PRINTED: 10/17/2022
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	==	COMPL	LETED	
		155502	B. WING		09/27/	/2022	
		1	<u> </u>				
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD			
			7336 W STATE ROAD 165				
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE	OWENSVILLE, IN 47665				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
E 0000	REGULATORT OF	CESC IDENTIF TING INFORMATION	IAG	+		DATE	
L 0000							
Bldg							
Blug	A E	1 C	E 0000				
		paredness Survey was	E 0000				
		ndiana Department of Health in					
	accordance with 42	CFR 483.73.					
	Survey Date: 09/27	7/22					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 100	287960					
	At this Emergency	Preparedness survey,					
	Transcendent Healt	thcare of Owensville was					
	found in complianc	e with Emergency					
	-	irements for Medicare and					
		ting Providers and Suppliers, 42					
	CFR 483.73	ting Froviders and Suppliers, 12					
	C1 K 405.75						
	The facility has 68	certified beds. At the time of					
	the survey, the cens						
	the survey, the cens	sus was 32.					
	Ovality Daviesy con	mpleted on 09/29/22					
	Quality Keview coi	inpleted oil 09/29/22					
K 0000							
11 0000							
Bldg. 01							
Diag. 01	A Life Sefety Code	Recertification and State	17,0000				
	_		K 0000				
	_	ras conducted by the Indiana					
	-	Ith in accordance with 42 CFR					
	483.90(a).						
	Survey Date: 09/27	7/22					
	Facility Number: 0						
	Provider Number:	155502					
	AIM Number: 100	287960					
	At this Life Safety	Code survey, Transcendent					

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

TITLE (X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 09/27/2022			LETED		
	PROVIDER OR SUPPLIED	CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD I STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION
K 0353 SS=C Bldg. 01	Healthcare of Owe compliance with R Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This one story facil Type V (000) cons sprinklered. The fa with hard wired sm and spaces open to operated smoke alarooms. The facility census of 52 at the All areas where the access were sprinkle facility services were sprinkled. Sprinkler System Automatic sprinkler System Automatic sprinkler inspected, test accordance with I Inspection, Testir Water-based Fire Records of system inspection and testing the safety of the safety	a LSC IDENTIFYING INFORMATION Insville was found not in equirements for Participation in I, 42 CFR Subpart 483.90(a), Ire and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. It was determined to be of truction and was fully acility has a fire alarm system toke detectors in the corridors the corridors, plus battery trms in all resident sleeping I has a capacity of 68 and had a time of this survey. The residents have customary lered and all areas providing the sprinklered. Impleted on 09/29/22 - Maintenance and Testing - Maintenance and Testing er and standpipe systems ated, and maintained in NFPA 25, Standard for the tog, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available.		TAG	DEFICIENCY	NATE	DATE
	a) Date sprinkled b) Who provided	r system last checked I system test					
	c) Water system	supply source					

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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 COMPLETED 01 B. WING 09/27/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 record review, observation, and K 0353 By submitting the enclosed 10/14/2022 interview; the facility failed to document sprinkler materials, we are not admitting the system inspections in accordance with NFPA 25 truth or accuracy of any specific for 1 of 1 dry sprinkler systems during 40 of the findings or allegations. We past 52 weeks. NFPA 25, Standard for the reserve the right to contest the Inspection, Testing, and Maintenance of findings or allegations as part of Water-Based Fire Protection Systems, 2011 any proceedings and submit these Edition, Section 5.2.4.2 states gauges on dry pipe responses pursuant to our sprinkler systems shall be inspected weekly to regulatory obligations. The facility ensure that normal air and water pressures are requests the plan of correction be being maintained. Section 4.3.1 states records considered our allegation of shall be made for all inspections, tests, and compliance effective 10/14/2022 to maintenance of the system and its components the state findings of the Life Safety and shall be made available to the authority Code Recertification and having jurisdiction upon request. This deficient Emergency Preparedness Survey practice could affect all residents, staff, and conducted on September 27, visitors in the facility. 2022. K 353 Findings include: The corrective action taken for those residents found to have Based on record review on 09/27/22 between 9:45 been affected by the deficient a.m. and 12:00 p.m. with the Director of practice is that although no Environmental Services and Administrator specific residents were identified present, there was documentation available to during the survey, all residents, show the facility's sprinkler system gauges were staff and visitors have the potential inspected, however, the documentation only to be affected by this deficient indicated the inspections were performed monthly practice. The facility is now instead of weekly as required for dry pipe documenting their weekly sprinkler systems. Based on interview at the time inspections of the facility's of record review, the Administrator said he sprinkler system including inspects the gauges and control valves almost documenting the air and water daily but only documents the gauge readings on a pressure of all gages on the monthly basis. Based on observations with the facility's dry pipe sprinkler Director of Environmental Services during a tour system. of the facility between 12:00 p.m. and 2:00 p.m. the The corrective action taken for the facility had two pressure gauges at the sprinkler other residents that have the

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AND PLAN OF CORRECTION IDENTIFICATION NUMB 155502		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2022
	PROVIDER OR SUPPLIE	R HCARE OF OWENSVILLE	7336 V	ADDRESS, CITY, STATE, ZIP COD V STATE ROAD 165 ISVILLE, IN 47665	
TRANSO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C riser. This finding was r	ACARE OF OWENSVILLE T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Eviewed with the Administrator Supervisor during the exit			DATE COMPLETION DATE The hat all have by this lity is ekly ater e recur is has tenance policy ction of ler he to ient it the ll tive ection nsure
K 0500 SS=F	NFPA 101 Building Services	s - Other		inspections are being comp and documented in accorda with the regulation.	pleted

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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 COMPLETED 01 B. WING 09/27/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility K 0500 K 500 10/14/2022 failed to ensure 4 of 4 fuel-fired boiler had a The corrective action taken for current inspection certificate to ensure the boiler those residents found to have was in safe operating condition. NFPA 101, been affected by the deficient Section 19.1.1.3.1 requires all health facilities to be practice is that although no designed, constructed, maintained, and operated specific residents were identified to minimize the possibility of a fire emergency during the survey, all residents, requiring the evacuation of occupants. This staff and visitors have the potential deficient practice could affect all residents, staff to be affected by this deficient and visitors. practice. The facility has contacted their boiler inspection Findings include: vendor and has scheduled an inspection of the facility's four Based on observations on 09/27/22 between 12:00 fuel-fired boilers and will retain a p.m. and 2:00 p.m. during a tour of the facility with copy of this inspection in the the Director of Environmental Services, the four facility's maintenance prevention fuel-fired boilers in the Mechanical Room had manual. These inspections will certificates with an expiration date of 05/2020. continue to be scheduled and Based on interview at the time of observation and copies of the certificates during the exit conference, the Director of maintained in accordance with Life Environmental Services and Administrator Safety Code requirements. confirmed the expiration dates of the four The corrective action taken for the fuel-fired boilers. other residents that have the potential to be affected by the This finding was reviewed with the Director of same deficient practice is that all Environmental Services and Administrator during residents, staff and visitors have the exit conference. the potential to be affected by this deficient practice. The facility has 3.1-19(b) contacted their boiler inspection vendor and has scheduled an inspection of the facility's four

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fuel-fired boilers and will retain a

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2022		
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 DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					copy of this inspection in the facility's maintenance prevention manual. These inspections will continue to be scheduled and copies of the certificates maintained in accordance with Safety Code requirements. The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service has been provided for the mainten supervisor on the required inspections and certification of facility's boiler system. The maintenance supervisor was educated on their responsibilitiensure that these inspections/certifications were completed in accordance with Safety Code and a copy of the certifications maintained in the maintenance prevention manual The corrective action taken to monitor to ensure the deficient practice will not recur is that the maintenance supervisor will submit to the Executive Direct copy of the inspection certifications.	ill Life put ur is as ance f the Life e ual. t ne	

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of all four of the fuel-fired boilers to validate that the inspections are current and in compliance with the regulation as part of the facility preventative maintenance program.

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ′	ULTIPLE CO JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
THIS I ETHY	or conduction	155502	B. WI			09/27/2022	
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE		7336 W	ADDRESS, CITY, STATE, ZIP COD / STATE ROAD 165 SVILLE, IN 47665		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
		the transmission of a fire					
	-	simulation of emergency fire					
		ills are held at expected					
	-	mes under varying					
		t quarterly on each shift.					
		r with procedures and is					
		re part of established					
routine. Where drills are conducted between							
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	0.7.4.7					
	19.7.1.4 through 1		17.0	710	14.740	10/14/202	
		review and interview, the	K 0	/12	K 712	10/14/202	.2
		ovide quarterly fire drill 2 of 3 shifts during 2 of 4			1 a). The corrective action tak		
		eient practice could affect all			for those residents found to he		
	residents in the facil	-			been affected by the deficient		
	residents in the fact	nty.			practice is that all residents, si	l l	
	Findings include:				and visitors could be affected this deficient practice. A fire d has now been conducted on	-	
	Based on review of	the facility's fire drill reports			second shift and the results of	the	
	on 09/27/22 betwee	n 9:45 a.m. and 12:00 p.m. with			fire drill documented in the		
	the Director of Envi	ironmental Services and			maintenance supervisor's fire	drill	
	Administrator prese	ent, the facility lacked fire drill			binder.		
	documentation for t	he following shifts and			1 b.) The corrective action tak	en	
	quarters:				for those residents found to ha	ave	
	a. Second shift (eve	ening) of the third quarter			been affected by the deficient		
		September) of 2021 and so far			practice is that all residents, s	taff	
		orth quarter (October,			and visitors could be affected	by	
	November, and Dec	,			this deficient practice. A fire d	rill	
		t) of the fourth quarter			has now been conducted on the	пе	
		er, and December) of 2021.			third shift and the results of the	e fire	
		at the time of record review,			drill documented in the		
		onfirmed the lack of a fire drill			maintenance supervisor's fire	drill	
		d and third shifts of the third			binder.		
	and fourth quarters	of 2021.			2.) The corrective action taker	ı for	
					those residents found to have		

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3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Based on review of the facility's fire drill reports on 09/27/22 between 9.45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on review of the facility's fire drill reports on 09/27/22 between 9.45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company. Based on review of the facility's fire drill sports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on includes verification that the fire alarm signal was received at the facility's monitoring company/fire department at the time of each fire drill conducted. A schedule has	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
TRANSCENDENT HEALTHCARE OF OWENSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE TAG 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 09/27/22 between 9/45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not interview at the time of record review, the Administrator acknowledged there was no information on all 10 fire drill reports to reinformation on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company. 7336 W STATE ROAD 165 OWENSVILLE, IN 47665 DE 1D 1D 1D 1AACT PREFIX TAG COMPLETIC COMPLETIC PREFIX TAG DATE DE PREFIX TAG SUMMARY STATEMENT OF CORRECTION (X5) COMPLETIC PREFIX TAG SUMMARY STATEMENT OF CORRECTION (AS) CAMPICATION SACRICIATION (AS) COMPLETIC PREFIX TAG SACRICIATION Administrator presental Quality and visitors social be affected by the semicoring company. Social be affected by the semicoring company. The facility is practice is that all residents, staff and visitors could be affected by the semicoring company. The department at the time of the fire drill of the fire drill. The corrective action taken for the other residents that have the potential to be affected by this deficient practice is that all residents, staff and visitors have the potential to be affected by this deficient practice is that all residents and visitors have the potential to be affected by the semical process of the fire drill have been documented			IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
(X4) ID SUMMARY STATEMENT OF DEFICIENCE TAG PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Administrator acknowledged there was no information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company.	NAME OF	PROVIDER OR SUPPLIER	3					
REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company.	TRANSO	CENDENT HEALTH	CARE OF OWENSVILLE	OWEN	SVILLE, IN 47665			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b) been affected by the deficient practice is that all residents, staff and visitors could be affected by the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on information on all 10 fire drill reports to information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company. COMPLETIC DATE AGE (18 perfective) (20 be affected by the deficient practice. In the all residents, staff and visitors could be affected by this deficient practice. In the facility's monitoring company/fire department received the fire drill on the time of the fire drill of the fire drill of the fire drill of the fire drill of the time of record review, the Administrator acknowledged there was no information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company.	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OF CORRECTION			(X5)	
3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. been affected by the deficient practice is that all residents, staff and visitors could be affected by this deficient practice is that all resident that the facility's monitoring company. Facility is monitoring company, fire department at the time of record review, the and visitors could be affected by this deficient practice is that all residents, staff and visitors could be affected by this deficient practice is that all residents, staff and visitors could be affected by the facility's fire alarm signal at the time of each fire drill no each showledged there was no include documented in the maintenance supervisor's fire drill have been documented in the maintenance supervisor's fire drill binder. The documentation also includes verification that the fire alarm signal was received at the facility's monitoring company, fire department at the time of each fire drill conducted. A schedule has	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on review of the facility's fire drill reports of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on review of the facility's fire drill reports of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm signal and the maintenance supervisor's fire drill have been documented in the maintenance supervisor's fire drill binder. The documentation also includes verification that the fire alarm signal was received at the facility's monitoring company/fire department at the time of each fire drill conducted. A schedule has	TAG	+	R LSC IDENTIFYING INFORMATION	TAG			DATE	
that fire drills are conducted on each shift at least quarterly in accordance with Life Safety Code. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for the		3.1-19(b) 2. Based on record facility failed to ensincluded complete of transmission of a firmonitoring companipast twelve months drills in health care transmission of the simulation of emerg deficient practice of Findings include: Based on review of on 09/27/22 betwee the Director of Env Administrator preseperformed during the include documentate alarm to the monitor interview at the tim Administrator acknowledges.	review and interview, the sure 12 of 12 fire drill reports documentation of the re alarm signal to the py/fire department during the . LSC 19.7.1.4 requires fire occupancies shall include the fire alarm signal and gency conditions. This build affect all residents. The facility's fire drill reports and ent, all 10 fire drill reports are past 12 month period did not cion for the transmission of the pring company. Based on the of record review, the owledged there was no to fire drill reports to verify that alarm was received by the		practice is that all residents, see and visitors could be affected this deficient practice. The fact has now revised their fire drill to include the documentation verifying that the facility's monitoring company/fire department received transmiss of the facility's fire alarm signate the time of the fire drill. 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 conducted a fire drill on eshift and the results of the fire have been documented in the maintenance supervisor's fire binder. The documentation all includes verification that the fire alarm signal was received at the facility's monitoring company/department at the time of each drill conducted. A schedule halso been established to ensure that fire drills are conducted on each shift at least quarterly in accordance with Life Safety of The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service has an additional service has a mandatory in-service has an additional service has a mandatory in-service has a mandatory in-service has an additional service has a mandatory in-service has an additional service has a mandatory in-service ha	staff by cility log ssion al at or the t all ave this has each drill lso ire the fire h fire as		

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maintenance supervisor on their responsibility to ensure that fire drills are completed on each shift

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/27/2022
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
				at least quarterly and the result of those fire drills documented the maintenance supervisor's drill binder. The maintenance supervisor was also instructed the required documentation of verifying that the fire alarm signed was successfully received by monitoring company/fire department and that this verification is being document on the fire drill log. The corrective action taken to monitor to ensure the deficient practice will not recur is that the maintenance supervisor will submit to the Executive Direct monthly documentation on the drills conducted, including documentation that the fire all signal was successfully received by the monitoring company/findepartment to validate complimited the regulation.	d in fire ed on f gnal the ted ted ted ted arm yed re
K 0761 SS=C Bldg. 01					
	interview; the facili inspection and testi door assembly was LSC 19.1.1.4.1.1. (dividing fire barrier permitted only in compared self-cl (See also Section 8, required to have a f 8.3.4.2 shall be pro-	on, record review, and ty failed to ensure an annual ing of 1 of 1 oxygen room fire completed in accordance with Communicating openings in is required by 19.1.1.4.1 shall be corridors and shall be protected cosing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table tected by approved, listed, semblies and fire window	K 0761	K 761 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 potto be affected by this deficien practice. The facility has now inspected and tested the fire assembly on the door of the	ried 5, ential t

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have been performed that void the label.

accordance with the regulation.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/27/2022	
	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	(11) Gasketing and inspected to verify t	edge seals, where required, are heir presence and integrity. ice could affect all residents,			
	Findings include:				
	a.m. and 12:00 p.m. Environmental Serv present, the facility documentation for a oxygen transfilling Based on interview the Administrator sa documentation of an oxygen transfilling Based on observation with the Director of between 12:00 p.m. oxygen transfilling in the facility. This finding was rev	n annual inspection of the room fire door assembly. Ons during a tour of the facility Environmental Services and 2:00 p.m., there was one room fire door assembly noted viewed with the Director of rices and Administrator during			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qual	ent - Power Cords and ent - Power Cords and eatient care vicinity are only nts of movable ed electrical equipment les that have been elified personnel and meet 0.2.3.6. Power strips in			

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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 COMPLETED 01 B. WING 09/27/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 K 920 10/14/2022 failed to ensure a power strip was not used as a The corrective action taken for substitute for fixed wiring in 1 of 1 Beauty Shop. those residents found to have LSC 19.5.1 requires utilities to comply with Section been affected by the deficient 9.1. LSC 9.1.2 requires electrical wiring and practice is that although no equipment to comply with NFPA 70, National specific residents were identified, Electrical Code, 2011 Edition. NFPA 70, Article any resident and staff member in 400.8 requires that, unless specifically permitted, the beauty shop has the potential flexible cords and cables shall not be used as a to be affected by this deficient substitute for fixed wiring of a structure. This practice. The power strip was deficient practice could affect one resident and immediately removed from the staff. beauty shop at the time of the survey. The facility has now Findings include: installed an additional hard wired electrical outlet in the beauty shop Based on observations on 09/27/22 between 12:00 providing additional electrical p.m. and 2:00 p.m. during a tour of the facility with outlets for the beautician's use. the Director of Environmental Services, there were The corrective action taken for the four curling irons and one hand held hair dryer other residents that have the plugged into a power strip in the Beauty Shop. potential to be affected by the Based on interview at the time of observation, the same deficient practice is that any Director of Environmental Services acknowledged resident utilizing the beauty shop the use of the power strip in the Beauty Shop. along with the beautician have the

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	A. BUILDING B. WING	B. WING		SURVEY ETED '2022	
	PROVIDER OR SUPPLIEF	CARE OF OWENSVILLE	STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, 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)	TE	(X5) COMPLETION DATE	
	This finding was re	viewed with the Director of vices and Administrator during		potential to be affected by this deficient practice. The facility now installed an additional har wired electrical outlet in the beauty shop providing addition electrical outlets for the beautician's use. The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service has been provided for the beauticianstruct them on the need to ensure that all electrical device are plugged into a hard-wired electrical outlet and that powe strips are not permitted to be used. 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 will of the beauty shop monthly to ensure that all electrical device are plugged into a hard-wired electrical outlet and that powe strips are not being used.	has rd put put ur is as an to es r t s ve		
K 0923 SS=F Bldg. 01	NFPA 101 Gas Equipment - Storag	Cylinder and Container					

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Gas Equipment - Cylinder and Container

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 09/27/2022			ETED		
	F PROVIDER OR SUPPLIE	CARE OF OWENSVILLE	•	7336 W	ODDRESS, CITY, STATE, ZIP COD STATE ROAD 165 SVILLE, IN 47665		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAG	Storage Greater than or e Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 o Storage locations enclosure or withi space of non- or l construction, with that can be secur stored with flamm from combustible sprinklered) or en noncombustible of minimum 1/2 hr. f Less than or equa ln a single smoke cylinders availabl patient care areas of less than or eq required to be sto Cylinders must be as specified in 11 A precautionary so on each door or g room, where the se a minimum "CAU" STORED WITHIN Storage is planne order of which the supplier. Empty of from full cylinders cylinders with inte threshold pressur established. Empl avoid confusion. O are protected from	qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an n an enclosed interior imited- combustible door (or gates outdoors) ed. Oxidizing gases are not tables, and are separated as by 20 feet (5 feet if closed in a cabinet of construction having a ire protection rating. al to 300 cubic feet compartment, individual e for immediate use in as with an aggregate volume ual to 300 cubic feet are not ared in an enclosure. e handled with precautions and a cylinder storage sign includes the wording as TION: OXIDIZING GAS(ES) and NO SMOKING." d so cylinders are used in ey are received from the cylinders are segregated and with pressure gauge, a e considered empty is oty cylinders are marked to Cylinders stored in the open		IAG	DISTRICT 1		DATE
	99)						

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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 COMPLETED 01 B. WING 09/27/2022 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0923 10/14/2022 failed to ensure cylinders of nonflammable gases The corrective action taken for such as oxygen were properly secured from falling those residents found to have in 1 of 1 oxygen transfilling/storage room. NFPA been affected by the deficient 99, Health Care Facilities Code, 2012 Edition, practice is that although no Section 11.3.3 states storage for nonflammable specific residents were identified gases with a total volume equal to or less than during the survey, all residents, greater than 8.5 cubic meters (300 cubic feet) shall staff and visitors have the potential comply with 11.3.3.1 and 11.3.3.2. NFPA 99, to be affected by this deficient Section 11.3.3.2 states precautions in handling practice. The E size oxygen cylinders specified in 11.3.3.1 shall be in cylinder identified during the accordance with 11.6.2. Section 11.6.2.3(11) states survey was immediately placed in freestanding cylinders shall be properly chained a secure oxygen cylinder stand to or supported in a proper cylinder stand or cart. ensure that the cylinder was This deficient practice could affect all residents, secure and free of the potential of staff and visitors since the oxygen room is across falling over. from the dining room. The corrective action taken for the other residents that have the Findings include: potential to be affected by the same deficient practice is that all Based on observations on 09/27/22 between 12:00 residents, staff and visitors have p.m. and 2:00 p.m. during a tour of the facility with the potential to be affected by this the Director of Environmental Services, there was deficient practice. The E size one of four E size oxygen cylinders in the oxygen oxygen cylinder identified during transfilling/storage room freestanding on the floor the survey was immediately and was not supported in a proper cylinder stand placed in a secure oxygen or otherwise secured from falling. Based on cylinder stand to ensure that the interview at the time of the observation, the cylinder was secure and free of Director of Environmental Services acknowledged the potential of falling over. All the E size oxygen cylinder in the oxygen oxygen cylinders are securely transfilling/storage room was not supported in a stored to prevent them from falling cylinder stand or otherwise secured from falling. The measures that have been put This finding was reviewed with the Director of into place to ensure that the Environmental Services and Administrator during deficient practice does not recur is the exit conference. that a mandatory in-service has been provided for all nursing, 3.1-19(b) housekeeping and maintenance staff on the facility's policy related to secure oxygen storage. All

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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 <u>01</u>	(X3) DATE SURVEY COMPLETED 09/27/2022	
	ROVIDER OR SUPPLIER	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 CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=F Bldg. 01	Gas Equipment - Transfilling of oxyg another is in according another is in according of High Oxygen Used for I any gas from one prohibited in patient to liquid oxygen containers over 50 under 11.5.2.3.1 (liquid oxygen containers under 50 conditions under 11.5.2.2 (NFPA 95)	1.5.2.3.2 (NFPA 99).	K 0927	staff members were instructed the proper means to secure oxygen cylinders. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented monitor the secure storage of oxygen cylinders. This tool word completed by the maintenance supervisor and/or their design weekly for four weeks, then monthly for three months and quarterly for three quarters. Outcome of this tool will be reviewed at the facility's Qual Assurance meetings to determif any additional action is warranted. K 927	ont nt a een to rill be se nee, then The

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155502	B. Wl	ING		09/27	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			STATE ROAD 165		
TDANSC	ENDENT HEALTH	CARE OF OWENSVILLE					
TRANSC	LINDENI NEALIN	CAIL OF OWEINSVILLE		OVVEINS	SVILLE, 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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to ensure 1 of	f 1 oxygen storage location			The corrective action taken for	r	
	where transfilling occurs had proper distance from				those residents found to have		
	combustible items. NFPA 99, Health Care				been affected by the deficient		
	Facilities Code 2012 Edition, Section 11.5.2.3.1				<i>practice is that</i> although no		
	states oxygen transfilling locations shall include				specific residents were identifi	ed	
	the following:				during the survey, all residents	s,	
	(1) A designated area separated from any portion				staff and visitors have the pote	ential	
	of a facility wherein patients are housed,				to be affected by this deficient		
	examined, or treated by a fire barrier of 1 hour fire				practice. All the cardboard bo	xes,	
	resistive construction.				papers and plastic items were		
	(2) The area is mechanically vented, is sprinklered,				immediately removed from the)	
	and has ceramic or concrete flooring.				oxygen storage area at the tim	ne of	
	(3) The area is posted with signs indicating that				the survey. No combustible it	ems	
	transfilling is occurring and that smoking in the				are left in the oxygen storage		
	immediate area is not permitted.				area.		
	(4) The individual t	ransfilling the container(s) has			The corrective action taken for	r the	
	been properly traine	ed in the transfilling			other residents that have the		
	procedures.				potential to be affected by the		
	NFPA 99, 11.3.2.3	requires oxidizing gases such as			same deficient practice is that	all	
	oxygen shall be sep	arated from combustibles by			residents, staff and visitors ha	ve	
	one of the following	g: (1) a minimum distance of 20			the potential to be affected by	this	
	feet. (2) a minimur	m distance of 5 feet if the			deficient practice. The oxyger	า	
	required storage loc	cation is protected by an			storage area is free of any		
	automatic sprinkler	system in accordance with			combustible items, such as		
		for the Installation of Sprinkler			cardboard, paper or plastic ite	ms.	
	Systems. (3) Enclo	sed cabinet of noncombustible			The measures that have been	put	
	construction having	a minimum fire protection			into place to ensure that the		
	rating of ½ hour.				deficient practice does not rec	ur is	
	This deficient pract	ice could affect all residents,			that a mandatory in-service ha	as	
	as well as staff and	visitors since the oxygen room			been provided for all nursing,		
	is across from the d	ining room.			housekeeping and maintenand	ce	
					staff on the facility policy relate	ed	
	Findings include:				to oxygen storage. The staff v	was	
					re-educated on ensuring that i	no	
	Based on observation	ons on 09/27/22 between 12:00			combustible items are placed	in	
	p.m. and 2:00 p.m.	during a tour of the facility with			the oxygen storage area.		
	the Director of Env	ironmental Services, the			The corrective action taken to		
	oxygen transfilling	and storage room where three			monitor to ensure the deficien	t	
		and four oxygen cylinders			practice will not recur is that a		
		ad four cardboard boxes plus	1		Ouglity Assurance tool has be		

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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 09/27/2022		
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 TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE		ГЕ	(X5) COMPLETION DATE	
	paper and plastic items stored on a rack that was within three feet of the liquid oxygen tanks. Based on interview at the time of observation, the Director of Environmental Services acknowledged the cardboard boxes, plus paper and plastic items stored within three feet of the three liquid oxygen tanks. This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference. 3.1-19(b)				developed and implemented to monitor the oxygen storage areas to ensure that the oxygen storage area is free of any combustible items. This tool will be completed by the maintenance supervisor and/or their designee, weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.			

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