STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING -- B. WING	05/28/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/28/25 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Emergency Preparedness survey, Transcendent Healthcare of Owensville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 68 certified beds. At the time of the survey, the census was 50. Quality Review completed on 05/29/25	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective June 6, 2025 to the state findings of the Life Safety Code Recertification & Emergency Preparedness Survey conducted on May 28, 2025.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/28/25 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective June 6, 2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tommy J O'niones		06/05/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Healthcare of Owensville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/29/25		to the state findings of the Life Safety Code Recertification & Emergency Preparedness Survey conducted on May 28, 2025.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.	K 0324	K 324 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now clearly marked the areas on the dietary department floor to identify the location of all cooking appliances to ensure they are	06/06/2025

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	Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff plus residents while in the adjoining dining room. Findings include: Based on observations on 05/28/25 at 1:05 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the oven/stove, deep fryer, and flat grill located under the range hood in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved designed location after they had been moved for maintenance and/or cleaning. Based on interview at 1:05 p.m. the Maintenance Director and Maintenance Assistant were not aware an approved method had to be provided to ensure the appliances were returned to an approved designed location after maintenance or cleaning. This finding was reviewed with the Administrator, General Manager, and Maintenance Director during the exit conference. 3.1-19(b)		utilized under the protection of the kitchen hood fire extinguishing system. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now clearly marked the areas on the dietary department floor to identify the location of all cooking appliances to ensure they are utilized under the protection of the kitchen hood fire extinguishing system. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all dietary staff to ensure their understanding of the requirement to utilize the stove, oven, grills and/or fryers under the protection of the kitchen hood fire suppression system which is clearly marked on the kitchen floor. These items may be moved for routine cleaning and maintenance but are to be returned to their designated areas when in use. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that the dietary department floor is clearly marked for the	

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			location of the any stoves, ovens, grills and fryers to ensure they are located under the fire extinguishing hood when in use and only moved for routine cleaning. This tool will be completed by the Maintenance Director 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.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure all 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 05/28/25 at 10:25 a.m. with the Maintenance Director and Maintenance Assistant present, all 12 fire drill reports did not include information about the transmission the alarm was received by the monitoring company. Based on interview at 10:25 a.m., the Maintenance Director confirmed all	K 0712	K 712 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents, staff and visitors have the potential to be affected by this deficient practice. The fire drill form has now been amended to include the time of transmission that the fire alarm was received by the monitoring company along with the name of the individual or operator number who received the fire alarm notification. *The corrective action taken for the other residents that have the potential to be affected by the*	06/06/2025

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	12 fire drill reports during the past 12 month period were not provided with a time of transmission the monitoring company received the alarm, plus the name or operator number was not included on the fire drill reports as well. This finding was reviewed with the Administrator, General Manager, and Maintenance Director during the exit conference. 3-1.19(b) 3.1-51(c)		*same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The fire drill form has now been amended to include the time of transmission that the fire alarm was received by the monitoring company along with the name of the individual or operator number who received the fire alarm notification. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been conducted for the maintenance staff on the updated fire drill form. The staff was instructed of their responsibility to complete all sections of the form including the time of the transmission of the fire alarm signal to the monitoring company as well as the name or operator number of the individual who received the fire alarm notification. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* each completed fire drill report will now be submitted to the Executive Director each month for review. The Executive Director and/or their designee will be responsible for ensuring that all required components are listed on the fire drill report as required by the regulation.	

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K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 05/28/25 at 11:45 a.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation	K 0921	K 921 *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 that utilizes or operate portable patient care related electrical equipment have the potential to be affected by this deficient practice. All new and or recently repaired portable patient care related electrical equipment is now being inspected by the maintenance staff to ensure resident safety prior to being place into service. A record of these inspections will be documented in the facility's preventative maintenance manual. This will be an on-going process. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff that utilize or operate any portable patient care related electrical equipment have the potential to be affected by this deficient practice. All new and or recently repaired portable patient care related electrical equipment is now being inspected by the maintenance staff to ensure resident safety prior to being place into service. A record of these	06/06/2025

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	for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items as of yet. Based on observation between 12:30 p.m. to 2:30 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator, General Manager, and Maintenance Director during the exit conference. 3.1-19(b)		inspections will be documented in the facility's preventative maintenance manual. This will be an on-going process. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on their responsibility to ensure that all new and/or repaired portable patient care related electrical equipment has been inspected by them prior to being placed into service. These inspections shall be documented in the facility's preventative maintenance manual for review. The maintenance staff was also advised that they were required to attend an annual in-service on the proper maintenance of and inspections of all portable patient care related electrical equipment utilized in the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will now submit a copy of the facility's PCREE report to the Executive Director monthly for their review and any additional recommendations that may be warranted. This will be a monthly on-going process.	