STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/24/23 Facility Number: 000450 Provider Number: 155801 AIM Number: 100273890 At this Emergency Preparedness survey, Transitional Healthcare of Boonville-North was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 56 certified beds. At the time of the survey, the census was 46. Quality Review completed on 11/01/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/24/23, to the state findings of the Emergency Preparedness Survey conducted on October 24, 2023.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Van Hoy	Administrator	11/13/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review could not be determined. Based on interview at the time of review, the Administrator said he has only been working at the facility for a short time and has not seen evidence that the emergency preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	E 0004	E 004 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now reviewed and updated the facility's emergency preparedness plan. The emergency preparedness plan will continue to be reviewed by the facility at least annually and updated as warranted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now reviewed and updated the facility's emergency preparedness plan. The emergency preparedness plan will continue to be reviewed by the facility at least annually and updated as warranted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility management team has now reviewed and updated the facility's emergency preparedness plan and will continue to review and update the plan as warranted and at least annually. *The corrective action taken to monitor to ensure the deficient*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			practice will not recur is that as part of the facility's Quality Assurance program, the QA committee will review the facility's emergency preparedness plan quarterly to ensure it is current and updated at least annually.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a)(1) and 42 CFR 483.73(a)(2). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, facility-based and community-based risk hazards were addressed in the plan, however, there was no facility-based and community-based risk assessment utilizing an all-hazards approach available for review. Based on interview at the time of record review, the Administrator agreed the facility-based and community-based risk assessment utilizing an all-hazards approach was not available for review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	E 0006	E 006 *The corrective action taken for those residents found to have been affected by the deficient* practice is that all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now completed a facility based and community- based risk assessment utilizing an all-hazard approach including missing clients and includes strategies for addressing emergency events that were identified by the completion of the risk assessment. *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 completed a facility based and community-based risk assessment utilizing an all-hazard approach including missing clients and includes strategies for addressing emergency events that were identified by the completion of the risk assessment. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Executive	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Director and the maintenance supervisor on the facility's policies related to emergency preparedness, including the completion of a facility based and community-based risk assessment every two years. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the facility's Quality Assurance committee will now review the facility's Emergency Preparedness plan annually to ensure that all components of the Emergency Plan have been completed timely and updated as warranted including the facility based and community-based risk assessment.	
E 0009 SS=C Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4) Local, State, Tribal Collaboration Process §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, no documentation was available which included a process for	E 0009	E009 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility now has the documentation to support that the facility has a process for the cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation. There is documentation in the facility's emergency preparedness binder of each contact with these officials as well as the outcome of these contacts.	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of review, the Administrator acknowledged there was no cooperation and collaboration process in the emergency preparedness plan available for review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility now has the documentation to support that the facility has a process for the cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation. There is documentation in the facility's emergency preparedness binder of each contact with these officials as well as the outcome of these contacts. *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 Executive Director of their responsibility in making contacts with the with local, tribal, regional, State and Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation. The Executive Director has been educated on their responsibility to document each contact with these officials as well as their response to these contacts in the emergency preparedness binder. *The corrective action taken to monitor to ensure the deficient*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			practice will not recur is that the QA Committee will review the E.P. plan quarterly to ensure that there is documentation to support that the facility has made the required contacts with local, tribal, regional, state and Federal emergency preparedness officials to develop cooperation and collaboration in developing and maintaining an integrated response during a disaster or emergency situation.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present,, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review could not be determined. Based on interview at the time of review, the Administrator said he has only been working at the facility for a short time and has not seen evidence that the emergency preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	E 0013	E013 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now developed and implemented emergency preparedness policies and procedures. These policies and procedures will be reviewed at least annually and updated as warranted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now developed and implemented emergency preparedness policies and procedures. These policies and procedures will be reviewed at least annually and updated as warranted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the Executive Director on their responsibility to ensure that the facility has	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			developed and implemented emergency preparedness policies and procedures and that the policies and procedures have been reviewed at least annually and updated as warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review at least annually to ensure that the facility has documentation to support that the facility's emergency preparedness policies and procedures have been reviewed and updated at least annually.	
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in	E 0015	E 015 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the plan provided did address food, water, medical, and pharmaceutical supplies to protect residents health and safety in an emergency, however, these items have not been updated for over ten years in the plan provided. Based on interview at the time of record review, the Administrator confirmed the plan provided has not been updated for the food, water, medical, and pharmaceutical supplies for at least the past ten years. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		staff have the potential to be affected by this deficient practice. The facility has updated their emergency preparedness policies and procedures to address the subsistence needs for staff and patients whether they evacuate or shelter in place. The policy and procedure now addresses, at the minimum the provision of food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain; temperatures to protect resident health and safety, and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm system as well as sewage and waste disposal. *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 have the potential to be affected by this deficient practice. The facility has updated their emergency preparedness policies and procedures to address the subsistence needs for staff and patients whether they evacuate or shelter in place. The policy and procedure now addresses, at the minimum the provision of food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain; temperatures to protect resident health and safety, and for the safe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm system as well as sewage and waste disposal. *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 all staff on the facility's revised emergency preparedness policy and procedure on subsistence needs for staff and patients. The staff members were educated on their individual responsibilities in complying with the revised policy and procedure. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA Committee will review the emergency preparedness policy and procedure on subsistence of needs of staff and patients at least annually to ensure that the policy and procedure complies with the regulation and meets the current needs of the facility staff and patients.	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents	E 0018	E018 *The corrective action taken for those residents found to have been affected by the deficient*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Administrator confirmed there was no system to track the location of on-duty staff and sheltered residents in the event of an emergency in the available plan. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure on the system for the tracking of on-duty staff and sheltered residents during and after an emergency. *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 have the potential to be affected by this deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure on the system for the tracking of on-duty staff and sheltered residents during and after an emergency. *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 all staff on the facility's new emergency preparedness policy on the system for tracking on-duty staff and sheltered residents during and after an emergency. The staff members have been educated on their responsibility in following this tracking system should an emergency arise. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			QA committee will review the policy and procedure for tracking on-duty staff and sheltered residents at least annually to ensure that the procedure remains effective and will make any changes to the policy if warranted.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	E 0024	E024 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure that addresses the use of volunteers in an emergency. The policy addresses emergency staffing strategies including the process and role for integration of State and Federally regulated health care professionals to address surge needs during an emergency. *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 have the potential to be affected by this	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure that addresses the use of volunteers in an emergency. The policy addresses emergency staffing strategies including the process and role for integration of State and Federally regulated health care professionals to address surge needs during an emergency. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's new emergency preparedness policy and procedure on the use of volunteers in an emergency. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review at least annually the facility's emergency preparedness policy and procedure on the use of volunteers and emergency staffing strategies to ensure that the policy remains effective and will make necessary changes to the policy when warranted.	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, at least two of the facility's on the list have changed names. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be corrected and updated. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	E 0025	E025 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has now updated the emergency preparedness policy and procedure related to the arrangement with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services for the residents. The policy now contains the current names of other facilities that have agreed to accept the residents if a situation arises that meets the regulatory requirements. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has now updated the emergency preparedness policy and procedure related to the arrangement with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services for the residents. The policy now contains the current names of	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			other facilities that have agreed to accept the residents if a situation arises that meets the regulatory requirements. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility management team on the facility's updated emergency preparedness policy and procedure related to other facilities that have agreed to receive residents in the event of limitations or cessation of operations to maintain the continuity of services for the residents. The policy now contains the current names of other facilities that have agreed to accept the residents if a situation arises that meets the regulatory requirements. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review at least annually the facility's emergency preparedness policy and procedure on the arrangement with other facilities who have agreed to receive residents in the event of limitations or cessation of operations to maintain the continuity of care for the residents. The policy and procedure will be updated if there are any changes in these agreements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility	E 0026	E026 *The corrective action taken for those residents found to have*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Administrator acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*been affected by the deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure related to the facility's role under a waiver declared by the Secretary in the provision of care and treatment at an alternate care site identified by emergency management officials. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has now developed and implemented an emergency preparedness policy and procedure related to the facility's role under a waiver declared by the Secretary in the provision of care and treatment at an alternate care site identified by emergency management officials. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility's management team on the facility's emergency preparedness policy and procedure related to the facility's role under a waiver by the Secretary in the provision of care and treatment at an alternate care site identified by emergency management officials. The team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			was advised of their responsibilities in providing care and services at an alternate care site as outlined by the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review at least annually to ensure there is documentation to support that the facility's emergency preparedness policy and procedure on the role of the facility of providing care and treatment at an alternate care site as outlined by the regulation has been reviewed and updated annually.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies	E 0029	E029 *The corrective action taken for those residents found to have*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility's emergency preparedness plan provided did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review could not be determined. Based on interview at the time of review, the Administrator said he has only been working at the facility for a short time and has not seen evidence that the emergency preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The Executive Director has now reviewed and updated the facility's emergency communication plan. The Executive Director will be responsible for ensuring that the communication plan is reviewed and updated at least annually. *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 have the potential to be affected by this deficient practice. The Executive Director has now reviewed and updated the facility's emergency communication plan. The Executive Director will be responsible for ensuring that the communication plan is reviewed and updated at least annually. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Executive Director on their responsibility for ensuring that the facility's emergency preparedness communication plan is reviewed and updated at least annually. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review at least annually the facility's emergency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			preparedness communication plan to ensure that there is documentation to support that it has been reviewed and updated annually.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility	E 0036	E036	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review could not be determined. Based on interview at the time of review, the Administrator said he has only been working at the facility for a short time and has not seen evidence that the emergency preparedness plan has been reviewed and updated within the past twelve months. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		*The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility's emergency preparedness training and testing program has now been reviewed and updated. The program will continue to be reviewed and updated at least annually. *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 have the potential to be affected by this deficient practice. The facility's emergency preparedness training and testing program has now been reviewed and updated. The program will continue to be reviewed and updated at least annually. *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 Executive Director on their responsibility to ensure that the facility's emergency preparedness training and testing program is reviewed and updated at least annually. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA Committee will review the facility's emergency preparedness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			training and testing program to ensure there is documentation to support that it has been reviewed and updated at least annually.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance	E 0037	E037 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. All staff members have now received their annual training and testing on the facility's emergency preparedness program. *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 have the potential to be affected by this deficient practice. All staff members have now received their annual training and testing on the facility's emergency preparedness	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Supervisor present, no documentation of annual emergency preparedness training and no documentation to show staff could demonstrate knowledge of the emergency preparedness plan was available for review. Based on an interview at the time of record review, the Administrator confirmed there was no documentation of annual emergency preparedness plan training and no documentation to show staff could demonstrate knowledge of the emergency preparedness plan was available for review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		program. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service with testing has been conducted for all employees on the facility's emergency preparedness program. The facility will continue to provide training and testing on the facility's emergency preparedness program for all new hires and for all employees at least annually. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for ensuring that all employees are provided training and testing on the facility's emergency preparedness program upon hire and at least annually thereafter. The Executive Director will review in-service documentation annually to ensure there is documentation in each employee's record to reflect this training and testing.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following	E 0039	E039 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility has now conducted the second annual exercise to test the facility's emergency plan. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility has	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the emergency preparedness plan on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility was able to provide documentation of a table top exercise dated 10/04/23, however, the facility was unable to provide documentation of a community based exercise performed during the past 12 month period. This was confirmed by the Administrator during record review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		now conducted the second annual exercise to test the facility's emergency plan. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the Executive Director on their responsibility for ensuring that exercises are conducted at least twice a year on the facility's emergency plan. The Executive Director is responsible for maintaining records of these exercises along with the outcome of these exercises. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the QA committee will review semi-annually the documentation on the facility's emergency plan to ensure that there is documentation to support the facility based and community-based exercises are conducted at least twice a year.	
E 0041 SS=C	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. --	§482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building	E 0041	E041 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents and staff have the potential to be affected by this deficient practice. The facility has now conducted the required inspection, testing and maintenance of the facility's emergency power system including the 4-hour load test. The facility will continue to conduct the required inspections, testing and maintenance of the facility's emergency power system per regulations. *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 have the potential to be affected by this	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occupants. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Maintenance Supervisor and Administrator present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		deficient practice. The facility has now conducted the required inspection, testing and maintenance of the facility's emergency power system including the 4-hour load test. The facility will continue to conduct the required inspections, testing and maintenance of the facility's emergency power system per regulations. *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 maintenance supervisor on the regulation related to the required inspections, testing and maintenance of the facility's emergency power system. The maintenance supervisor has been re-educated on their responsibility of maintaining a copy of all inspections, testing and maintenance as required by the regulation in the facility's preventative maintenance binder. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for reviewing the maintenance supervisor's preventative maintenance binder at least annually to ensure that there is documentation to support the required inspections, testing and maintenance of the facility's emergency power system. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING -- B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Executive Director will validate that the required inspections, testing and maintenance has been completed as required. Any lack of required documentation will be immediately addressed with the maintenance supervisor.	
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: 10/24/23 Facility Number: 000450 Provider Number: 155801 AIM Number: 100273890 At this Life Safety Code survey, Transcendent Healthcare of Boonville-North 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 detectors in all resident sleeping rooms. The facility has a capacity of 56 and had a census of 46 at the time of this survey.	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 11/24/23, to the state findings of the Emergency Preparedness Survey conducted on October 24, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/01/23			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the west hall exit discharge had two double light fixtures, one on each corner of the building, however, all four light bulbs were missing. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor who said he realized the bulbs were all missing that morning and was going to replace them that day.	K 0281	K281 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified, this deficient practice could potentially affect thirty residents, staff and visitors. The missing light bulbs were replaced on the day of the survey and are now functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide audit of all six exit lighting has been conducted. All six egress exits are now well illuminated to ensure safe egress. *The measures that have been put into place to ensure that the*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*deficient practice does not recur is that* a mandatory in-service has been conducted for all maintenance and housekeeping staff to ensure they understand the importance that all egress areas are well illuminated for safe egress. The staff was re-educated on their responsibility to ensure missing or burned-out bulbs are promptly replaced. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the six exits to ensure that all light bulbs that illuminate the egress are present and functioning properly. 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.	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency	K 0291	K291 *The corrective action taken for*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	light sets was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the battery backup light set at the generator did not illuminate when tested several times. Based on interview at the time of observation, the Administrator and Maintenance Supervisor acknowledged the battery backup light set at the generator did not illuminate when tested several times. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The battery back up light set at the generator has been repaired and is now functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A house wide audit of all six battery powered emergency lights have been checked and are functioning properly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on their responsibility for routinely checking all battery powered emergency lights to ensure that they continue to function properly. This task has been added to the facility's preventative maintenance program. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the proper functioning of the facility's six battery powered emergency lights. This tool will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/oven in the Physical Therapy gym was shut off at the switch when not in use. LSC 19.3.2.5.4 states	K 0324	K324 *The corrective action taken for those residents found to have been affected by the deficient*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to 5 residents, staff and visitors in the Physical Therapy room. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there was a cooktop stove/oven in Physical Therapy gym. The stove/oven was not being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Maintenance Supervisor confirmed the cooktop stove/oven was not deactivated when not in use, furthermore, the Maintenance Supervisor said he didn't think there was a deactivation switch for the Physical Therapy gym stove/oven other than unplugging it from the receptacle.		*practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now installed a kill switch for the stove/oven located in the PT gym. The kill switch is located in a locked kitchen cabinet next to the stove to ensure that no unauthorized persons can access the switch. The switch is in the off position when not in use. *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 installed a kill switch for the stove/oven located in the PT gym. The kill switch is located in a locked kitchen cabinet next to the stove to ensure that no unauthorized persons can access the switch. The switch is in the off position when not in use. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the life safety cooking facilities regulation and advised of their responsibility to ensure that the regulation is being followed. In addition, a mandatory in-service has been provided for all therapy staff on the installation of the stove kill switch as well as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		their responsibility to ensure that the stove kill switch is on when the stove is not 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 monitor the stove/oven in the PT gym to ensure that the stove is disengaged when not in use. 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.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by	K 0345	K345 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, there was documentation provided regarding an annual fire alarm system inspection dated 11/17/22 by the facility's fire alarm inspection vendor, furthermore, there were quarterly inspections available dated 02/22/23, 05/22/23, and 08/02/23 by the facility's fire alarm inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices. Based on interview at the time of record review, the Maintenance Supervisor agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		and visitors have the potential to be affected by this deficient practice. The facility has now completed the required semi-annual visual inspection of the facility's fire alarm devices and there is documentation of this visual inspection along with the findings in the facility's preventative maintenance binder. These fire alarm system inspections will continue to be conducted and documented in accordance with the regulation. *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 completed the required semi-annual visual inspection of the facility's fire alarm devices and there is documentation of this visual inspection along with the findings in the facility's preventative maintenance binder. These fire alarm system inspections will continue to be conducted and documented in accordance with the regulation. *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 facility's maintenance supervisor on their responsibility to ensure all required tasks are completed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			documented in accordance with the fire alarm system testing and maintenance regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for reviewing the maintenance supervisor's preventative maintenance binder quarterly to ensure there is documentation to support that all required inspections of the facility's fire alarm system have been completed and documented in accordance with the regulation including the semi-annual visual inspection of the facility's fire alarm devices.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility.	K 0346	K346 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire watch	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained. Based on an interview at the time of record review, the Administrator confirmed the fire watch lacked the previously mentioned information, furthermore, the Administrator said he has had issues with the gateway web link when using it in the past. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		policy has now been updated to include IDOH notification of the implementation of any fire watch conducted as required by regulation. The policy has also been updated to reflect that all staff members will be trained at least annually on how to properly conduct a fire watch along with the required documentation of information during the fire watch. *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 fire watch policy has now been updated to include IDOH notification of the implementation of any fire watch conducted as required by regulation. The policy has also been updated to reflect that all staff members will be trained at least annually on how to properly conduct a fire watch along with the required documentation of information during the fire watch. *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 all staff on the facility's revised fire watch policy. All staff have now been trained on how to conduct a fire watch as well as what information must be documented during the fire watch	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			per facility policy. This training will be conducted at least annually and more often if warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be responsible for reviewing the documentation of any fire watch conducted to ensure that the task has been completed in accordance with facility policy and that there is documentation to support the tasks that were completed during the fire watch. Additional training will be provided by the Executive Director on the fire watch policy when warranted.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler system gauges on the front lobby sprinkler system riser was replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, one of two sprinkler gauges on the front lobby sprinkler system had a date of 2015 which was over three years past due for replacement or recalibration. No recalibration date information was affixed to the dry sprinkler system gauge. Based on interview at the time of the observation, the Maintenance Supervisor confirmed the sprinkler system gauge had not been recalibrated within the most recent five year period and would have the gauge replaced as soon as possible. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 4 sprinklered smoke compartments was maintained	K 0353	K353 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The identified sprinkler system gauge in the front lobby sprinkler riser has now been replaced. All sprinkler system gauges will now be replaced or documented testing by comparison with a calibrated gauge every five years as required by the regulation. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* at least 20 residents, staff and visitors could be affected by this deficient practice. The identified ceiling area in the washer room of the laundry has now been repaired and there are no gaps around the water lines and conduits that prohibit the sprinkler heads from functioning at full capability. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The spare sprinkler cabinet in the front lobby sprinkler rise room has been straightened up and the spare sprinklers are securely placed in slots to ensure	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there were four one inch to three inch gaps around water lines and conduits penetrating the ceiling in the washer room of the laundry room. The gaps around the water lines and conduits were not properly fire stopped. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the gaps penetrating the laundry room ceiling and said they would be fire stopped as soon as possible. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler systems spare sprinkler cabinets were properly maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special		they do not become broken or damaged. *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 identified sprinkler system gauge in the front lobby sprinkler riser has now been replaced. All sprinkler system gauges will now be replaced or documented testing by comparison with a calibrated gauge every five years as required by the regulation. A house wide audit of all ceiling areas has been conducted to ensure that all sprinkler heads can function at their full capability. No other ceiling problems were identified. The spare sprinkler cabinet is now being checked routinely by the maintenance supervisor as part of the preventative maintenance program to ensure the proper storage of the spare sprinklers continues. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the required maintenance and testing of the sprinkler system. The maintenance supervisor has been educated on their responsibility to ensure that the sprinkler system	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the spare sprinkler cabinet in the front lobby sprinkler riser room had four spare sprinkler heads that were laying loosely and not in slots, which could cause breakage to the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there were four spare sprinkler heads in the spare sprinkler cabinet laying loose and not secured in their own slots. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		gauges are replaced and/or tested every five years in accordance with the regulation. They are also responsible to ensure that there are no gaps around water lines or conduits that penetrate the ceiling which might allow sprinkler heads to no function to their full capability and to ensure the safe storage of the spare sprinkler heads to avoid any potential breakage/damage to the spare sprinklers. *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 facility's sprinkler system is being maintained and tested in accordance with the life safety regulations. The tool will monitor the sprinkler gauges to ensure they are functioning properly and being replaced and/or tested in accordance with the regulations, that ceiling surfaces are being maintained properly, free of gaps which allow the sprinkler heads to function to their full capabilities and to ensure that spare sprinklers are being stored in the appropriate manner to prevent breakage/damage to the spare sprinkler heads. This tool will be completed by the maintenance supervisor and/or their designee weekly for four weeks, then monthly for three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all occupants in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected	K 0354	K354 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility fire watch policy has now been updated to include IDOH notification of the implementation of any fire watch conducted as required by regulation. The policy has also been updated to reflect that all staff members will be trained at	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility provided fire watch documentation, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained. Based on an interview at the time of record review, the Administrator confirmed the fire watch lacked the previously mentioned information, furthermore, the Administrator said he has had issues with the gateway web link when using it in the past. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		least annually on how to properly conduct a fire watch along with the required documentation of information during the fire watch. *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 fire watch policy has now been updated to include IDOH notification of the implementation of any fire watch conducted as required by regulation. The policy has also been updated to reflect that all staff members will be trained at least annually on how to properly conduct a fire watch along with the required documentation of information during the fire watch. *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 all staff on the facility's revised fire watch policy. All staff have now been trained on how to conduct a fire watch as well as what information must be documented during the fire watch per facility policy. This training will be conducted at least annually and more often if warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			responsible for reviewing the documentation of any fire watch conducted to ensure that the task has been completed in accordance with facility policy and that there is documentation to support the tasks that were completed during the fire watch. Additional training will be provided by the Executive Director on the fire watch policy when warranted.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 1 of 26 resident room corridor doors would close completely and latch, and resist the passage of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, room 22 corridor door did not close fully and latch into its door frame. The door was hitting the top of the frame on the latching side leaving a half inch to one inch gap along the entire length of the door when closed to its fullest. Based on interview at the time of observation, the Maintenance Supervisor acknowledged resident room 22 corridor door did not close completely and latch and was not smoke resistant when closed fully. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit	K 0363	K363 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* at least 20 residents, staff and visitors have the potential to be affected by this deficient practice. The resident's room door identified as room 22 has now been adjusted by the maintenance department and the door closes completely, latches securely into the door frame and resists the passage of smoke. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* at least 30 residents have the potential to be affected by this deficient practice. The rooms identified as rooms 22 and 10 have now had the waste baskets removed and there are no objects impeding the doors from closing. The residents and staff	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 26 resident room corridor doors had no impediment to closing. This deficient practice could affect at least 30 residents. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, resident room doors 22 and 10 were both held wide open with waste baskets. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged resident room doors 22 and 10 were being held wide open with waste baskets. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		members have been reminded to not place any objects in from of the doors that could potentially prevent them from closing. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide audit has been conducted on all corridor doors to ensure that they close completely, latch into the door frame securely and resist the passage of smoke. The doors have also been checked to ensure no objects have been placed in front of the doors to prevent the doors from closure. All corridor doors are now closing securely to resist the passage of smoke. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the regulation regarding the closure of corridor doors to ensure that they close securely to resist the passage of smoke and that no objects are placed in front of the doors at any time to prevent proper closure. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the proper closure of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			corridor doors. This tool will monitor to ensure each door closes completely, latches securely into the door frame and resists the passage of smoke. The tool will also monitor to ensure that there are no objects placed in front of the door that might impede secure closure. 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.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier walls was protected to maintain the smoke resistance of the	K 0372	K372 *The corrective action taken for those residents found to have*	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 10/24/23 between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the smoke barrier wall above the smoke barrier doors between the west corridor and the front lobby/center hall area had an approximately three foot by four foot section of the dry wall missing. Based on interview at the time of observation, the Maintenance Supervisor said he did not know the opening in the smoke barrier wall existed, but would have it repaired as soon as possible. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The smoke barrier wall above the smoke barrier doors between the west corridor and the front lobby center has been repaired. The dry wall has been replaced and the smoke barrier walls are now protected to maintain smoke resistance. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A house wide review of all smoke barrier walls has now been conducted and no additional issues have been identified that could affect the resistance of smoke. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service for the maintenance supervisor on the regulation on smoke barrier walls was conducted to ensure their knowledge level of the regulation and to remind them of their responsibility to ensure smoke barrier walls are maintained in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* Inspections of the smoke barrier	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			walls will now be routinely conducted as part of the preventative maintenance program and the findings documented in the preventative maintenance binder. The results of these inspections will be reviewed quarterly by the Executive Director to ensure on-going compliance.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. Furthermore, 4 of 12 fire drills were not provided with fully detailed information for times of drills, and 4 of 4 third shift fire drills were not performed during the dedicated third shift time frame. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 10/24/23 between 9:30 a.m. and 2:15 p.m. with	K 0712	K712 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now completed fire drills on each shift. The documentation of these fire drills is complete and reflects all required documentation including the specific times that the drills were conducted and the transmission of the fire alarm	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Administrator and Maintenance Supervisor present, the following was noted: a. The facility lacked fire drill documentation for the third shift (night) of the second quarter (April, May, and June) of 2023, and the first shift (day) of the third quarter (July, August, and September) of 2023. b. Fire drills dated 11/19/22 at 8:00, 12/18/22 at 2:30, 02/14/23 at 2:30, and 06/26/23 at 3:45 did not include a.m. or p.m. to verify the actual time of day the drills were performed. c. Fire drills dated 11/19/22 at 8:00, 03/10/23 at 9:00 p.m., 07/31/23 at 6:30 p.m., and 09/29/23 at 7:30 p.m. were all listed as third shift fire drills. When asked, the Administrator said the third shift time frame for fire drills was supposed to be between 10:00 p.m. and 6:00 a.m. Based on interview at the time of record review, the Administrator and Maintenance Supervisor confirmed the lack of a fire drill report during the first and third shifts of the second and third quarters of 2023, plus the lack of a.m. and p.m. on four fire drill reports. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 1 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		signal to the fire department. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now completed fire drills on each shift. The documentation of these fire drills is complete and reflects all required documentation including the specific times that the drills were conducted and the transmission of the fire alarm signal to the fire department. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a fire drill schedule has been prepared by the Executive Director to ensure that fire drills are being conducted in accordance with the regulation. A mandatory in-service has been provided for the maintenance supervisor on the regulation related to fire drills to ensure their knowledge level as to when the fire drills are to be conducted and what information must be documented with each fire drill including the specific time of the drill as well as the transmission of the fire alarm signal to the fire department. The newly developed fire drill schedule has been reviewed with the maintenance supervisor to ensure that fire drills are being conducted as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, 1 of 12 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. This drill was dated 10/21/22 at 1:00 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no information on the 10/21/23 fire drill report to verify that the transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3-1.19(b) 3.1-51(c)		*The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will now review monthly the fire drill documentation to ensure that fire drills are being conducted in accordance with the regulation and that detailed information is documented with each fire drill as required. Additional education will be provided by the Executive Director when warranted.	
K 0761 SS=C Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window	K 0761	K761 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The fire door assembly to the oxygen storage room has now been inspected and tested. The documentation of this inspection is on file in the	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.		preventative maintenance binder. *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 fire door assembly to the oxygen storage room has now been inspected and tested. The documentation of this inspection is on file in the preventative maintenance binder. In addition, all fire door assemblies have been inspected annually and the documentation of these inspections and testings are on file in the preventative maintenance binder. *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 maintenance supervisor on the regulation related to the maintenance, inspection and testing of fire doors. The maintenance supervisor was re-educated on their responsibility to ensure that these inspections and testings are completed at least annually and to ensure the documentation of such inspections in maintained at the facility in the preventative maintenance binder. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff, and visitors. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Administrator and Maintenance Supervisor between 2:15 p.m. and 5:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility in the same smoke compartment as the front lobby. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		Executive Director will review semi-annually the preventative maintenance binder to ensure fire door assemblies are inspected and tested at least annually and that there is documentation on file to support these inspections and testing.	
K 0781 SS=F Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and	K 0781	K781	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview; the facility failure to ensure portable space heaters were not used in health care occupancies according to current written policy documentation for the facility which prohibited their use. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility's policy was that portable space heaters were not allowed in the facility. Based on observations between 2:15 p.m. and 5:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, a faux fire place was observed in the front entrance lobby. The fire place was not affixed to the wall or floor at the time of observation, and was not turned on at the time of observation either. When the Maintenance Supervisor turned the fire place on the logs lit up and it blew hot air out of the front vent. This was acknowledged by the Maintenance Supervisor who said the fire place has not been used during his time working in the facility, but said he would remove the heat element as soon as possible. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		*The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The heating element was promptly removed from the faux fire place located in the facility lobby. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A house wide audit was conducted throughout the facility for the use of portable space heaters. No other portable space heaters were located. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service was conducted for the maintenance supervisor on the regulation related to the use of portable space heaters. The maintenance supervisor was instructed to add to the preventative maintenance program that during routine rounds, any portable space heaters that may be identified are to be promptly removed from the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			maintenance program, the maintenance supervisor will monitor during routine rounds to ensure that no portable space heaters are being utilized in accordance with facility policy. Any identified space heaters will be promptly removed by the maintenance supervisor.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 10/24/23 between 9:30 a.m. and 2:15 p.m. with the Administrator and Maintenance Supervisor present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.	K 0918	K918 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now completed the required four-hour load test on the facility's emergency generator. Documentation of this testing has been retained in the facility's preventative maintenance binder. This test will be completed at least every 36 months and the supportive documentation of this test will be placed in the preventative maintenance binder. *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 completed the required four-hour load test on the facility's emergency generator. Documentation of this testing has been retained in the facility's preventative maintenance binder.	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 01 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		This test will be completed at least every 36 months and the supportive documentation of this test will be placed in the preventative maintenance binder. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service for the maintenance supervisor has been conducted on the regulation related to the testing of the emergency generator which includes a 4-hour load test of the emergency generator every 36 months. The maintenance supervisor has been instructed to retain a copy of this testing in the facility's preventative maintenance binder. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the Executive Director will review the maintenance supervisor's preventative maintenance binders at least annually to ensure the required documentation is available related to the inspection, testing and maintenance of the facility's emergency power system including the 4-hour load test of the emergency generator every 36 months.	