSTRUCTION	(X3) DATE : COMPL 04/30/	ETED
	OF PROVIDER OR SUPPLIED SCENDENT HEALTH	CARE OF OWENSVILLE	7	336 W	DDRESS, CITY, STATE, ZIP COD STATE ROAD 165 VILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policibe reviewed and *Additional Requi ESRD Facilities: *[For PACE at §4 procedures. The develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policies manager nonmedical emer limited to: Fire; ecfailure; care-related disasters likely to safety of the parti. The policies and previewed and upon the emergency (a) of this section. *[For ESRD Faciliand procedures. develop and imple preparedness pol on the emergency (a) of this section. paragraph (a)(1) communication ple communication ple communication ple communication ple communication ple section.	The LTC facility must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually. The ements for PACE and PACE organization must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ement of medical and gencies, including, but not appropriately appropriately and procedures must emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years. The dialysis facility must ement emergency icies and procedures, based y plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must be an at paragraph (c) of this cies and procedures must					

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		X1) PROVIDER/SUPPLIER/CLIA	ľ	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING COMPLETED B. WING 04/30/2024			
		155502	B. WI	ING		04/30/	2024
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TRANSO	ENDENT HEALTH	ICARE OF OWENSVILLE			/ STATE ROAD 165 SVILLE, IN 47665		
	ENDENI DEALID	IOANE OF OWENSVILLE		OVVEINS	OVILLE, IN 47 000	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		updated at least every 2					
	1 -	ergencies include, but are , equipment or power					
		ted emergencies, water					
		n, and natural disasters					
		the facility's geographic					
	area.	are received a geographic					
		view and interview, the facility	E 00	013	E 013		05/16/2024
		nd implement emergency		J 1 J	The corrective action taken for	or	05/10/2021
	1	ies and procedures. The			those residents found to have		
		dures must be reviewed and			been affected by the deficient	t	
		nually in accordance with 42			practice is that although no		
	CFR 483.73(b). This deficient practice could affect				specific residents were identif	fied	
	all residents in the	facility.			during the survey, all resident		
					staff and visitors have the pot	ential	
	Findings include:				to be affected by this deficien	t	
					practice. All emergency		
		f the Emergency Preparedness			preparedness policies and		
	1 ~	etween 9:45 a.m. and 1:45 p.m.			procedures have now been		
		nce Assistant present, there			reviewed and revised if warra		
		in the plan for facility policies			The emergency preparedness		
	_	wever the policies and			policies and procedures will n		
	1 ^	ot been reviewed by the facility			be reviewed and revised at le		
		cent twelve month period. The			annually by the Executive Dire		
		f review was 2021 (no exact ased on interview at the time of			and the facility's managemen team.	١	
		nance Supervisor confirmed the			The corrective action taken for	or the	
		dures within the Emergency			other residents that have the	,, ui c	
	1 ^	have not been reviewed and			potential to be affected by the	,	
		past twelve month period.			same deficient practice is that		
					residents, staff and visitors ha		
	This finding was re	eviewed with the Administrator,			the potential to be affected by		
	_	stant, and six staff members			deficient practice. All emerge		
	during the exit con				preparedness policies and		
	-				procedures have now been		
					reviewed and revised if warra	nted.	
					The emergency preparedness	s	
					policies and procedures will n	iow	
					be reviewed and revised at le	ast	
					annually by the Executive Dire	ector	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION _ 	(X3) DATE SURVEY COMPLETED 04/30/2024
	PROVIDER OR SUPPLIED	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				and the facility's management team. The measures that have been into place to ensure that the deficient practice does not red that a mandatory in-service had been provided for the Executive Director and the maintenance supervisor on the requirement review and revise if warranted policies and procedures related the facility's emergency preparedness plan. The E.D. maintenance supervisor will mannually 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 a audit will be conducted quarted by the Executive Director and environmental supervisor to e that the emergency prepared policies and procedures are current and have been review least annually. The review will documented with the Executive Director's and maintenance supervisor's signatures and the date of when the review was conducted.	cur is as ve t to d all ed to and now y the ensure ness ved at ll be ve
E 0029 SS=F Bldg	484.102(c), 485.6	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			

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Development of Communication Plan

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Facility ID: 000328

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPL				
		155502	B. W	ING		04/30/	2024
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE N. AN OF CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
TAG	S403.748(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.		E 0		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 identification.	ed	DATE 05/16/2024
	Findings include: Based on review of plan on 04/30/24 be with the Maintenan facility's Emergency include a plan to de emergency prepared complies with Fede however the communication planter was 2021 (non interview at the Maintenance Assist Communication Planter Preparedness planter was planter with the Maintenance Assist Communication Planter was planter with the Maintenance was planter with the Maintenance was planter was planter with the Maintenance was planter was planter with the Maintenance was planter with the Maintenance was planter was planter was planter with the Maintenance was planter was planter was planter was planter with the Maintenance was planter was plant	the Emergency Preparedness etween 9:45 a.m. and 1:45 p.m. ce Assistant present, the y Preparedness plan did velop and maintain an dness communication plan that ral, State, and local laws, unication plan has not been fility within the most recent d. The most recent date of the exact date provided). Based time of review, the					

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PRINTED: 05/22/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155502	A. BUILDING B. WING		COMPLETED 04/30/2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Maintenance Assista during the exit confe			warranted. The communication plan will be reviewed at least annually by the facility's Exect Director and the maintenance supervisor. The measures that have been into place to ensure that the deficient practice does not red that a mandatory in-service has been provided for the Executiv Director and the maintenance supervisor on the requirement review and update the facility's communication plan at least annually. The Executive Director and the maintenance supervisive were instructed on their responsibility to review the facility's communication plan when warranted. The corrective action taken to monitor to ensure the deficient practice will not recur is that a audit will be conducted quarted by the Executive Director and environmental supervisor to e that the facility's emergency preparedness communication is current. Updates to the pla will be made when warranted review will be documented with Executive Director's and maintenance supervisor's signatures and date of when the review was conducted.	t to sector sor at the name of
E 0036 SS=F	403.748(d), 416.54 441.184(d), 482.1	4(d), 418.113(d), 5(d), 483.475(d), 483.73(d),			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9SL421

Facility ID: 000328

If continuation sheet

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

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ABULDING ABS. 727(d), 485.625(d), 485.686(d), 485.727(d), 485.920(d), 486.360(d), 5441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$483.475(d), \$481.113(d), \$446.59.20(d), \$486.360(d), \$485.920(d), \$485.625(d), \$485.625(d), \$485.920(d), \$486.360(d), \$485.625(d), \$484.102(d), \$486.860, \$486.360, \$485.625, \$485.620, \$486.360, \$485.625, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620, \$485.620,	
STREET ADDRESS, CITY, STATE, ZIP COD	
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TRANSCENDENT HEALTHCARE OF OWENSVILLE TRANSCENDENT HEALTHCARE OF OWENSVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Bidg. — 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), §4441.184(d), §460.844(d), §482.15(d), §485.68(d), §485.625(d), §485.727(d), §485.68(d), §485.625(d), §485.727(d), §485.68(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/FHOs 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)(f) of this section, policies and procedures at paragraph (b) of this section, and the communication	
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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), §482.15(d), §483.73(d), §483.73(d), §483.75(d), §485.727(d), 885.920(d), §485.625(d), §485.727(d), 845.920(d), §485.625(d), §485.727(d), §485.920(d), §485.625(d), §485.727(d), §485.920(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	
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§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	
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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	
§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	
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assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication	
section, policies and procedures at paragraph (b) of this section, and the communication	
(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	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9SL421

Facility ID: 000328

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	annually.	and updated at least			
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk at (a)(1) of this section at paragraph (b) ocommunication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facility Training, testing, adialysis facility multiple and testing and testi	evacuation drills and training ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing			
	on the emergency (a) of this section, paragraph (a)(1) of procedures at par and the communit of this section. The	ation program that is based plan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) ne training, testing and m must be evaluated and 2 years.			
	failed to develop an preparedness trainin was reviewed and u	view and interview, the facility d maintain an emergency ng and testing program that updated at least annually in CFR 483.73(d). This deficient all occupants.	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 resident staff and visitors have the pot to be affected by this deficient.	ied s, ential

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	ESURVEY LETED 0/2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP CONSTATE ROAD 165 SVILLE, IN 47665	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE
	plan on 04/30/24 be with the Maintenan was documentation had an emergency place testing program, he program has not be within the most recent date of date provided). Bareview, the Maintentraining and testing the Emergency Prepreviewed and update month period.	the Emergency Preparedness etween 9:45 a.m. and 1:45 p.m. ce Assistant present, there available to show the facility preparedness training and wever the training and testing en reviewed by the facility ent twelve month period. The review was 2021 (no exact sed on interview at the time of nance Assistant confirmed the policy and procedure within paredness plan has not been red within the past twelve wiewed with the Administrator, and, and six staff members herence.		practice. The facility's expreparedness training a program has now been and revised as warranted the corrective action tax other residents that have potential to be affected asame deficient practice residents, staff and visit the potential to be affected deficient practice. The emergency preparedness and testing program has reviewed and revised as The measures that have into place to ensure that deficient practice does not that a mandatory in-service been provided for the Edicient practice does not that a mandatory in-service facility's emergency pretraining and testing program is conduct an annual revier facility's emergency pretraining and testing program is conducted on their restores of the staff member does not each staff member does not each staff member does not ensure the depractice will not recur is audit will be conducted by the Executive Director maintenance supervisor review of the facility's energial to the facility is energial t	and testing reviewed ed. ken for the re the by the is that all tors have ted by this facility's sas training as now been as warranted. It the not recur is vice has ement to ew of the eparedness gram. The remaining any the total test an appropriate that an appropriate remaining any the that an appropriate remaining any the training and the remaining and	

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ng and testing hat the and complete. COMPLE DATE	TION
hat the and complete.	
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١	and complete. documented Director's and visor's e of when the ted.

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155502	r í	JILDING	nstruction 	COMPI 04/30	ETED
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				7336 W	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	functional exercises actual event. (ii) Conduct an add every 2 years, oppor functional exercises (i) of this section is include, but is not (A) A second full-scommunity-based functional exercises (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an erection (iii) Analyze the [famaintain document exercises, and enterection the [facility's] emeth [facili	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise rgency plan, as needed. 418.113(d):] spices that provide care in a. The hospice must to test the emergency ally. The hospice must do					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	<u></u>	COMPI	LETED	
		155502	B. WI	NG		04/30	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			STATE ROAD 165		
TRANSCENDENT HEALTHCARE OF OWENSVILLE				SVILLE, IN 47665			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund	ctional exercise following the					
	onset of the emer	rgency event.					
	(ii) Conduct an a	dditional exercise every 2					
	years, opposite th	ne year the full-scale or					
	functional exercis	e under paragraph (d)(2)(i)					
	of this section is o	conducted, that may					
	include, but is not	t limited to the following:					
	(A) A second full-	-scale exercise that is					
	community-based	d or a facility based					
	functional exercis	se; or					
	(B) A mock disas	ster drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	1 ' '	r and includes a group					
	discussion using	- -					
		emergency scenario, and a					
		atements, directed					
		pared questions designed					
	to challenge an e						
	(3) Testing for hos	spices that provide inpatient					
	1	e hospice must conduct					
	exercises to test t	the emergency plan twice					
	per year. The hos	spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	/-based; or					
	(A) When a comn	nunity-based exercise is not					
		uct an annual individual					
	facility-based fund	ctional exercise; or					
	(B) If the hospice	experiences a natural or					
	man-made emerg	gency that requires activation					
	1	plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event	_					
		dditional annual exercise					
	` '	but is not limited to the					
	following:						

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(A) A second full-scale exercise that is community-based or a facility based

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	UILDING	NSTRUCTION	COMP	SURVEY LETED 1/2024
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			7336 W	NDDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE
	facilitator that inclusing a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the hamaintain documer exercises, and em	ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ted messages, or prepared				
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu facility-based func (B) If the [PRTF, I an actual natural o that requires activ plan, the [facility] i its next required fr or individual, facili following the onse (ii) Conduct a exercise or and th limited to the follo (A) A second full- community-based	PRTF, Hospital, CAH] must a to test the emergency ar. The [PRTF, Hospital, of following: In annual full-scale exercise abased; or nunity-based exercise is not act an annual individual, actional exercise; or Hospital, CAH] experiences for man-made emergency action of the emergency action of the emergency action of the emergency action and exercise at of the emergency event. In an [additional] annual act may include, but is not wing: Inscale exercise that is a or individual, a				
	facility-based fund	or individual, a ctional exercise; or ock disaster drill; or				

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ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED		
		155502	B. WI	B. WING			04/30/2024		
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD				
					STATE ROAD 165				
TRANSCENDENT HEALTHCARE OF OWENSVILLE			OWENS	SVILLE, IN 47665					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE		
	(C) A tabletor	exercise or workshop that							
		or and includes a group							
	discussion, using								
	_	emergency scenario, and a							
	set of problem sta	- ·							
	•								
	to challenge an er	pared questions designed							
	1								
	1 ' ' -	he [facility's] response to							
		umentation of all drills,							
		s, and emergency events							
	I -	cility's] emergency plan, as							
	needed.								
	*IF-" DAOF -+ \$4/	20.04/4/-1							
	*[For PACE at §46	· · -							
	1 ' '	ACE organization must							
		to test the emergency							
	plan at least annu	_							
	organization must	_							
	1 ' '	n annual full-scale exercise							
	that is community								
		nunity-based exercise is not							
		ct an annual individual,							
		ctional exercise; or							
	, ,	xperiences an actual natural							
		ergency that requires							
		mergency plan, the PACE							
	· ·	gaging in its next required							
		nity based or individual,							
		tional exercise following the							
	onset of the emer	- -							
		n additional exercise every							
		he year the full-scale or							
		e under paragraph (d)(2)(i)							
		onducted that may include,							
	but is not limited to	_							
	(A) A second full-	scale exercise that is							
	community-based	or individual, a facility							
	based functional e	exercise; or							
	(B) A mock disas	ter drill; or							

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(C) A tabletop exercise or workshop that is

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155502	B. W	ING		04/30/	2024
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
					STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENS	SVILLE, IN 47665		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	· ·	and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
		pared questions designed					
	to challenge an er	•					
	_	PACE's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	ano i y to E o omorg	goney plan, as necasa.					
	*[For LTC Facilitie	es 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 pr	ocedures. The [LTC facility,					
	ICF/IID] must do t	he following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund						
	_ ' ' -	ility] facility experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
	1	mpt from engaging its next					
		lle community-based or					
	I	based functional exercise					
	1	et of the emergency event.					
	· '	dditional annual exercise					
	i i	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
		or an individual, facility					
	based functional e	•					
	(B) A mock disas						
	1 ' '	ercise or workshop that is					
	led by a facilitator	- ,					
	discussion, using						
	ciinicaliy-relevant	emergency scenario, and a					

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i '		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			(3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155502	B. W.			04/30		
		133302	В. W.			04/30/	2024	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
TDANCO	SENDENT HEALTH	CARE OF OMENIONALE			STATE ROAD 165			
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENS	SVILLE, IN 47665			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	set of problem sta							
		pared questions designed						
	to challenge an er	• • •						
	. ,	LTC facility] facility's						
		maintain documentation of						
		exercises, and emergency						
	events, and revise the [LTC facility] facility's emergency plan, as needed.							
	emergency plan, a	as needed.						
	*[For ICF/IIDs at §	§483.475(d)]:						
	-	CF/IID must conduct						
		he emergency plan at least						
	twice per year. Th	ne ICF/IID must do the						
	following:							
	(i) Participate in a	n annual full-scale exercise						
	that is community							
	(A) When a comm	nunity-based exercise is not						
	accessible, condu	ıct an annual individual,						
	facility-based fund	ctional exercise; or.						
	(B) If the ICF/IID 6	experiences an actual						
	natural or man-ma	ade emergency that requires						
		mergency plan, the ICF/IID						
	· ·	ngaging in its next required						
		nity-based or individual,						
	,	ctional exercise following the						
	onset of the emer	-						
	, , ,	Iditional annual exercise						
	_	but is not limited to the						
	following:							
	' '	scale exercise that is						
	community-based							
	-	ctional exercise; or						
	(B) A mock disast							
	, ,	ercise or workshop that is						
		and includes a group						
	discussion, using							
	•	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er	mergency plan.						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	
		155502	B. W	ING		04/30	/2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE	_	OWENS	SVILLE, IN 47665		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	. ,	CF/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 §48	R4 1021					
	(d)(2) Testing. The HHA must conduct						
	` ' ' '	he emergency plan at					
		e HHA must do the					
	following:	2					
		full-scale exercise that is					
	community-based						
		ommunity-based exercise					
	, ,	conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from enga	aging in its next required					
	full-scale commur	nity-based or individual,					
	_	tional exercise following the					
	onset of the emer						
	` '	ditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	· · · · · · · · · · · · · · · · · · ·					
		limited to the following:					
		full-scale exercise that is					1
	community-based						
	_	ctional exercise; or					
		isaster drill; or					
	, ,	o exercise or workshop that for and includes a group					
	discussion, using	.					
	_	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	• •					
	_	HA's response to and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		A. BUILDING B. WING	onstruction 	COMPLETED 04/30/2024	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 ISVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
1110	maintain documer exercises, and em	ntation of all drills, tabletop nergency events, and revise ency plan, as needed.			2.112
	exercises to test the OPO must do the (i) Conduct a paper or workshop at least exercise is led by group discussion, relevant emergency problem statement prepared questions emergency plan. It actual natural or not require activation OPO is exempt from the emergency (ii) Analyze the OF maintain document exercises, and emergency activation of the emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency or workshop at least exercises to the exercise to the exe	e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an f the OPO experiences an anan-made emergency that a of the emergency plan, the om engaging in its next exercise following the onset			
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually. A group discussion in arrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN	e RNHCI must conduct he emergency plan. The			

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155502	B. W	ING		04/30/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE			SVILLE, IN 47665		
	1				T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		nergency events, and revise					
		rgency plan, as needed.		020	F 000		05/16/2024
	Based on record review and interview, the facility failed to conduct exercises to test the emergency		E 00	039	E 039		05/16/2024
	plan at least twice p	_ ,			The corrective action taken for		
	_	drills using the emergency			those residents found to have		
		C facility must do the			been affected by the deficient		
	following:	C facility must do the			practice is that although no specific residents were identif	ied	
	Č	annual full-scale exercise that			during the survey, all resident		
	is community-base				staff and visitors have the pot		
	1	ity-based exercise is not			to be affected by this deficient		
		an annual individual,			practice. The facility has now		
	facility-based funct				conducted a table top exercis		
	<u> </u>	ty experiences an actual natural			test the facility's emergency	0 10	
		gency that requires activation			preparedness plan.		
	1	lan, the LTC facility is exempt			The corrective action taken for	r the	
		ext required full-scale in a			other residents that have the		
		or individual, facility-based			potential to be affected by the	,	
	· ·	l exercise for 1 year following			same deficient practice is that		
	the onset of the act	ual event.			residents, staff and visitors ha		
	(ii) Conduct an add	itional exercise that may			the potential to be affected by	this	
	include, but is not l	imited to the following:			deficient practice. The facility	has	
	a. A second full-sca	ale exercise that is			now conducted a table top		
	community-based of	or an individual, facility-based			exercise to test the facility's		
	functional exercise				emergency preparedness pla	n.	
	b. A mock disaster				The measures that have beer	n put	
	_	ise or workshop that is led by a			into place to ensure that the		
		ides a group discussion, using			deficient practice does not red		
	· ·	y-relevant emergency scenario,			that a mandatory in-service ha		
	_	n statements, directed			been provided for the Executi		
		red questions designed to			Director and the maintenance		
	challenge an emerg				supervisor on the requiremen		
	· · ·	TC facility's response to and			conduct a testing of the facility		
		ation of all drills, tabletop			emergency preparedness pla	n at	
	· ·	rgency events, and revise the			least twice annually. The		
		gency plan, as needed in			Executive Director and the	h	
		CFR 483.73(d)(2).			maintenance supervisor have		
	-	cice could affect all occupants			re-educated on their responsi	DIIITY	
	in the facility.				to conduct the testing of the		
	1				facility's emergency prepared	ness	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 0/2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZII V STATE ROAD 165 ISVILLE, IN 47665	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	plan on 04/30/24 be with the Maintenand facility was able to actual event involvi 04/02/24, however, provide documentate conducted during the Based on interview the Maintenance As no documentation of during the past 12 m. This finding was re Maintenance Assist during the exit confusion of the	viewed with the Administrator, ant, and six staff members ference. (e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. and the CAH] must ency and standby power the emergency plan set (a) of this section.		plan at least twice a document the testing the outcome of these The corrective action monitor to ensure the practice will not recu audit will be conduct by the Executive Diremaintenance supervirequired documentate exercises conducted twice annually of the facility's emergency plan. The review will documented with the Director's and mainten supervisor's signature when the review was	g as well as e testings. In taken to e deficient It is that an eed quarterly ector and the risor on the tion of the d at least e testing of the preparedness Il be e Executive enance res and date of	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		A. BUILDING B. WING		CON	TE SURVEY IPLETED 30/2024	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZIP / STATE ROAD 165 SVILLE, IN 47665	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	Care Facilities Co- Interim Amendment 12-4, TIA 12-5, and Code (NFPA 101) Amendments TIA and TIA 12-4), and structure is built of structure or buildir 482.15(e)(2), §483 Emergency generative The [hospital, CAI- implement the eminspection, testing requirements found Facilities Code, NI Code. 482.15(e)(3), §483 Emergency generative and LTC facilities] source to power endiand LTC facilities]	and is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] d in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency erational during the s it evacuates. §482.15(h), LTC at AHs §485.625(g):] orporated by reference in eproved for incorporation by birector of the Office of the in accordance with 5 U.S.C. part 51. You may obtain the sources listed below.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/30/2024	
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 SVILLE, IN 47665	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION ARA, call 202-741-6030, or	TAG	DEFICIENCY)	DATE
	go to: http://www.archive _of_federal_regula If any changes in incorporated by redocument in the Fannounce the cha (1) National Fire F Batterymarch Part Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issue (ii) Technical inter NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF	es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are afterence, CMS will publish a federal Register to ages. Protection Association, 1 k, 2, www.nfpa.org, and Care Facilities Code, and August 11, 2011. Im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, and FPA 99, issued August 1, and FPA 99, issued August 1, and FPA 99, issued August 1, and FPA 99, issued March 3, and fe Safety Code, 2012			
	22, 2013. (xiii) NFPA 110, S Standby Power Sy	rPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,			
	Based on record rev	riew and interview, the facility the emergency power system	E 0041	E 041 The corrective action taken fo	o5/16/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		ľ	UILDING	ONSTRUCTION	(X3) DATE COMPI 04/30	LETED	
NAME OF I	PROVIDER OR SUPPLIEI	R	_		ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE			SVILLE, IN 47665		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		and maintenance requirements Care Facilities Code, NFPA			those residents found to have been affected by the deficient		
		y Code in accordance with 42			practice is that although no		
	CFR 483.73(e)(2).	y Code in accordance with 42			specific residents were identif	iod	
	C1 K 103.75(c)(2).				during the survey, all resident		
	Based on record rev	view and interview, the facility			staff and visitors have the pot		
	failed to provide complete documentation for the				to be affected by this deficient		
	testing of 1 of 1 Emergency Power Standby				practice. The facility has now		
	System in accordan	ace with NFPA 110, Standard			successfully conducted the		
	for Emergency and	Standby Power Systems,			required four hour load test of	the	
	Section 8.4.9, as required by NFPA 99 Health Care				emergency power generator.		
	Facilities Code, Section 6.4.1.1.6.1. NFPA 110				The corrective action taken fo	r the	
	Section 8.4.9 states that all Level 1 Emergency				other residents that have the		
	Power Systems shall be tested at least once within				potential to be affected by the		
	every three years (36 months). Where the				same deficient practice is that		
		eater than 4 hours, it shall be			residents, staff and visitors ha		
	_	ate the test after 4 hours.			the potential to be affected by		
		6.4.1.1.6.1 states that Type 1 and			deficient practice. The facility		
		ectrical system power sources			now successfully conducted t		
		at Type 10, Class X, Level 1			required four hour load test of	the	
	affect all building of	s deficient practice could	emergency power generator.				
	affect an building c	occupants.			The measures that have been	ι ραι	
	Findings include:				into place to ensure that the deficient practice does not red	our is	
	i manigs merade.				that a mandatory in-service ha		
	Based on record rev	view on 04/30/24 between 9:45			been provided for the Executi		
		with the Maintenance Assistant			Director and the maintenance		
	•	was unable to provide		supervisor on the required			
		four hour load test of the			inspections, testing and		
	emergency generate	or conducted within the past			maintenance requirements of	the	
	36 month period. I	Based on interview at the time			facility's emergency power		
		ne Maintenance Assistant said			system. The Executive Direct	tor	
		in for more than four hours			and the maintenance supervis		
		long power outage at the			have been re-educated on the	eir	
	, ,	past 12 month period, however,			responsibilities related to this		
	it was not documen	ited.			requirement as well as their		
	T1 ' C' 1'	1 24 4 4 1 1 1 1			responsibility to ensure that		
		eviewed with the Administrator,			complete and accurate		
		tant, and six staff members			documentation of all inspection		
	during the exit conf	iciciice.			testing and maintenance of th	е	1

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/30/2024
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 ISVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) .D BE OPRIATE COMPLETION DATE
				facility's emergency power is maintained in the emergency preparedness binder for in by the authorities. The corrective action taken monitor to ensure the defining practice will not recur is the audit will be conducted queries by the Executive Director maintenance supervisor or required documentation or inspections, testing and maintenance of the facility emergency power system ensure all required documented timely and avainspection by the authoriting review will be documented Executive Director's and maintenance supervisor's signatures and date of whe review was conducted.	gency en to cient eat an earterly and the of the f the f's to enents are ilable for es. The d with the
K 0000					
Bldg. 01	Licensure survey w Department of Heal 483.90(a). Survey Date: 04/30 Facility Number: 0 Provider Number: 1000 At this Life Safety 0 Healthcare of Ower	00328 155502	K 0000	By submitting the enclose materials, we are not adm truth or accuracy of any specifindings or allegations. We reserve the right to contest findings or allegations as pany proceedings and submaresponses pursuant to our regulatory obligations. The requests the plan of correct considered our allegation compliance effective 05/10 the state findings of the Li Code Recertification. State	nitting the pecific //e st the part of mit these refacility ction be of 6/2024 to fee Safety

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		 UILDING	onstruction 01	(X3) DATE : COMPL 04/30/	ETED	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa	ty was determined to be of		Licensure and Emergency Preparedness survey conduct on April 30, 2024.	ed	
	Type V (000) constructions sprinklered. The factorial with hard wired smooth and spaces open to the operated smoke alar	cuction and was fully cility has a fire alarm system oke detectors in the corridors the corridors, plus battery the in all resident sleeping has a capacity of 68 and had a				
	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					
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme patients comply w 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer patents	IFPA 96, Standard for and Fire Protection of and Fire Protection of ang Operations, unless: ang equipment (i.e., small smicrowaves, hot plates, for food warming or limited ance with 18.3.2.5.2, appen to the corridor in ants with 30 or fewer with the conditions under				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155502	B. W	ING		04/30/	2024
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	REGULATORY OR Cooking facilities NFPA 96 per 9.2.3 enclosed as hazal be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation failed to ensure 1 of extinguishing system coverage over the e 2011 edition, Section equipment that proof that might be a sour hood, grease remove protected by fire-ext Section 11.1.6 state be operated while it exhaust system is not. This deficient pract staff, plus all reside which was adjacent compartment as the Findings include: Based on observation p.m. and 3:00 p.m. the Maintenance As the five extinguishing range hood were all cook top stove, grill pointed directly to to on interview at the to Maintenance Assist agreed the range ho not pointed to the k Furthermore, the Di hood inspection ver	protected according to a are not required to be redous areas, but shall not rridor. 1. 18.3.2.5.4, 19.3.2.5.1 2. 9.2.3, TIA 12-2 2. on and interview, the facility for 1 kitchen range hood moveled provide complete entire cooking area. NFPA 96, and 10.1.2 requires cooking duces grease-laden vapors and aree of ignition of grease in the all device, or duct shall be tinguishing equipment. It is scooking equipment shall not as fire-extinguishing system or conoperational or impaired. The could affect mostly kitchen ents while in the dining room to and in the same smoke kitchen. The son 04/30/24 between 1:45 during a tour of the kitchen with assistant and Dietary Manager, and nozzles under the kitchen pointed to the wall behind the land deep fryer and not the cooking appliances. Based time of observation, the ant and Dietary Manager od extinguishing nozzles were	KO		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 pludietary staff have the potential be affected by this deficient practice. The kitchen range has now been repaired and the range hood extinguishing nozare now pointed to the cooking appliances. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents and staff in the dining area plus all dietary staff have potential to be affected by the same deficient practice. The kitcher range hood has now been repand the range hood extinguish nozzles are now pointed to the cooking appliances. The measures that have been into place to ensure that the deficient practice does not rect that a mandatory in-service has been provided for the mainten supervisor and all dietary staff requirements of the kitchen's	r ied s us all to ood e zles g r the all ug e the caired hing e ur is as ance	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155502	B. WI	NG		04/30/	/2024
NAME OF A	DOLUBER OF GUIDNI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		7336 W	/ STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWEN	SVILLE, IN 47665		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION eviewed with the Administrator,		TAG			DATE
	_	tant, and six staff members			range hood extinguishing syst		
	during the exit con				need for kitchen range hood	II IC	
		icience.			nozzles to be pointed to the er	ntire	
	3.1-19(b)				cooking surface to provide		
					complete coverage.		
					The corrective action taken to		
					monitor to ensure the deficient		
					practice will not recur is that a		
					part of the facility's preventativ		
					maintenance program, the kitc range hood extinguishing syst		
					will be inspected monthly by the		
					maintenance supervisor and/o		
					their designee to ensure that t		
					device is functioning properly	and	
					is providing complete coverage	e of	
					the cooking area. The		
					documentation of these month	-	
					inspections will be maintained	in	
					the preventative maintenance		
					binder for inspection by the authorities.		
					danomio.		
K 0345	NFPA 101						
SS=F	Fire Alarm Syster	m - Testing and					
Bldg. 01	Maintenance	m. Tooting and					
	Fire Alarm Syster Maintenance	II - Testing and					
		m is tested and maintained					
		h an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
		m acceptance, maintenance					
	and testing are re						
		IFPA 70, NFPA 72	17.00	2.45	14.045		05/16/2024
		I review and interview, the sure the annual testing of all	K 03	345	K 345	for	05/16/2024
		_			The corrective action taken those residents found to have	101	
	devices connected	to 1 of 1 fire alarm system was			those residents found to have		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED B. WING 04/30/2024 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **7336 W STATE ROAD 165** TRANSCENDENT HEALTHCARE OF OWENSVILLE OWENSVILLE, IN 47665 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE performed. NFPA 72, National Fire Alarm Code, been affected by the deficient the 2010 Edition, at 14.6.2.4 requires a record of all practice is that although no inspections, testing, and maintenance shall be specific residents were identified provided that includes the following information during the survey, all residents, regarding tests and all the applicable information staff and visitors have the potential requested in Figure 14.6.2.4: to be affected by this deficient (1) Date practice. The facility's fire alarm (2) Test frequency system vendor has now completed (3) Name of property an annual inspection of the (4) Address facility's fire alarm system in (5) Name of person performing inspection, accordance with the regulation. maintenance, tests, or combination thereof, and This inspection includes a visual affiliation, business address, and telephone inspection and functional testing of number all devices connected to the fire (6) Name, address, and representative of alarm system. Documentation of approving agency (ies) this inspection is now on file in the (7) Designation of the detector(s) tested facility's preventative maintenance (8) Functional test of detectors binder for review by the authorities. (9)*Functional test of required sequence of 2.) The corrective action taken for operations those residents found to have (10) Check of all smoke detectors been affected by the deficient (11) Loop resistance for all fixed-temperature, practice is that although no line-type heat detectors specific residents were identified (12) Functional test of mass notification system during the survey, all residents, control units staff and visitors have the potential (13) Functional test of signal transmission to mass to be affected by this deficient notification systems practice. The facility fire alarm (14) Functional test of ability of mass notification system vendor has now completed system to silence fire alarm notification appliances a semi-annual visual inspection of (15) Tests of intelligibility of mass notification all smoke detectors and heat system speakers detectors. (16) Other tests as required by the equipment The corrective action taken for the manufacturer's published instructions other residents that have the (17) Other tests as required by the authority potential to be affected by the having jurisdiction same deficient practice is that all (18) Signatures of tester and approved authority residents, staff and visitors have representative the potential to be affected by this (19) Disposition of problems identified during test deficient practice. The facility's (e.g., system owner notified, problem fire alarm system vendor has now corrected/successfully retested, device conducted an annual visual

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>		COMPLETED	
155502		B. Wl	ING		04/30/	2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			/ STATE ROAD 165		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE			SVILLE, IN 47665		
	T		1		,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	abandoned in place				inspection and functional testi	ng of	
	_	ice could affect all occupants			all devices connected to the		
	in the facility.				facility's fire alarm system. The		
	Findings includes				inspection included the visual		
	Findings include:				inspection and testing of all		
	Rosed on magard may	view on 04/30/24 between 9:45			smoke detectors and heat detectors. Documentation of t	hio	
		with the Maintenance Assistant					
	_	did have quarterly fire alarm			inspection is now on file in the		
		documentation from its fire			facility's preventative maintena		
		or which were performed on			binder for review by the autho		
	1	and 04/24/24. These			The measures that have been	put	
		ted as quarterly inspections of			into place to ensure that the	ur io	
	_	m. There was no annual fire			deficient practice does not red		
					that a mandatory in-service ha		
		ction documentation available		been provided for the maintenance			
		cluded a visual inspection and l devices connected to the fire			supervisor on the required tes	-	
		ed on interview at the time of			and maintenance of the facility		
		was confirmed by the			fire alarm system. The superv	/ISOr	
		ant. Furthermore, after calling			was re-educated on all	aual	
		arm system vendor, the			components of the required vi	Suai	
	I	ant was notified that the			inspections and testing of all		
		stem inspection/test was			components/devices that are		
		formed in December 2023, but			connected to the facility's fire alarm system.		
	was never performe				The corrective action taken to		
	was never performe				monitor to ensure the deficien		
	This finding was re	viewed with the Administrator,			practice will not recur is that a		
	_	ant, and six staff members			audit will be conducted by the		
	during the exit conf			Executive Director and the			
	daring the exit colli	0101100.			maintenance supervisor on the	_	
	3.1-19(b)				documentation of the inspection		
	3.1 17(0)				testing and maintenance of th		
	2. Based on record	review and interview, the			alarm system. These quarterly		
		intain 1 of 1 fire alarm system in			audits will be conducted to en		
	1	FPA 72, as required by LSC 101			that all the required visual	Juic	
		and 9.6. NFPA 72, Section			inspections, testing of all device	200	
		alless otherwise permitted by			connected to the fire alarm	JU3	
		ctions shall be performed in			system and maintenance of the	10	
	_	e schedules in Table 14.3.1, or			fire alarm system are docume		
		red by the authority having			in accordance with the regulat		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2024			
155502		B. W.	ing		04/30/2024				
	NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION			
	iurisdiction. Table must be visually ins a. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op. This deficient pract in the facility. Findings include: Based on record reva.m. and 1:45 p.m. present, there was regarding quarterly dated 07/05/23, 09/facility's fire alarm the quarterly inspection of the facility's pull station quarterly inspection quarterly inspection quarterly inspection quarterly inspection quarterly inspection	14.3.1 states that the following spected semi-annually: ble signals ators (e.g. duct detectors, manual eat detectors, smoke detectors, iances			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The review will be document with the Executive Director's a maintenance supervisor's signatures and date of when to review was conducted.	COMPLETION DATE ed and			
	information of a set the facility's fire ala smoke detectors and This finding was re	viewed with the Administrator, and, and six staff members							
K 0353 SS=F	NFPA 101 Sprinkler System	- Maintenance and Testing							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 155502	A. BUILDING <u>01</u> B. WING			COMPLETED 04/30/2024	
		100002				04/30/	2024
NAME OF I	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165				
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE			VILLE, IN 47665		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG Bldg. 01		LISC IDENTIFYING INFORMATION - Maintenance and Testing	TAC	J	BEIGHNOTT		DATE
Diag. 01		er and standpipe systems					
	·	ted, and maintained in					
		NFPA 25, Standard for the					
		g, and Maintaining of					
	Water-based Fire	Protection Systems.					
	Records of systen	n design, maintenance,					
	•	sting are maintained in a					
		nd 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		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 pote to be affected by the deficient practice. The appropriate FDC signage has now been placed the front of the facility and on the east side of the facility to ensure the fire department prompt act to the fire department connect the corrective action taken for other residents that have the potential to be affected by the same deficient practice is that	ed , ential C on the tre cess ion. r the	05/16/2024
	place and operating	properly.			residents, staff and visitors ha	ve	
This deficient practice could affect all occupants.		1		the potential to be affected by	this		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155502		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/30/2024	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 ISVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON (X5) BE COMPLETION DATE
	Findings include:			deficient practice. The app FDC signage has now been placed on the front of the fa	n
	p.m. and 3:00 p.m. the Maintenance A department connect east side of the faci signage provided a connection, further signage at the front responding fire dep FDC for easy ident the time of observation by the Maintenance should be FDC sign of the facility.	ons on 04/30/24 between 1:45 during a tour of the facility with ssistant, the facility's fire tion (FDC) was located on the lity. There was no FDC t the fire department more, there was no FDC of the building for the sartment to lead them to the iffication. Based on interview at tion, this was acknowledged e Assistant who agreed there mage at the FDC and the front eviewed with the Administrator, tant and six staff members ference.		and on the east side of the to ensure the fire department prompt access to the fire department connection. The measures that have be into place to ensure that the deficient practice does not that a mandatory in-service been provided for the main supervisor on the required to ensure the fire department prompt access to the facilit department connection. The maintenance supervisor was re-educated on their responsion to ensure that the FDC consignage remain clearly visit the facility for the responding department to give immedia access to the fire department connection. The corrective action taken monitor to ensure the deficient prompt access to the fire department to ensure the deficient monitor to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire department to ensure the deficient access to the fire dep	facility int een put e recur is e has tenance signage int y's fire ne as nsibility inection ole on ng fire ate ent to ient
				practice will not recur is the part of the facility's prevent maintenance program, the maintenance supervisor and their designee will visually in the FDC signed manths.	ative d/or inspect
				the FDC signage monthly to ensure it remains clearly visuary responding fire departrimmediate access to the fir department connection. The visual inspections will be documented in the facility's preventative maintenance is monthly for inspection by the	sible to ment for e nese pinder

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155502 B. WING 04/30/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **7336 W STATE ROAD 165** TRANSCENDENT HEALTHCARE OF OWENSVILLE OWENSVILLE, IN 47665 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE authorities. K 0761 SS=F Bldg. 01 Based on record review, observation and K 0761 K 761 05/16/2024 interview, the facility failed to maintain 2 of 2 The corrective action taken for rolling fire doors in accordance with NFPA 80, those residents found to have Standard for Fire Doors and Other Opening been affected by the deficient practice is that although no Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, residents were identified during the arrangement, level of protection, or any other survey, all occupants in the dining feature is required for compliance with the room have the potential to be provision of this Code, such device, equipment, affected by this deficient practice. system, condition, arrangement, level of The facility has now secured the protection, or other feature shall thereafter be two rolling fire doors between the maintained unless the Code exempts such kitchen and the dining room so maintenance. NFPA 80 5.2.1 requires fire door that they can no longer be utilized. The corrective action taken for the assemblies shall be inspected and tested not less than annually, and a written record of the other residents that have the inspection shall be signed and kept for inspection potential to be affected by the by the AHJ. This deficient practice could affect all same deficient practice is that all occupants while in the dining room. occupants in the dining room have the potential to be affected by this Findings include: deficient practice. The facility has now secured the two rolling fire Based on record review on 04/30/24 between 9:45 doors between the kitchen and the a.m. and 1:45 p.m. with the Maintenance Assistant dining room so that they can no present, the annual rolling fire door inspection longer be utilized. dated 07/05/23 indicated both rolling fire doors The measures that have been put between the kitchen and dining room failed the into place to ensure that the inspection. The Maintenance Assistant was able deficient practice does not recur is to provide a vendor report dated 08/23/23 that a mandatory in-service has indicating two new rolling fire doors have been been provided for the maintenance ordered to replace the current rolling fire doors. supervisor and the dietary staff on Based on interview at the time or record review, the modification of the two rolling the Maintenance Assistant said the new rolling fire doors between the dining room fire doors have been on back order but was told and the kitchen. The two rolling by the vendor that a June 2024 date was expected fire doors have now been secured for the rolling fire doors to be delivered to the and the staff will no longer be able

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		A. BUILDING B. WING	01	COMPLETED 04/30/2024	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	7336 W	ADDRESS, CITY, STATE, ZIP COD I STATE ROAD 165 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0918	-	viewed with the Administrator, and, and six staff members erence.		to utilize these rolling fire door The corrective action taken to monitor to ensure the deficient practice will not recur is that a 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 door remain securely closed and cano longer be utilized. These checks will be documented in facility's preventative maintenation of the correction of the c	t s //e or wo ors an the ance
SS=F Bldg. 01	Electrical Systems Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the electric switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mon Scheduled test unda complete simula automatic or manu- loads, and are con-	other alternate power ated equipment is capable the within 10 seconds. If the in is not met during the the provided to inis capability for the life the branches. Maintenance generator and transfer fried in accordance with the inspected weekly, and 30 minutes 12 times a sintervals, and exercised inthe for 4 continuous hours. der load conditions include			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/30/2024 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7336 W STATE ROAD 165 TRANSCENDENT HEALTHCARE OF OWENSVILLE OWENSVILLE, IN 47665 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0918 K 918 05/16/2024 failed to provide complete documentation for the The corrective action taken for testing of 1 of 1 Emergency Power Standby those residents found to have System in accordance with NFPA 110, Standard been affected by the deficient for Emergency and Standby Power Systems, practice is that although no Section 8.4.9, as required by NFPA 99 Health Care specific residents were identified Facilities Code, Section 6.4.1.1.6.1. NFPA 110 during the survey, all residents, Section 8.4.9 states that all Level 1 Emergency staff and visitors have the potential Power Systems shall be tested at least once within to be affected by this deficient every three years (36 months). Where the practice. The facility has now assigned class is greater than 4 hours, it shall be successfully conducted the permitted to terminate the test after 4 hours. required four hour load test of the NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and emergency power generator. Type 2 essential electrical system power sources The corrective action taken for the shall be classified at Type 10, Class X, Level 1 other residents that have the generator sets. This deficient practice could potential to be affected by the affect all building occupants. same deficient practice is that all residents, staff and visitors have Findings include: the potential to be affected by this deficient practice. The facility has Based on record review on 04/30/24 between 9:45 now successfully conducted the

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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

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required four hour load test of the

The measures that have been put

emergency power generator.

into place to ensure that the

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155502	B. W	ING		04/30	/2024	
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			STATE ROAD 165			
TDANGO	TRANSCENDENT HEALTHCARE OF OWENSVILLE							
TRANSC	LINDENI DEALID	CAIL OF OWEINSVILLE		OWENSVILLE, IN 47665				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Based on interview at the time			deficient practice does not rec			
		e Maintenance Assistant said			that a mandatory in-service ha			
	_	n for more than four hours			been provided for the Executive	/e		
		long power outage at the			Director and the maintenance			
		ast 12 month period, however,			supervisor on the required			
	it was not documen	ted.			inspections, testing and			
					maintenance requirements of	the		
		viewed with the Administrator,			facility's emergency power			
		ant, and six staff members			system. The Executive Direct			
	during the exit conf	erence.			and the maintenance supervis			
	2.1.10(1)				have been re-educated on the	ir		
	3.1-19(b)				responsibilities related to this			
					requirement as well as their			
					responsibility to ensure that			
					complete and accurate			
					documentation of all inspectio			
					testing and maintenance of the			
					facility's emergency power sys			
					is maintained in the emergence	-		
					preparedness binder for inspe by the authorities.	Clion		
					The corrective action taken to			
					monitor to ensure the deficien			
					practice will not recur is that a			
					audit will be conducted quarte			
					by the Executive Director and	-		
					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			
					inspection by the authorities.			
					review will be documented wit			
					Executive Director's and			
					maintenance supervisor's			
					signatures and date of when t	he		
					review was conducted.			

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	A. BU) MULTIPLE CONSTRUCTION (X3) DATE S BUILDING 01 COMPLE WING 04/30/2			ETED
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFINITION OF LIGHT PROPERTY OF THE PROPERTY OF T			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		TE.	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0923	NFPA 101						
SS=F	Gas Equipment - 0	Cylinder and Container					
Bldg. 01	Storag Gas Equipment - 0	Cylinder and Container					
	Storage						
	Greater than or ed	ual to 3,000 cubic feet					
	Storage locations	are designed, constructed,					
	-	accordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000 c	ubic feet					
	Storage locations	are outdoors in an					
	enclosure or within	n an enclosed interior					
	space of non- or li	mited- combustible					
	construction, with	door (or gates outdoors)					
	that can be secure	ed. Oxidizing gases are not					
	stored with flamma	ables, and are separated					
	from combustibles	by 20 feet (5 feet if					
	sprinklered) or end	closed in a cabinet of					
	noncombustible co	onstruction having a					
	minimum 1/2 hr. fi	re protection rating.					
	Less than or equa	I to 300 cubic feet					
	In a single smoke	compartment, individual					
	cylinders available	e for immediate use in					
	patient care areas	with an aggregate volume					
	of less than or equ	ual to 300 cubic feet are not					
	required to be stor	red in an enclosure.					
	Cylinders must be	handled with precautions					
	as specified in 11.	6.2.					
	A precautionary si	gn readable from 5 feet is					
	on each door or ga	ate of a cylinder storage					
		ign includes the wording as					
	a minimum "CAUT	TION: OXIDIZING GAS(ES)					
	STORED WITHIN	NO SMOKING."					
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
	•	When facility employs					
		gral pressure gauge, a					
		e considered empty is					
	established. Emp	ty cylinders are marked to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/30/2024	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			gas equipment. The maintena supervisor was re-educated or ensuring that the oxygen stora area meets all storage requirements including mainta 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 a part of the preventative maintenance program, the maintenance supervisor and/of their designee will inspect more the ceiling area around all sprinkler heads to ensure them to breach in the fire resistance ratings. These checks will be documented in the facility's preventative maintenance bind for review by the authorities.	n age ining t s or nthly e is	

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