PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING CO			COMPL	ETED
		155801	B. WING			10/24/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TRANSC	ENDENT HEALTH(	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
		SAME OF BOOMVILLE MORALL		BOOM	1		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Preparedness Survey was		E 0000 By submitting the enclosed				
	-	diana Department of Health in			materials, we are not admitting		
	accordance with 42	CFR 483.73.			truth or accuracy of any specif	ic	
	G - D - 16/5:				findings or allegations. We		
	Survey Date: 10/24	1/23			reserve the right to contest the		
	E004-NT 1 04	00450			findings or allegations as part		
	Facility Number: 00 Provider Number: 1				any proceedings and submit th	iese	
					responses pursuant to our		
	AIM Number: 100273890  At this Emergency Preparedness survey,				regulatory obligations. The factoring requests the plan of correction	•	
					considered our allegation of	be	
		care of Boonville-North was			compliance effective 11/24/23	to	
		ance with Emergency			the state findings of the	io	
	_	rements for Medicare and			Emergency Preparedness Sur	VAV	
		ing Providers and Suppliers, 42			conducted on October 24, 2023.		
	CFR 483.73	mg 110 viders and Suppliers, 12			Conducted on October 24, 202	J.	
	0110 100170						
	The facility has 56 c	certified beds. At the time of					
	the survey, the cens						
	3,						
	Quality Review con	npleted on 11/01/23					
	The requirement at	42 CFR, Subpart 483.73 is NOT					
	MET as evidenced b	by:					
							l l
E 0004	403.748(a), 416.54						
SS=C	• •	5(a), 483.475(a), 483.73(a),					
Bldg	484.102(a), 485.62	, ,					
	485.727(a), 485.92						
	491.12(a), 494.62(	• •					
	•	Review and Update					
	Annually	NEA( ) 0440 (151)					
	` ' '	5.54(a), §418.113(a),					
	- ' ' -	0.84(a), §482.15(a),					
	§483.73(a), §483.475(a), §484.102(a),						
	- , , -	625(a), §485.727(a),					
	§485.920(a), §486	3.360(a), §491.12(a),					
					i .		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: V2WV21 Facility ID: 000450 If continuation sheet

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155801		A. BUILDING COMPI B. WING 10/24					
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX TAG	\$494.62(a).  The [facility] must Federal, State and preparedness required must develop estate comprehensive errogram that mee section. The emer program must include following element (a) Emergency Pladevelop and main preparedness planand updated at leamust do all of the  * [For hospitals at §485.625(a):] Emergency Plane CAH] must comprehensive errogram that mee section, utilizing at preparedness required comprehensive errogram that mee section, utilizing at the section of the secti	comply with all applicable d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this gency preparedness ude, but not be limited to, tents:  an. The [facility] must tain an emergency on that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital analy with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this in all-hazards approach.  es at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], in the complex properties of the complex properties properties of the complex properties of the		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 2 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155801	B. WI	NG		10/24/	2023
	F PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST /ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	failed to develop and preparedness plant at least annually in 483.73(a). This determined residents in the facing and has not seen every preparedness plant and the facing and has not seen every preparedness plant and the facing and has not seen every preparedness plant and the facing and has not seen every preparedness plant and the facing and has not seen every preparedness plant and the facing and has not seen every preparedness plant and the facing and the facing and the facing and the facing and has not seen every preparedness plant and the facing and	wiew and interview, the facility and maintain an emergency hat was reviewed and updated accordance with 42 CFR ficient practice could affect all lity.  The emergency preparedness etween 9:30 a.m. and 2:15 p.m. ator and Maintenance the facility did provide an dness manual, however, it has and updated during the past e most recent date of review nined. Based on interview at the Administrator said he has at the facility for a short time idence that the emergency has been reviewed and past twelve months.  Viewed with the Administrator upervisor during the exit	E 00	004	E 004  The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, stand visitors have the potential be affected by this deficient practice. The facility has now reviewed and updated the facilemergency preparedness will continue to be reviewed by facility at least annually and updated as warranted.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now reviewed and updated the facility's emergency prepared plan. The emergency prepared plan. The emergency prepared plan and updated as warranted.  The measures that have been into place to ensure that the deficient practice does not rece that the facility management to has now reviewed and update facility's emergency prepared plan and will continue to reviewed and update facility's emergency prepared plan and will continue to reviewed and update the plan as warranted.  The corrective action taken to monitor to ensure the deficient to monitor to ensure the deficient.	lity's and plan of the all we this has been east and the all we all without and the all we are all without and the all we are all without and the all we are all without and the all without all without and the all without all without and the all without all w	11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 3 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY COMPLETED 10/24/2023		
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST 'ILLE, IN 47601		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	practice will not recur is that as part of the facility's Quality Assurance program, the QA committee will review the facili emergency preparedness plar quarterly to ensure it is current and updated at least annually.	ty's I	DATE
E 0006 SS=F Bldg	(1)-(2), 441.184(a); 483.475(a)(1)-(2), (1)-(2), 485.625(a); 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2); §481.113(a)(1)-(2); §483.73(a)(1)-(2); §485.625(a)(1)-(2); §485.625(a)(1)-(2); §485.920(a)(1)-(2); §491.12(a)(1)-(2), [(a) Emergency Pl develop and maint preparedness plar and updated at learnust do the follow (1) Be based on a facility-based and assessment, utiliziapproach.*	491.12(a)(1)-(2), 494.62(a)  Hazards Risk Assessment  ), §416.54(a)(1)-(2),  ), §441.184(a)(1)-(2),  §482.15(a)(1)-(2),  §485.68(a)(1)-(2),  ), §485.727(a)(1)-(2),  ), §486.360(a)(1)-(2),  §494.62(a)(1)-(2)  an. The [facility] must tain an emergency on that must be reviewed, ast every 2 years. The planting:]  and include a documented, community-based risk ing an all-hazards					

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 4 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155801	ì í	JILDING	NSTRUCTION	COMPL 10/24/	ETED
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	NDDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Plan. The Hospice maintain an emerge that must be review every 2 years. The following:  (1) Be based on an facility-based and assessment, utilizing approach.  (2) Include strategemergency events assessment, include the consequences disasters, and other affect the hospice with the following:  *[For LTC facilities and the strategemergency Plan. In develop and maintower preparedness plan and updated at least of the following:  (1) Be based on an facility-based and assessment, utilizing approach, including (2) Include strategemergency events assessment.  *[For ICF/IIDs at & Plan. The ICF/IID an emergency prepared be reviewed, and updated.]	and include a documented, community-based risk ing an all-hazards ies for addressing is identified by the risk ding the management of a of power failures, natural er emergencies that would is ability to provide care.  Seat §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ig missing residents. ies for addressing is identified by the risk  483.475(a):] Emergency must develop and maintain paredness plan that must updated at least every 2 ust do the following:  and include a documented, community-based risk in paredness plan that must updated at least every 2 ust do the following:					

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 5 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES  IN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	ľ	JILDING	ONSTRUCTION	(X3) DATE COMPL 10/24/	ETED
	F PROVIDER OR SUPPLIES	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	(2) Include strategemergency event assessment.  Based on record refailed to maintain a preparedness plant includes a documer community-based rall-hazards approach and (2) included stremergency events in assessment in according and 42 CFR 48 practice could affect Findings include:  Based on review of plan on 10/24/23 be with the Administrator present, community-based rall-hazards approach on interview at the Administrator agree community-based rall-hazards approach all-hazards approach all-haza	Ethe emergency preparedness etween 9:30 a.m. and 2:15 p.m. ator and Maintenance	E 0	006	E 006  The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, so and visitors have the potential be affected by this deficient practice. The facility has now completed a facility based and community- based risk assessment utilizing an all-har approach including missing cland includes strategies for addressing emergency events were identified by the complet of the risk assessment.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors has the potential to be affected by deficient practice. The facility now completed a facility base and community-based risk assessment utilizing an all-har approach including missing cland includes strategies for addressing emergency events were identified by the complet of the risk assessment.  The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service has been provided for the Executive.	taff I to  d zard ients s that cion r the tall eve this has d zard ients s that cion o put cur is as	11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 6 of 82

PRINTED: 11/17/2023

	OF HEALTH AND HU MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	` ′	JILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  10/24/2023	
	ROVIDER OR SUPPLIEI	CARE OF BOONVILLE - NORTH		305 E I	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0009 SS=C Bldg	441.184(a)(4), 48 483.73(a)(4), 484 485.68(a)(4), 485 486.360(a)(4), 49 Local, State, Triba §403.748(a)(4), § §441.184(a)(4), § §483.73(a)(4), §4 §485.68(a)(4), §4	6.54(a)(4), 418.113(a)(4), 2.15(a)(4), 483.475(a)(4), .102(a)(4), 485.625(a)(4), .727(a)(5), 485.920(a)(4), 1.12(a)(4), 494.62(a)(4) al Collaboration Process 416.54(a)(4), §418.113(a)(4), 460.84(a)(4), §482.15(a)(4), 83.475(a)(4), §484.102(a)(4), 85.625(a)(4), §485.727(a)(5), 486.360(a)(4), §491.12(a)(4),			Director and the maintenance supervisor on the facility's porrelated to emergency preparedness, including the completion of a facility based 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 the ensure that all components of Emergency Plan have been completed timely and updated warranted including the facility based and community-based assessment.	and  ont he of the d as	

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

following:]

§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

Event ID:

V2WV21

Facility ID: 000450

If continuation sheet

Page 7 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			COMPL	(X3) DATE SURVEY COMPLETED 10/24/2023	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	collaboration with and Federal emer officials' efforts to response during a situation. *  * [For ESRD faciliti (4) Include a proceed collaboration with and Federal emer officials' efforts to response during a situation. The dialy the local emergent least annually to caware of the dialy event of an emergengased on record reversible to ensure the included a process of collaboration with 1 Federal emergency to maintain an integend documentation of the contact such official participation in collaboration in collaboration with 1 Federal emergency to maintain an integency to maintain an integenc	when and interview, the facility emergency preparedness plan for cooperation and ocal, tribal, regional, State, or preparedness officials' efforts grated response during a cy situation, including the LTC facility's efforts to als and, when applicable, of its aborative and cooperative accordance with 42 CFR deficient practice could affect all the emergency preparedness streen 9:30 a.m. and 2:15 p.m. attor and Maintenance no documentation was	E 00	009	E009 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, stand visitors have the potential be affected by this deficient practice. The facility now has documentation to support that facility has a process for the cooperation and collaboration local, tribal, regional, State and Federal emergency preparedrofficials to maintain an integrar response during a disaster or emergency situation. There is documentation in the facility's emergency preparedness bind each contact with these official as well as the outcome of these contacts.	taff to the the with d ness ted	11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 8 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY  COMPLETED  10/24/2023	
	OF PROVIDER OR SUPPLIE	R CARE OF BOONVILLE - NORTH	305 I	ET ADDRESS, CITY, STATE, ZIP CO E NORTH ST NVILLE, IN 47601	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION (X5) OULD BE PPROPRIATE COMPLETION DATE	
	regional, State, or l preparedness offici integrated response emergency situatio time of review, the there was no coope process in the emer	als' efforts to maintain an e during a disaster or n. Based on interview at the Administrator acknowledged eration and collaboration rgency preparedness plan		The corrective action to other residents that have potential to be affected same deficient practice residents, staff and visit the potential to be affected deficient practice. The has the documentation that the facility has a proper the cooperation and collection with local, tribal, regional and Federal emergency preparedness officials to an integrated response disaster or emergency of there is documentation facility's emergency prebinder of each contact to officials as well as the contract of the contact of th	by the by the by the by the by the is that all tors have been by this facility now to support occess for laboration al, State of omaintain during a situation.  In the exparedness with these butcome of the been put by the mot recur is vice has Executive sibility in the e with the exparedness integrated been by the bee	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 9 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  (X3) DATE SUF  COMPLETE  10/24/20			ETED		
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	403.748(b), 416.5-441.184(b), 482.1-484.102(b), 485.62(b), 491.12(b), 494.62(c) Development of E §403.748(b), §446.5441.184(b), §460(c) §483.73(b), §485.68(b), §485.920(b), §485.920(b), §486.9494.62(b).  (b) Policies and prodevelop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe reviewed and u years.  *[For LTC facilities]	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 1.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 1.360(b), §491.12(b),			practice will not recur is that the QA Committee will review the plan quarterly to ensure that the is documentation to support the facility has made the requirement of the facility has made the require	E.P. nere nat red	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 10 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023	
	F PROVIDER OR SUPPLIE	CARE OF BOONVILLE - NORTH		305 E N	NDDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
TAG	develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policible reviewed and example and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policible address manager nonmedical emerging the preparedness pol on the emergency (a) of the particular care-related disasters likely to safety of the pa	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.  The ments for PACE and procedures and procedures and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not puipment, power, or water end energencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years.  The dialysis facility must		TAG	DEFICIENCY)		DATE	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 11 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING COMPLE B. WING 10/24/2			ETED	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF		тЕ	(X5) COMPLETION DATE
	years. These eme not limited to, fire, failures, care-relat supply interruption likely to occur in the area.  Based on record rever failed to develop an preparedness policites and proced updated at least ann CFR 483.73(b). The all residents in the failed to review of plan on 10/24/23 be with the Administrate Supervisor present, the plan for facility however the policite been reviewed by the recent twelve month of review could not interview at the times and has remergency prepared and updated within.	ergencies include, but are equipment or power ted emergencies, water in, and natural disasters ine facility's geographic view and interview, the facility implement emergency es and procedures. The ures must be reviewed and interview and in accordance with 42 is deficient practice could affect	E 00		E013 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, s and visitors have the potential be affected by this deficient practice. The facility has now developed and implemented emergency preparedness policand procedures will be review least annually and updated as warranted. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now developed and implement emergency preparedness policand procedures. These policicand procedures will be review least annually and updated as warranted. The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service had been conducted for the Executive Director on their responsibility ensure that the facility has	taff to  cies es ed at r the tall ve this has ted cies es ed at cies es ed at tall tall tall tall tall tall tall t	11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 12 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155801	ILDING		COMPL 10/24/	ETED
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD ORTH ST ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0015 SS=C Bldg	(1), 482.15(b)(1), 4485.625(b)(1) Subsistence Need §403.748(b)(1), §4841.184(b)(1), §4841.184(b)(1), §481.73(b)(1), §481.73(b)	8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), s for Staff and Patients 418.113(b)(6)(iii), 60.84(b)(1), §482.15(b)(1), 33.475(b)(1), §485.625(b)(1)  rocedures. [Facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at f this section, and the an at paragraph (c) of this ies and procedures must pdated every 2 years facilities]. At a minimum, ocedures must address		developed and implemented emergency preparedness policiand procedures and that the policies and procedures have 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 leannually to ensure that the fact has documentation to support the facility's emergency preparedness policies and procedures have been reviewed and updated at least annually.	been e ast ility that	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 13 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801		JILDING	NSTRUCTION	(X3) DATE : COMPL 10/24/	ETED
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS PETERS FOR THE APPROVI			(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	shelter in place, ir to the following: (i) Food, water, m supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency light (C) Fire detections systems. (D) Sewage and water in the policies and procession of the following of the following of the following and the policies address the following in the provision hospice employees.	edical and pharmaceutical ces of energy to maintain to protect patient health the safe and sanitary ons. thting. the extinguishing, and alarm vaste disposal. spice at §418.113(b)(6)(iii):] edures. are additional requirements ted inpatient care facilities and procedures must ving: of subsistence needs for es and patients, whether shelter in place, include, but		TAG	DEPICIENCY		DATE
	<ul><li>(A) Food, water, n supplies.</li><li>(B) Alternate sour the following:</li></ul>	nedical, and pharmaceutical					
	and safety and for storage of provision (2) Emergency lig	hting. extinguishing, and alarm					
	Based on record rev failed to ensure em- and procedures incl provision of subsist	view and interview, the facility ergency preparedness policies ude at a minimum, (1) The tence needs for staff and hey evacuate or shelter in	E 0	015	E 015 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents ar		11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 14 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	place, include, but a (i) Food, water, med supplies. (ii) Altern maintain - (A) Temp health and safety an storage of provision Fire detection, extin and (D) Sewage and with 42 CFR 483.73 could affect all occu Findings include:  Based on review of plan on 10/24/23 be with the Administra Supervisor present, food, water, medica to protect residents emergency, howeve updated for over ter Based on interview the Administrator of has not been update and pharmaceutical ten years.  This finding was rev	LISC IDENTIFYING INFORMATION  are not limited to the following: dical, and pharmaceutical ate sources of energy to peratures to protect resident d for the safe and sanitary as; (B) Emergency lighting; (C) aguishing, and alarm systems; d waste disposal in accordance as(b)(1). This deficient practice apants.  the emergency preparedness atween 9:30 a.m. and 2:15 p.m. attor and Maintenance the plan provided did address and pharmaceutical supplies health and safety in an are, these items have not been an years in the plan provided. at the time of record review, confirmed the plan provided d for the food, water, medical, supplies for at least the past  wiewed with the Administrator apervisor during the exit	TAG	staff have the potential to be affected by this deficient pract The facility has updated their emergency preparedness poli and procedures to address the subsistence needs for staff an patients whether they evacual shelter in place. The policy ar procedure now addresses, at minimum the provision of food water, medical and pharmaceutical supplies, alter sources of energy to maintain temperatures to protect reside health and safety, and for the and sanitary storage of provis emergency lighting, fire detect extinguishing and alarm syste as well as sewage and waste disposal.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents and staff have the potential to be affected by this deficient practice. The facility updated their emergency preparedness policies and procedures to address the subsistence needs for staff and patients whether they evacual shelter in place. The policy are procedure now addresses, at minimum the provision of food water, medical and pharmaceutical supplies, alter sources of energy to maintain temperatures to protect reside health and safety, and for the	ice.  cies e d d e or nd the l, nate sent safe ions, tion, m  r the  all has  d d e or nd the l, nate sent safe ions, tion, m	

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

Event ID:

 $V2WV21 \quad \ \ {\rm Facility\ ID:} \quad \ 000450$ 

If continuation sheet Page 15 of 82

PRINTED: 11/17/2023

	I OF HEALTH AND HU! R MEDICARE & MEDIC						MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		A. B	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	1	STREET A 305 E N BOON			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  and sanitary storage of provemergency lighting, fire determined as well as sewage and wasted disposal.  The measures that have been into place to ensure that the deficient practice does not retain that a mandatory in-service been conducted for all staff of facility's revised emergency preparedness policy and procedure on subsistence not for staff and patients. The sembers were educated on individual responsibilities in complying with the revised pand procedure.  The corrective action taken amonitor to ensure the deficien practice will not recur is that QA Committee will review the deficient practice	isions, ection, tem e en put ecur is has on the eeds taff their colicy	(X5) COMPLETION DATE
E 0018 SS=C Bldg	and (v), 441.184(b) 483.475(b)(2), 483	5.54(b)(1), 418.113(b)(6)(ii) b)(2), 482.15(b)(2), 3.73(b)(2), 485.625(b)(2), 5.360(b)(1), 494.62(b)(1)			emergency preparedness por and procedure on subsistence needs of staff and patients an annually to ensure that the pand procedure complies with regulation and meets the cur needs of the facility staff and patients.	ce of at least policy on the rrent	

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

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)

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 16 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		ľ	UILDING	NSTRUCTION	COMP	E SURVEY PLETED 4/2023				
	OF PROVIDER OR SUPPLIE SCENDENT HEALTH	R ICARE OF BOONVILLE - NORTH	_	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ).		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
	[(b) Policies and preparedness polon the emergency (a) of this section paragraph (a)(1) communication placetion. The policies and perviewed and upolon [annually for LTC the policies and perviewed and upolon [annually for LTC the policies and perviewed and upolon [annually for LTC the policies and perviewed and upolon [acility's] care during the following:]  [(2) or (1)] A system on-duty staff and relocated during the must document the location of the recolocation.  *[For PRTFs at §4 §483.73(b), ICF/II §460.84(b):] Policies system to track the and sheltered reserved in the properties of the pergency. If on residents are relocated must document the location in the percentage of the pergency in the percentage of the pergency in the percentage of the percentage	procedures. The [facilities] d implement emergency licies and procedures, based y plan set forth in paragraph, risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must be dated at least every 2 years facilities]. At a minimum, procedures must address em to track the location of sheltered patients in the ring an emergency. If sheltered patients are the emergency, the [facility] he specific name and ceiving facility or other 441.184(b), LTC at IDs at §483.475(b), PACE at cies and procedures. (2) A he location of on-duty staff sidents in the [PRTF's, LTC, care during and after an laduty staff and sheltered								
	Policies and proc	ospice at §418.113(b)(6):] edures. on from the hospice, which								

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 17 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/24/2023			
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	needs of evacuee transportation; ide location(s) and pri of communication assistance.  (v) A system to traemployees' on-du the hospice's care the on-duty emploare relocated duri hospice must doc and location of the location.  *[For CMHCs at § procedures. (2) Sc CMHC, which incland treatment nearesponsibilities; traof evacuation location location.  *[For OPOs at § 4 procedures. (2) A documentation that actual donor information, and savailability of recommendation of the location.	86.360(b):] Policies and system of medical at preserves potential and mation, protects potential and actual donor secures and maintains the ords.  194.62(b):] Policies and afe evacuation from the nich includes staff and needs of the patients.	E 0010		11/24/2022			
	failed to ensure emo	view and interview, the facility ergency preparedness policies ude a system to track the staff and sheltered residents	E 0018	E018 The corrective action taken for those residents found to have been affected by the deficient				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 18 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI 10/24	
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	305 E	TADDRESS, CITY, STATE, ZIP C NORTH ST IVILLE, IN 47601	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	emergency. If on-diresidents are relocal LTC facility must of location of the rece in accordance with deficient practice of Findings include:  Based on review of plan on 10/24/23 be with the Administra Supervisor present, that include a system on-duty staff and sleacility's care during available for review time of record review time of record review there was no system on-duty staff and sleacility staff a	s care during and after an auty staff and sheltered ted during the emergency, the document the specific name and aiving facility or other location 42 CFR 483.73(b) (2). This bould affect all occupants.  The emergency preparedness etween 9:30 a.m. and 2:15 p.m. ator and Maintenance no policies and procedures m to track the location of neltered residents in the LTC g and after an emergency was w. Based on interview at the two, the Administrator confirmed in to track the location of neltered residents in the event the available plan.  Viewed with the Administrator upervisor during the exit		practice is that all resic staff have the potential affected by this deficient. The facility has now desimplemented an emergore preparedness policy are procedure on the system tracking of on-duty staff sheltered residents durafter an emergency. The corrective action to other residents that has potential to be affected deficient practice. The now developed and im an emergency prepare policy and procedure of system for the tracking staff and sheltered residents and after an emergency prepare policy and procedure of system for the tracking staff and sheltered residential and after an emergency in-section to place to ensure that deficient practice does that a mandatory in-section to ensure the deficient practice does that a mandatory in-section to ensure the corrective action to tracking system should emergency arise.  The corrective action to monitor to ensure the corrective will not recur in the practice will not recur in the corrective will not recur in the practice will not recur in the prac	to be int practice. eveloped and gency ind em for the if and ring and  aken for the ve the is that all e the l by this facility has plemented dness in the of on-duty idents ergency. ve been put at the not recur is rvice has staff on the cy in the duty staff is during and he staff ducated on following this l an aken to deficient	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 19 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		(X2) MULTIPLE CONSTRUCTION (X:  A. BUILDING  B. WING			COMPL	x3) date survey COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	DDRESS, CITY, STATE, ZIP COD ORTH ST ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					QA committee will review the policy and procedure for track on-duty staff and sheltered residents at least annually to ensure that the procedure remeffective and will make any changes to the policy if warran	nains	
E 0024 SS=C Bldg	441.184(b)(6), 482.483.73(b)(6), 484.485.68(b)(4), 495.491.12(b)(4), 494.Policies/Procedure §403.748(b)(6), §4841.184(b)(6), §48485.68(b)(4), §485.68(b)(4), §485.920(b)(5), §485.920(b)(5), §485.920(b)(5), §4985.920(b)(5), §4985	es-Volunteers and Staffing 116.54(b)(5), §418.113(b)(4), 160.84(b)(7), §482.15(b)(6), 13.475(b)(6), §484.102(b)(5), 13.475(b)(6), §485.727(b)(4), 191.12(b)(4), §494.62(b)(5).  Trocedures. The [facilities] Implement emergency Idea and procedures, based In plan set forth in paragraph In risk assessment at If this section, and the Idea and procedures must Indian at paragraph (c) of this Idea and procedures must Indian at least every 2 In LTC facilities]. At a Idea and procedures must Indian at paragraph In the section of the sec					

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

Event ID:

 $V2WV21 \quad \ \ {\rm Facility\ ID:} \quad \ 000450$ 

If continuation sheet

Page 20 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	LETED
		155801	B. WI	NG		10/24	/2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			VILLE, IN 47601		
		Of the of Bootwille Horitin		Воон	1		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_ ·	§403.748(b):] Policies and					
	. , ,	he use of volunteers in an					
		ther emergency staffing					
		ess surge needs during an					
	emergency.						
	*r= 1	2440 440/b\:1 Daliaina and					
		§418.113(b):] Policies and					
	. , ,	The use of hospice					
		emergency and other ng strategies, including the					
	process and role for integration of State and Federally designated health care professionals to address surge needs during						
	an emergency.	duress surge needs during					
		view and interview, the facility	E 00	)24	E024		11/24/2023
		ensure emergency preparedness policies		) <u>2</u> T	The corrective action taken fo	r	11/24/2023
		lude the use of volunteers in			those residents found to have		
	_	her emergency staffing			been affected by the deficient		
		g the process and role for			practice is that all residents ar		
		or Federally designated health			staff have the potential to be		
	_	to address surge needs during			affected by this deficient pract	ice.	
	an emergency in ac	ecordance with 42 CFR			The facility has now develope		
	483.73(b)(6). This	deficient practice could affect			implemented an emergency		
	all occupants.				preparedness policy and		
					procedure that addresses the	use	
	Findings include:				of volunteers in an emergency	/.	
					The policy addresses emerge	ncy	
		f the emergency preparedness			staffing strategies including th	е	
	-	etween 9:30 a.m. and 2:15 p.m.			process and role for integration		
		ator and Maintenance			State and Federally regulated		
		, the facility's plan did not			health care professionals to		
		volunteers in an emergency.			address surge needs during a	.n	
		at the time of review, the			emergency.		1
		irmed the plan provided did not			The corrective action taken fo	r the	
	address the use of v	volunteers in an emergency.			other residents that have the		
					potential to be affected by the		
		eviewed with the Administrator			same deficient practice is that	all	
		upervisor during the exit			residents and staff have the		1
	conference.	conference.			potential to be affected by this	;	1

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

Event ID: V2WV21 Facility ID: 000450

If continuation sheet Page 21 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	LETED	
		155801	B. W	ING		10/24	/2023	
				CTREET !	ADDRESS CITY STATE ZIR COR			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
TDANCO	ENDENT HEALTH	CARE OF BOONVILLE MORTH	305 E NORTH ST BOONVILLE, IN 47601					
IKANSU	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOON	/ILLE, IN 4/001			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	•	DATE	
					deficient practice. The facility	has		
					now developed and implemen	ted		
					an emergency preparedness			
					policy and procedure that			
					addresses the use of voluntee	ers in		
					an emergency. The policy			
					addresses emergency staffing			
					strategies including the proces			
					and role for integration of Stat			
					and Federally regulated health	า		
					care professionals to address			
					surge needs during an emerge	-		
					The measures that have been	put		
					into place to ensure that the			
					deficient practice does not rec			
					that a mandatory in-service ha			
					been provided for all staff on t	he		
					facility's new emergency			
					preparedness policy and			
					procedure on the use of volun	teers		
					in an emergency.			
					The corrective action taken to			
					monitor to ensure the deficien			
					practice will not recur is that the			
					QA committee will review at le			
					annually the facility's emerger preparedness policy and	Ю		
					l ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	toors		
					procedure on the use of volun and emergency staffing strate			
					to ensure that the policy rema	~		
					effective and will make necess			
			1		changes to the policy when	oai y		
					warranted.			
					wananteu.			
E 0025	403.748(b)(7), 41	8.113(b)(5), 441.184(b)(7),						
SS=F	, , , ,	.475(b)(7), 483.73(b)(7),						
Bldg	, , , ,	5.920(b)(6), 494.62(b)(6)						
	Arrangement with							
	_	418.113(b)(5), §441.184(b)						

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

Event ID:

(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)

 $V2WV21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000450$ 

If continuation sheet

Page 22 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		lì í	UILDING	NSTRUCTION	(X3) DATE COMPL 10/24/	ETED			
	PROVIDER OR SUPPLIER	R CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	(7), §483.475(b)(7 §485.920(b)(6), §4	7), §485.625(b)(7), 494.62(b)(6).							
	must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication placetion. The policible reviewed and uyears [annually fominimum, the polion address the follow	orocedures. The [facilities] I implement emergency icies and procedures, based y plan set forth in paragraph , risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a icies and procedures must ving:]							
	§441.184,(b) Hos LTC Facilities at § procedures. (7) [o arrangements with other providers to of limitations or ce	pitals at §482.15(b), and §483.73(b):] Policies and or (5)] The development of h other [facilities] [and] a receive patients in the event essation of operations to inuity of services to facility							
	§483.475(b), CAF at §485.920(b) an §494.62(b):] Polic (6), (8)] The devel with other [facilitie receive patients in cessation of opera	60.84(b), ICF/IIDs at Hs at §486.625(b), CMHCs and ESRD Facilities at ties and procedures. (7) [or lopment of arrangements as] [or] other providers to an the event of limitations or ations to maintain the ces to facility patients.							
	procedures. (7) Ti arrangements with	§403.748(b):] Policies and he development of h other RNHCIs and other ve patients in the event of							

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 23 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	limitations or cess maintain the continuity of services to RNHC Based on record review of and procedures included arrangements with opproviders to receive limitations or cessat the continuity of service accordance with 42 deficient practice continuity of services accordance wi	ation of operations to nuity of non-medical I patients. Tiew and interview, the facility ergency preparedness policies ude the development of other LTC facilities and other residents in the event of cion of operations to maintain revices to LTC residents in CFR 483.73(b)(7). This ould affect all occupants.  The emergency preparedness atween 9:30 a.m. and 2:15 p.m. and Maintenance documentation of emergency es and procedures including arrangements with other LTC providers to receive residents ations or cessation of lable for review, however, at lity's on the list have changed atterview at the time of record	E 00	TAG	E025 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents had the potential to be affected by deficient practice. The facility now updated the emergency preparedness policy and procedure related to the arrangement with other facilities receive residents in the event 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 agree accept the residents if a situatiarises that meets the regulator requirements.  The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents have the potential to affected by this deficient practic. The facility has now updated the emergency preparedness policiand procedure related to the arrangement with other facilities receive residents in the event limitations or cessation of operations to maintain the continuity of services for the residents. The policy now contains the current names of	d to ion ry r the all be ice. he cy es to of	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 24 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155801			ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  10/24/2023			
ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST BOONVILLE, IN 47601					
ENDENT HEALTHO SUMMARY S (EACH DEFICIEN		305 E N	NORTH ST	d to ion ry  put  ur is is is lity's ness o d to of  d to ion ry  t ne ast ocy t with ed to of			
			agreements.				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 25 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	L CARE OF BOONVILLE - NORTH	<u> </u>	305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E 0026 SS=C Bldg	403.748(b)(8), 416 (iv), 441.184(b)(8) (8), 483.73(b)(8), 4 (7), 494.62(b)(7) Roles Under a Wa §403.748(b)(8), §4 (C)(iv), §441.184(l) §482.15(b)(8), §48 §485.625(b)(8), §4 [(b) Policies and p must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policity be reviewed and u years [annually for minimum, the policy address the follow (8) [(6), (6)(C)(iv), [facility] under a w Secretary, in accoof the Act, in the p treatment at an alt by emergency ma  *[For RNHCIs at § procedures. (8) The waiver declared by accordance with s provision of care as identified by emergoners.	6.54(b)(6), 418.113(b)(6)(C) 6, 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b)  aiver Declared by Secretary 416.54(b)(6), §418.113(b)(6) b)(8), §460.84(b)(9), 83.73(b)(8), §483.475(b)(8), 485.920(b)(7), §494.62(b)(7).  Arocedures. The [facilities] implement emergency cies and procedures, based of plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must ving:]  (7), or (9)] The role of the various declared by the ordance with section 1135 orovision of care and ternate care site identified oragement officials.  (403.748(b):] Policies and the role of the RNHCI under a by the Secretary, in the section 1135 of Act, in the at an alternative care site organic management						
	failed to ensure eme	view and interview, the facility ergency preparedness policies ude the role of the LTC facility	E 00	)26	E026 The corrective action taken for those residents found to have	•	11/24/2023	

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

Event ID: V2WV21 Facility ID: 000450 If continuation sheet Page 26 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER 155801			CONSTRUCTION	(X3) DATE SURVEY  COMPLETED  10/24/2023			
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
IAU	under a waiver declaccordance with see provision of care are care site identified to officials in accordance. This deficient pract. Findings include:  Based on review of plan on 10/24/23 be with the Administra Supervisor present, role of the LTC fact the Secretary. Based record review, the Administration of the LTC fact the Secretary. This finding was record review, the Administration of the LTC facility under Secretary.	ared by the Secretary, in etion 1135 of the Act, in the ad treatment at an alternate by emergency management ince with 42 CFR 483.73(b)(8). itee could affect all occupants.  The emergency preparedness etween 9:30 a.m. and 2:15 p.m. ator and Maintenance the plan did not address the illity under a waiver declared by ad on interview at the time of Administrator acknowledged id not address the role of the a waiver declared by the viewed with the Administrator upervisor during the exit	TAU	been affected by the opractice is that all resist the potential to be affed deficient practice. The now developed and iman emergency prepare policy and procedure in facility's role under a videclared by the Secret provision of care and the an alternate care site in emergency managem. The corrective action is other residents that has potential to be affected same deficient practice residents have the post affected by this deficient. The facility has now do implemented an emergency procedure related to the role under a waiver descretary in the provision and treatment at an all site identified by emermanagement officials. The measures that has into place to ensure the deficient practice does that a mandatory in-section provided for the management team on emergency preparednand procedure related facility's role under a videntified by emermanagement at an all site identified by emermanagement officials.	deficient dents have detected by this defacility has enplemented dedness related to the waiver dents have dentess related to the waiver denteration of the denteratio	DATE		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 27 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155801		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/24/2023				
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
E 0029 SS=C Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §483.73(c), §483.8 §485.68(c), §485.9 §485.920(c), §486: §494.62(c).  (c) The [facility] man emergency preplan that complies local laws and mulat least every 2 year facilities]. Based on record reversiled to develop and	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 0.84(c), §482.15(c), 475(c), §484.102(c), 625(c), §485.727(c), 6.360(c), §491.12(c), cust develop and maintain exparedness communication with Federal, State and st be reviewed and updated ears [annually for LTC riew and interview, the facility d maintain an emergency	E 0029	was advised of their responsibilities in providing car and services at an alternate cosite 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 leannually to ensure there is documentation to support that facility's emergency prepared policy and procedure on the return the facility of providing care attreatment at an alternate care as outlined by the regulation in been reviewed and updated annually.	are on.  t ne east the ness ole of nd site nas			
	preparedness comm	unication plan that complies		those residents found to have				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 28 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE ( COMPL 10/24/	ETED			
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	with Federal, State, and updated at leas: 42 CFR 483.73(c). affect all occupants  Findings include:  Based on review of plan on 10/24/23 be with the Administra Supervisor present, preparedness plan properties of the most recent date of review and interview Administrator said the facility for a she evidence that the er has been reviewed at twelve months.	and local laws was reviewed t annually in accordance with This deficient practice could		been affected by the de practice is that all reside staff have the potential affected by this deficien. The Executive Director reviewed and updated the emergency communication plan is reand updated at least and the corrective action to the residents that have potential to be affected same deficient practice residents and staff have potential to be affected deficient practice. The Director has now review updated the facility's emergency been provided for the Endirector on their responsible for ensuring communication plan. The measures that have into place to ensure that deficient practice does in that a mandatory in-sense been provided for the Endirector on their responsion ensuring that the facility emergency preparedness communication plan is read updated at least and the the facility emergency preparedness communication plan is read updated at least and the corrective action that monitor to ensure the depractice will not recur is QA committee will revie annually the facility's entangled.	ficient ents and to be t practice. has now he facility's tion plan. will be g that the reviewed nually. ken for the e the by the is that all e the by this Executive wed and nergency he be g that the reviewed nually. e been put t the not recur is vice has xecutive sibility for 's ss reviewed nually. ken to eficient that the w at least			

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 29 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155801		r í	UILDING	NSTRUCTION		SURVEY LETED /2023		
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE	
					preparedness communication to ensure that there is documentation to support the has been reviewed and updannually.	at it		
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §485. §485.68(d), §485. §485.920(d), §486 Hospice at §418.1 PACE at §460.84 HHAs at §484.102 CAHs at §486.626 485.727, CMHCs §486.360, and RHTraining and testindevelop and main preparedness traithat is based on thin paragraph (a) of assessment at pasection, policies at (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)  esting 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 63.360(d), §491.12(d), 6403.748, ASCs at §416.54, 6413, PRTFs at §441.184, 6413, PRTFs at §482.15, 6413, PRTFs at §485.68, 65, "Organizations" under at §485.920, OPOs at 640/FHQs at §491.12:] (d) fig. The [facility] must tain an emergency pring and testing program the emergency plan set forth						

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 30 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		r í	ILDING	NSTRUCTION	(X3) DATE : COMPL 10/24/	ETED	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	NDDRESS, CITY, STATE, ZIP COD NORTH ST YILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	training and testin the emergency plate of this section, risk (a)(1) of this section at paragraph (b) of communication plate section. The train must be reviewed annually.	mergency preparedness g program that is based on an set forth in paragraph (a) c assessment at paragraph on, policies and procedures if this section, and the an at paragraph (c) of this ing and testing program and updated at least					
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/II	D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every					
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the community of this section. The orientation program updated at every 2						
	Based on record rev	view and interview, the facility	E 00	36	E036		11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 31 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI 10/24	LETED			
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PPROPRIATE	(X5) COMPLETION DATE		
	failed to develop and preparedness training was reviewed and to accordance with 42 practice could affect Findings include:  Based on review of plan on 10/24/23 be with the Administrate Supervisor present, available to show the preparedness training been reviewed by the recent twelve month of review could not interview at the times and he has only been short time and has a emergency prepared and updated within.	nd maintain an emergency ng and testing program that updated at least annually in CFR 483.73(d). This deficient		The corrective action to those residents found to been affected by the depractice is that all reside staff have the potential affected by this deficien. The facility's emergency preparedness training a program has now been and updated. The program has now been and updated at least annual The corrective action to their residents that have potential to be affected same deficient practice residents and staff have potential to be affected deficient practice. The emergency preparedne and testing program has reviewed and updated. program will continue to reviewed and updated annually. The measures that have into place to ensure that deficient practice does that a mandatory in-serbeen conducted for the Director on their responensure that the facility's emergency preparedne and testing program is and updated at least an The corrective action to the practice will not recur is QA Committee will reviet facility's emergency presence of the practice will not recur is QA Committee will reviet facility's emergency presence of the practice will reviet facility and the practice will reviet facility and the practice wi	o have efficient ents and to be at practice.  y and testing reviewed aram will d and ly. ken for the re the by the is that all e the by this facility's ss training s now been The o be at least e been put tt the not recur is vice has Executive asibility to ss straining reviewed anually. ken to efficient ethat the ew the			

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 32 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2023		
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
E 0037 SS=F Bldg	441.184(d)(1), 482	6.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1),			training and testing program ensure there is documentati support that it has been revi and updated at least annual	on to ewed	
Diug	485.68(d)(1), 485. 486.360(d)(1), 49° EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §48	727(d)(1), 485.920(d)(1), 1.12(d)(1) am 116.54(d)(1), §418.113(d)(1), 160.84(d)(1), §482.15(d)(1), 133.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)					
	Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training in	emergency preparedness					
	existing staff, indivunder arrangemer consistent with the (ii) Provide emergat least every 2 years.	eir expected roles. ency preparedness training ears. mentation of all emergency					
	and procedures a	dures.  cy preparedness policies  re significantly updated, the  duct training on the					

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

Event ID:

 $V2WV21 \quad \ \ {\rm Facility\ ID:} \quad \ 000450$ 

If continuation sheet

Page 33 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155801	B. WI		<del></del>	10/24	
		100001	D. 111	_		10/24/	2020
NAME OF P	ROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP COD		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
	The hospice must (i) Initial training in	§418.113(d):] (1) Training. do all of the following: n emergency preparedness edures to all new and					
		mployees, and individuals					
providing services under arrangement,							
	consistent with the	_					
	(ii) Demonstrate s	_					
	emergency procedures.						
	(iii) Provide emergency preparedness training						
	at least every 2 years.  (iv) Periodically review and rehearse its						
	emergency preparedness plan with hospice						
		ling nonemployee staff),					
		asis placed on carrying out					
	the procedures ne	cessary to protect patients					
	and others.						
		mentation of all emergency					
	preparedness train	•					
		ncy preparedness policies					
	-	re significantly updated, the					
	updated policies a	duct training on the					
	procedures.	iild					
	p. 000 a.a. 00.						
	*[For PRTFs at §4	41.184(d):] (1) Training					
	. •	ΓF must do all of the					
	following:						
	``	emergency preparedness					
		dures to all new and					
	-	viduals providing services					
	under arrangemer		1				
	consistent with their expected roles.  (ii) After initial training, provide emergency						
		ning every 2 years.					
	(iii) Demonstrate s		1				
	emergency proced	_					
		mentation of all emergency					
preparedness training.							

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 34 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER  155801	 JILDING		COMPL 10/24	ETED
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
TAG	(v) If the emergent and procedures are PRTF must condupolicies and procedures are procedures and procedures are procedures and procedures and procedures and procedures and procedures are participants, and witheir expected roledures are procedures and procedures	cy preparedness policies re significantly updated, the loct training on the updated edures.  50.84(d):] (1) The PACE do all of the following: a emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with less. ency preparedness training ears. It is staff knowledge of edures, including informing eat to do, where to go, and in case of an emergency. In the case of an emergency ears ency preparedness policies are significantly updated, the lact training on the updated edures.  Se at §483.73(d):] (1) The LTC facility must do all the emergency preparedness edures to all new and viduals providing services int, and volunteers, ear expected role. ency preparedness training mentation of all emergency ining. It is staff knowledge of	TAG	DEFICIENCY)		DATE
	emergency proced	auros.				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 35 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155801		JILDING	COMP		ETED /2023	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601				
(X4) II PREFI TAC	X (EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	CORF must do al  (i) Provide initial to preparedness pol new and existing services under an consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docu (iv) Demonstrate emergency procesus to be oriented responsibilities remergency plan workday. The traininstruction in the I systems and signequipment.  (v) If the emerge and procedures a CORF must condicies and procedures a CORF must condicies and procedures and policies and procedures	raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting and irrefighting the corresponding on the updated edures.  85.625(d):] (1) Training H must do all of the emergency preparedness edures, including prompt inguishing of fires, here necessary, evacuation innel, and guests, fire properation with firefighting orities, to all new and widuals providing services int, and volunteers, eir expected roles. ency preparedness training						

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 36 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155801	B. WI	NG		10/24/	/2023
NAME OF 1	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD		
TRANSC	CENDENT HEALTH	CARE OF BOONVILLE - NORTH		305 E NORTH ST BOONVILLE, IN 47601			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION  DD FFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ' '	staff knowledge of					
	emergency proce						
	. ,	ncy preparedness policies re significantly updated, the					
	1	ct training on the updated					
	policies and proce						
	*[For CMHCs at §485.920(d):] (1) Training.						
	-	provide initial training in					
	emergency prepa	redness policies and					
	procedures to all i	new and existing staff,					
	individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain						
		the training. The CMHC					
		e staff knowledge of					
		dures. Thereafter, the					
	CMHC must provi	ning at least every 2 years.					
		view and interview, the facility	E 00	137	E037		11/24/2023
		nnual training for the		<i>) )  </i>	The corrective action taken for	r	11/24/2023
		edness Program (EPP). The			those residents found to have		
		lo all of the following: (i) Initial			been affected by the deficient		
	I	cy preparedness policies and			practice is that all residents a		
	procedures to all ne	ew and existing staff,			staff have the potential to be		
	-	ng services under arrangement,			affected by this deficient pract	tice.	
		sistent with their expected			All staff members have now		
		mergency preparedness			received their annual training		
	_	ually; (iii) Maintain			testing on the facility's emerge	ency	
		ll emergency preparedness			preparedness program.	4la -	
		nstrate staff knowledge of ares in accordance with 42 CFR			The corrective action taken for other residents that have the	rtne	
					potential to be affected by the		
	483.73(d) (1). This deficient practice could affect all residents in the facility.  Findings include:  Based on review of the emergency preparedness				same deficient practice is that		
					residents and staff have the	. an	
					potential to be affected by this	3	
					deficient practice. All staff	-	
					members have now received	their	
		etween 9:30 a.m. and 2:15 p.m.			annual training and testing on		
	_	ator and Maintenance			facility's emergency prepared		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 37 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		JILDING	ONSTRUCTION	(X3) DATE COMPL 10/24	ETED	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	emergency prepared documentation to sl knowledge of the er was available for rethe time of record reconfirmed there was emergency prepared documentation to sl knowledge of the er was available for rethis finding was reand Maintenance St conference.	viewed with the Administrator apervisor during the exit		program.  The measures that have been into place to ensure that the deficient practice does not reat that a mandatory in-service we testing has been conducted for employees on the facility's emergency preparedness program. The facility will control to provide training and testing the facility's emergency preparedness program for all 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 employees are provided training and testing on the facility's emergency preparedness proupon hire and at least annually thereafter. The Executive Director will review in-service documentation annually to enthere is documentation in each employee's record to reflect the training and testing.	cur is ith or all tinue on new of the earling gram y ector sure h	
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requires \$416.54(d)(2), \$4460.84(d)(2), \$4483.475(d)(2), \$4483	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 38 of 82

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155801	B. W	ING		10/24/	2023
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	_		ADDRESS, CITY, STATE, ZIP COD	-	
TRANSO	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			IORTH ST /ILLE, IN 47601		
	T		ı		ILLE, IIN 47001		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	(2), §491.12(d)(2)			IAG			DATE
	(2), 3401.12(d)(2)	, 3434.02(4)(2).					
	*[For ASCs at §41	6.54, CORFs at §485.68,					
	_	ons" under §485.727,					
	CMHCs at §485.9	20, RHCs/FQHCs at					
	§491.12, and ESRD Facilities at §494.62]:						
	(2) Testing. The [facility] must conduct						
		he emergency plan					
		ility] must do all of the					
	following:						
	loneg.						
	(i) Participate in a full-scale exercise that is community-based every 2 years; or						
	' '	nunity-based exercise is					
		nduct a facility-based					
		e every 2 years; or					
	, ,	ility] experiences an actual					
		ade emergency that requires					
		mergency plan, the [facility]					
	-	gaging in its next required					
	1	or individual, facility-based					
		e following the onset of the					
	actual event.	dition of course of the cot					
	' '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2) s conducted, that may					
	` '	•					
		limited to the following: scale exercise that is					
	' '	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	` '	er drill, or ercise or workshop that is					
		and includes a group					
	discussion using a	- · · · · · · · · · · · · · · · · · · ·					
	_	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	·					

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

Event ID: V2WV21 Facility ID: 000450

If continuation sheet Page 39 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155801		r /	JILDING	NSTRUCTION	COMPL 10/24/	ETED	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST I'ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	maintain documer exercises, and em the [facility's] eme  *[For Hospices at (2) Testing for ho the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional emerged for the emergency exempt from engascale community-facility-based functional exercise of the section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disassion using a clinically-relevant set of problem star	spices that provide care in the hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or unity based exercise is not content an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full based exercise or individual tional exercise following the gency event. Inditional exercise every 2 eyear the full-scale or equipment and the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 40 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155801			UILDING	NSTRUCTION	(X3) DATE COMPL 10/24/	ETED	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	•	305 E N	ODDRESS, CITY, STATE, ZIP COD ORTH ST ILLE, IN 47601	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	care directly. The exercises to test to per year. The hose (i) Participate in a state that is community (A) When a community (A) When a community-based functional exercise emergency exempt from engatull-scale community-based functional exercise emergency event. (ii) Conduct an actual that may include, following:  (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extenditator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the hospice's emergers and enter the hospice's emergers.	nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem end messages, or prepared ed to challenge an espice's response to and matation of all drills, tabletop nergency events and revise ergency 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						

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 41 of 82

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			UILDING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 10/24/2023		
		ROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601					
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE		E	(X5) COMPLETION	
_	TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
			ar. The [PRTF, Hospital,						
		CAH] must do the							
			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							
		•	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							
			at may include, but is not						
		limited to the follo							
		• •	scale exercise that is						
		community-based							
		•	ctional exercise; or						
			ock disaster drill; or						
		, ,	exercise or workshop that						
		-	or and includes a group						
		discussion, using							
		set of problem sta	emergency scenario, and a						
		•	pared questions designed						
		to challenge an er	-						
		-	he [facility's] response to						
		, ,	umentation of all drills,						
			s, and emergency events						
		and revise the [fac	cility's] emergency plan, as						
		needed.  *[For PACE at §460.84(d):]							
			PACE organization must						
			to test the emergency						
		plan at least annu	-						
		organization must	do the following: an annual full-scale exercise						
		(i) Failicipale in a	an annual lun-scale exercise	1				Ī	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 42 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		l í	UILDING	NSTRUCTION	COME	E SURVEY PLETED 4/2023			
	ROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE		
	that is community (A) When a commaccessible, condu- facility-based function (B) If the PACE ex- or man-made emeractivation of the exempt from en- full-scale community-based functional exercise of this section is of the discommunity-based based functional exercises (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an er- (iii) Analyze the Framintain documer exercises, and em- the PACE's emergency of the community in the emergency procedure in the emergency procedure in the emergency procedure.	chased; or nunity-based exercise is not not an annual individual, stional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required nity based or individual, stional exercise following the gency event.  In additional exercise every the year the full-scale or ender paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is nor individual, a facility exercise; or the dill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a extements, directed pared questions designed mergency plan.  PACE's response to and thation of all drills, tabletop mergency events and revise gency plan, as needed.  Les at §483.73(d):]  Tity] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: an annual full-scale exercise							

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 43 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		ì	UILDING	NSTRUCTION	COM	e survey pleted 14/2023		
	PROVIDER OR SUPPLIE	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601						
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	TION ILD BE ROPRIATE	(X5) COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	(A) When a comn	nunity-based exercise is not							
		ıct 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									
		based functional exercise							
	_	et of the emergency event.							
	1 ' '	dditional annual exercise							
	that may include, but is not limited to the following:								
	(A) A second full-scale exercise that is								
	1	l or an individual, facility							
	based functional								
	(B) A mock disas								
	` '	ercise or workshop that is							
	led by a facilitator	— ·							
	discussion, using								
	I	emergency scenario, and a							
		atements, directed							
	1	pared questions designed							
	to challenge an e								
		LTC facility] facility's							
	•	maintain documentation of							
	1	exercises, and emergency							
	emergency plan,	e the [LTC facility] facility's							
	emergency plan,	as needed.							
	*[For ICF/IIDs at §	\$483.475(d)]·							
		CF/IID must conduct							
	` '	the emergency plan at least							
		ne ICF/IID must do the							
	following:	.5.7115 111451 45 416							
	_	n annual full-scale exercise							
	that is community								
		nunity-based exercise is not							
accessible, conduct an annual individual,									
		ctional exercise; or.							

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 44 of 82

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		 JILDING	nstruction 	COMPL 10/24/	ETED	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST ILLE, IN 47601		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	(B) If the ICF/IID e	xperiences an actual				
	natural or man-ma	ide emergency that requires				
	activation of the emergency plan, the ICF/IID is exempt from engaging in its next required					
		ity-based or individual,				
	1	tional exercise following the				
	onset of the emer	-				
	l ' '	ditional annual exercise				
		out is not limited to the				
	following:					
	1 ' '	scale exercise that is				
	community-based facility-based func					
	(B) A mock disaste					
	· '	rcise or workshop that is				
		and includes a group				
	discussion, using					
	_	emergency scenario, and a				
	set of problem sta	-				
	· ·	pared questions designed				
	to challenge an en	-				
	_	F/IID's response to and				
	1 ' '	station of all drills, tabletop				
		ergency events, and revise				
		gency plan, as needed.				
	*[Ear ULIA - at 940	4 1001				
	*[For HHAs at §48	e HHA must conduct				
		ne emergency plan at				
		e HHA must do the				
	following:	CTITIA Must do tito				
		full-scale exercise that is				
	community-based					
	1	ommunity-based exercise				
	` '	conduct an annual				
		pased functional exercise				
	every 2 years; or.					
	(B) If the HHA experiences an actual					
	1 ' '	ide emergency that requires				
		mergency plan, the HHA is				

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

Event ID:

 $V2WV21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000450$ 

If continuation sheet

Page 45 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155801		 UILDING	NSTRUCTION	(X3) DATE COMPL 10/24	ETED
	F PROVIDER OR SUPPLIED	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	exempt from engatull-scale community based functional exercise of this section is concentrated include, but is not a community-based facility-based functional exercise facility-based functionally-based facility-based functionally-relevant set of problem statemessages, or preto challenge an elevant exercises, and enthe HHA's emergent for the problem statemes and the head of the control of the c	aging in its next required nity-based or individual, ctional exercise following the gency event.  Iditional exercise every 2 the year the full-scale or the under paragraph (d)(2)(i) conducted, that may climited to the following: full-scale exercise that is the or an individual, ctional exercise; or isaster drill; or the exercise or workshop that for and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan.  HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed.  86.360]  e OPO must conduct the emergency plan. The				

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 46 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155801	B. WI	NG		10/24	/2023
e e e				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	ζ			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOON	/ILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEFFERET		DATE
	of the emergency	xercise following the onset					
		PO's response to and					
		ntation of all tabletop					
	exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as						
	needed.						
	*[ RNCHIs at §400	3.7481:					
	_	e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th	- · · ·					
	(i) Conduct a pape	er-based, tabletop exercise					
	at least annually.	A tabletop exercise is a					
	- '	led by a facilitator, using a					
		-relevant emergency					
		et of problem statements,					
	_	s, or prepared questions					
	_	enge an emergency plan.					
		NHCI's response to and ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 00	)39	E039		11/24/2023
		tercises to test the emergency			The corrective action taken for	r	
	plan at least twice p	per year, including			those residents found to have		
		drills using the emergency			been affected by the deficient		
	_	C facility must do the			practice is that all residents ar	nd	
	following:				staff have the potential to be		
		annual full-scale exercise that			affected by this deficient pract		
	is community-based				The facility has now conducted		
		ity-based exercise is not an annual individual,			second annual exercise to tes	ιτne	
					facility's emergency plan.  The corrective action taken for	r the	
	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			other residents that have the	<del></del>		
				potential to be affected by the			
				same deficient practice is that			
		ext required full-scale in a			residents and staff have the	J.,	
		or individual, facility-based			potential to be affected by this	;	
	-	l exercise for 1 year following			deficient practice. The facility		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 47 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155801		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey leted /2023
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUCK INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ.	(X5) COMPLETION
TAG	the onset of the acti (ii) Conduct an add include, but is not I a. A second full-sea community-based of functional exercise. b. A mock disaster c. A tabletop exerci facilitator that inclu a narrated, clinicall and a set of probler messages, or prepar challenge an emerg (iii) Analyze the L7 maintain document exercises, and emer LTC facility's emer accordance with 42 This deficient pract in the facility.  Findings include:  Based on review of plan on 10/24/23 be with the Administra Supervisor present, provide documenta dated 10/04/23, how provide documenta exercise performed period. This was co during record revie  This finding was re and Maintenance S conference.	itional exercise that may imited to the following: ale exercise that is or an individual, facility-based drill; or use or workshop that is led by a use a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to ency plan.  The facility's response to and ation of all drills, tabletop regency events, and revise the regency plan, as needed in CFR 483.73(d)(2). itie could affect all occupants  The emergency preparedness etween 9:30 a.m. and 2:15 p.m. ator and Maintenance the facility was able to tion of a table top exercise wever, the facility was unable to tion of a community based during the past 12 month onfirmed by the Administrator we.  Viewed with the Administrator upervisor during the exit		TAG	now conducted the second are exercise to test the facility's emergency plan.  The measures that have been into place to ensure that the deficient practice does not red that a mandatory in-service had been conducted for the Executive Director on their responsibility ensuring that exercises are conducted at least twice a year the facility's emergency plan. Executive Director is responsifor maintaining records of the exercises along with the outcous 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 the facility's emergency platensure that there is documentation to support the facility based and community-based exercises a conducted at least twice a year.	o put cur is as ative for ar on The ble se ome  t ne tion an to	DATE
E 0041 SS=C	482.15(e), 483.73 Hospital CAH and	(e), 485.625(e) LTC Emergency Power					

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 48 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  10/24/2023	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	DDRESS, CITY, STATE, ZIP COD ORTH ST ILLE, IN 47601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg	§482.15(e) Conditive (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this solid systems plan solid systems based on forth in paragraph (e) Emergency and The [LTC facility as implement emergency systems based on forth in paragraph (e) Emergency generator must be the location required Care Facilities Coulnterim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildin 482.15(e)(2), §483 Emergency generation, testing requirements found Facilities Code, Ni Code.	tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. and the CAH] must ency and standby power in the emergency plan set (a) of this section.  83.73(e)(1), §485.625(e)(1) actor location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new or when an existing eng is renovated.  3.73(e)(2), §485.625(e)(2) actor inspection and testing. Health Care FPA 110, and Life Safety and [maintenance] and in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3)		IAU			DATE	
	Emergency gener	ator fuel. [Hospitals, CAHs						

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 49 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/24/2023	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	•	305 E N	ADDRESS, CITY, STATE, ZIP COD ORTH ST 'ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and LTC facilities] source to power e have a plan for ho power systems op emergency, unless *[For hospitals at § §483.73(g), and C The standards ince this section are appreference by the E Federal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resource and Recounty (NARA). For information Resource and Recounty (NARA). For information the same and the section are appreference by the E Federal Register in 552(a) and 1 CFR the material from the You may inspect as Information Resource and Recounty (NARA). For information Resource (NARA) and Recounty (NARA) and (NARA)	that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the as it evacuates.  §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the in accordance with 5 U.S.C. is part 51. You may obtain the sources listed below. In a copy at the CMS curce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code actions/ibr_locations.html. This edition of the Code are efference, CMS will publish a federal Register to inges.  Protection Association, 1 k, 9, www.nfpa.org,  th Care Facilities Code, ed August 11, 2011. Im amendment (TIA) 12-2 to					
		PA QQ issued August 1					

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 50 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155801	B. W	NG		10/24/	/2023
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
TIVAINOC		OAKE OF BOOMVILLE - NORTH		DOON	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2013.						
	, ,	FPA 99, issued March 3,					
	2014. (vii) NFPA 101, Life Safety Code, 2012						
	edition, issued Au						
	(viii) TIA 12-1 to NFPA 101, issued August						
	11, 2011.	TDA 404 issued Ostober					
	30. 2012.	FPA 101, issued October					
	, -	FPA 101, issued October					
	22, 2013.	TA 101, Issued October					
	(xi) TIA 12-4 to NFPA 101, issued October						
	22, 2013.						
	, ·	tandard for Emergency and					
	` '	ystems, 2010 edition,					
	including TIAs to	chapter 7, issued August 6,					
	2009						
		view and interview, the facility	E 00	)41	E041		11/24/2023
	_	the emergency power system			The corrective action taken for	r	
	-	and maintenance requirements			those residents found to have		
		Care Facilities Code, NFPA			been affected by the deficient		
		y Code in accordance with 42			practice is that all residents an	nd	
	CFR 483.73(e)(2).				staff have the potential to be		
	D 1 1	. 1.4 . 4 6 774			affected by this deficient practi		
		view and interview, the facility			The facility has now conducted		
	_	Implete documentation for the nergency Power Standby			required inspection, testing an	u	
		ace with NFPA 110, Standard			maintenance of the facility's		
	I -	Standby Power Systems,			emergency power system including the 4-hour load test.	The	
		quired by NFPA 99 Health Care			facility will continue to conduct		
		etion 6.4.1.1.6.1. NFPA 110			required inspections, testing a		
	· · · · · · · · · · · · · · · · · · ·	that all Level 1 Emergency			maintenance of the facility's		
		ll be tested at least once within			emergency power system per		
	· ·	Where the assigned class is			regulations.		
		s, it shall be permitted to			The corrective action taken for	r the	
		fter 4 hours. NFPA 99 Section			other residents that have the	-	
	6.4.1.1.6.1 states th	at Type 1 and Type 2 essential			potential to be affected by the		
		ower sources shall be classified			same deficient practice is that	all	
	at Type 10, Class X	X, Level 1 generator sets. This			residents and staff have the		
	deficient practice co	ould affect all building			potential to be affected by this		

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

Event ID: V2WV21 Facility ID: 000450

If continuation sheet Page 51 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		A. BUILDING  B. WING		COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	a.m. and 2:15 p.m. v Supervisor and Adn was unable to provi hour load test of the conducted within th was confirmed by th the time of record re This finding was re-	riew on 10/24/23 between 9:30 with the Maintenance ininistrator present, the facility de documentation of a four remergency generator e past 36 month period. This ne Maintenance Supervisor at eview.  Viewed with the Administrator apervisor during the exit		deficient practice. The facility now conducted the required inspection, testing and maintenance of the facility's emergency power system including the 4-hour load test facility will continue to conducted inspections, testing maintenance of the facility's emergency power system peregulations.  The measures that have bee into place to ensure that the deficient practice does not rethat a mandatory in-service he been conducted for the maintenance supervisor on the regulation related to the requinspections, testing and maintenance of the facility's emergency power system. To maintenance supervisor has re-educated on their responsion of maintaining a copy of all inspections, testing and maintenance as required by the regulation in the facility's preventative maintenance bir the corrective action taken to monitor to ensure the deficient practice will not recur is that the testing and the process of the facility of the maintenance supervisor's preventative maintenance bir least annually to ensure that its documentation to support the required inspections, testing maintenance of the facility's emergency power system. The corrective power system. The corrective power system.	The ct the and r n put cur is as are ired the been ibility the ander. The ander at there and and and and and and are as a construction of the area.

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 52 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155801	B. W	ING		10/24/	2023
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Executive Director will validate the required inspections, testir and maintenance has been completed as required. Any la of required documentation will immediately addressed with the maintenance supervisor.	ng nck be	
K 0000							
Bldg. 01	1.T.O.O.O.O.O.	D. da da la					
	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 10/24  Facility Number: 00 Provider Number: 1002  At this Life Safety C Healthcare of Booncompliance with Re Medicare/Medicaid, Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa  This one story facilit Type V (000) constrist sprinklered. The fact with hard wired smoth and spaces open to to operated smoke deter	273890  Code survey, Transcendent ville-North was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, asc), Chapter 19, Existing ancies and 410 IAC 16.2.  The was determined to be of ruction and was fully cility has a fire alarm system toke detectors in the corridors the corridors, plus battery ectors in all resident sleeping has a capacity of 56 and had a	K 0	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The face requests the plan of correction considered our allegation of compliance effective 11/24/23 the state findings of the Emergency Preparedness Sur conducted on October 24, 202	of of nese cility be	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 53 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY COMPLETED	
MIDILAN	or condition	155801	B. WING	<u> </u>	10/24/2023
NAME OF P	PROVIDER OR SUPPLIER	₹		FADDRESS, CITY, STATE, ZIP COD NORTH ST	
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH	BOOM	IVILLE, IN 47601	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
	All areas where res were sprinklered an services were sprin Quality Review con	idents have customary access and all areas providing facility	IAU		DATE
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:		K 0281	K281 The corrective action taken for those residents found to have been affected by the deficien practice is that although no specific residents were identified this deficient practice could potentially affect thirty resides staff and visitors. The missin light bulbs were replaced on a day of the survey and are now functioning properly. The corrective action taken for	fied, nts, g the
	p.m. and 5:00 p.m. the Administrator a the west hall exit di fixtures, one on each however, all four li on interview at the acknowledged by the who said he realize	ons on 10/24/23 between 2:15 during a tour of the facility with and Maintenance Supervisor, ischarge had two double light the corner of the building, ght bulbs were missing. Based time of observation, this was the Maintenance Supervisor d the bulbs were all missing was going to replace them that		other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors hat the potential to be affected by deficient practice. A housewill audit of all six exit lighting has been conducted. All six egreexits are now well illuminated ensure safe egress.  The measures that have been into place to ensure that the	e  it all  ave  y this  ide  s  ss  I to

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

Event ID:

V2WV21

Facility ID: 000450

If continuation sheet

Page 54 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155801	B. WI	NG		10/24/	2023
			<u> </u>	CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TDANICO		DADE OF BOONIVILLE MODELL					
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOOM	'ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
	This finding was re	viewed with the Administrator			deficient practice does not rec	ur is	
	and Maintenance St	apervisor during the exit			that a mandatory in-service ha		
	conference.				been conducted for all		
				maintenance and housekeepir	na		
	3.1-19(b)				staff to ensure they understand	•	
	(-)				the importance that all egress	-	
					areas are well illuminated for s	afe	
					egress. The staff was re-educ		
					on their responsibility to ensur		
					missing or burned-out bulbs a		
					promptly replaced.	•	
					The corrective action taken to		
					monitor to ensure the deficient	•	
					practice will not recur is that a	•	
					Quality Assurance tool has be	on	
					developed and implemented to		
					monitor the six exits to ensure	,	
						to	
					that all light bulbs that illumina	ıe	
					the egress are present and		
					functioning properly. This tool		
					be completed by the maintena		
					supervisor and/or their designed	ee	
					weekly for four weeks, then	u	
					monthly for three months and		
					quarterly for three quarters. T	ne	
					outcome of this tool will be		
					reviewed at the facility's Qualit	•	
					Assurance meetings to determ	iine	
					if any additional action is		
					warranted.		
14 0004	NEDA 464						
K 0291	NFPA 101						
SS=C	Emergency Lightin	_					
Bldg. 01	Emergency Lightin	•					
		g of at least 1-1/2-hour					
	duration is provide						
	accordance with 7	.9.					
	18.2.9.1, 19.2.9.1						
		on and interview, the facility	K 02	291	K291		11/24/2023
	failed to ensure 1 of	f 6 battery powered emergency			The corrective action taken for		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 55 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155801	B. WI	ING		10/24	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
TIVAINOC	·	DON'T BOOMVILLE - NORTH	_	BOON	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	tained in accordance with LSC			those residents found to have		
		tates battery operated			been affected by the deficient		
		hall use only reliable types of			practice is that all residents, s		
	rechargeable batteries provided with suitable				and visitors have the potentia	l to	
		aining them in properly charged			be affected by this deficient		
		es used in such lights or units			practice. The battery back up		
		for their intended use and shall			light set at the generator has		
		A 70 National Electric Code. LSC			repaired and is now functionir	ng	
		mergency lighting system shall			properly.		
		asly in operation or shall be			The corrective action taken for	r the	
		l automatic operation without			other residents that have the		
		n. This deficient practice could			potential to be affected by the		
	affect all residents,	as well as staff and visitors.			same deficient practice is that		
					residents, staff and visitors ha		
	Findings include:				the potential to be affected by		
					deficient practice. A house w		
		ons on 10/24/23 between 2:15			audit of all six battery powere	d	
	_	during a tour of the facility with			emergency lights have been		
		and Maintenance Supervisor,			checked and are functioning		
		light set at the generator did			properly.		
		n tested several times. Based			The measures that have been	n put	
		time of observation, the			into place to ensure that the		
		Maintenance Supervisor			deficient practice does not red		
	_	battery backup light set at the			that a mandatory in-service ha		
	_	luminate when tested several			been provided for the mainter		
	times.				supervisor on their responsibi	-	
	Tri . C. 1.	1 11 1 1 1 1			for routinely checking all batte	ery	
	_	eviewed with the Administrator			powered emergency lights to		
		supervisor during the exit			ensure that they continue to		
	conference.				function properly. This task h	as	
	2.1.10(1.)				been added to the facility's		
	3.1-19(b)				preventative maintenance pro	•	
					The corrective action taken to		
					monitor to ensure the deficier		
					practice will not recur is that a		
					Quality Assurance tool has be		
					developed and implemented t		
					monitor the proper functioning		
					the facility's six battery power		
	ĺ		1		emergency lights. This tool wi	III be	

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					completed by the maintenance supervisor and/or their designed weekly for four weeks, then monthly for three months and quarterly for three quarters. To outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determ if any additional action is warranted.	ee then he ty	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordance 19.3.2.5.2 * cooking facilities smoke compartments comply whose 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer productions under 10 Cooking facilities producti	Int is protected in NFPA 96, Standard for oll and Fire Protection of sing Operations, unless: ang equipment (i.e., small as microwaves, hot plates, at for food warming or limited ance with 18.3.2.5.2, as open to the corridor in ents with 30 or fewer with the conditions under 1.5.3, or as in smoke compartments the protected according to 3 are not required to be redous areas, but shall not ridor.  19.11.12.12.13.13.13.13.13.13.13.13.13.13.13.13.13.					
	Based on observation failed to ensure the in the Physical Ther	on and interview, the facility cook top for 1 of 1 stove/oven rapy gym was shut off at the use. LSC 19.3.2.5.4 states	K 0	324	K324 The corrective action taken for those residents found to have been affected by the deficient		11/24/2023

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 57 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155801	B. WI	NG		10/24/	/2023
			<u> </u>	CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF I	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANCO	ENDENT HEALTH	CARE OF BOOM WILE MORTH			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOOM	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	within a smoke con	npartment, residential or			practice is that all residents, st	taff	
	commercial cooking	g equipment that is used to			and visitors have the potential		
		0 or fewer persons shall be			be affected by this deficient		
		that the cooking facility			practice. The facility has now		
		ne following conditions:			installed a kill switch for the		
	-	ining the cooking equipment			stove/oven located in the PT g	ıvm	
	is not a sleeping roo				The kill switch is located in a	, , ,	
		ining the cooking equipment			locked kitchen cabinet next to	the	
		rom the corridor by partitions			stove to ensure that no	110	
	-	3.6.2 through 19.3.6.5.			unauthorized persons can acc	-229	
		ts of 19.3.2.5.3(1) through (10)			the switch. The switch is in th		
	and (13) are met.	15 of 19.5.2.5.5(1) through (10)			position when not in use.	COII	
	` '	A switch meeting all the			The corrective action taken for	r the	
	following is provide				other residents that have the	uic	
		, or a switch located in a			potential to be affected by the		
	1 1	is provided within the cooking			same deficient practice is that	all	
		ates the cooktop or range.			residents, staff and visitors ha		
	•	sed to deactivate the cooktop			the potential to be affected by		
		the kitchen is not under staff			deficient practice. The facility		
	supervision.	the Ritelien is not under starr			now installed a kill switch for the		
	-	ice could affect up to 5			stove/oven located in the PT g		
	-	visitors in the Physical			The kill switch is located in a	gyiii.	
	Therapy room.	visitors in the r hysical			locked kitchen cabinet next to	tho	
	Therapy room.				stove to ensure that no	uic	
	Findings include:				unauthorized persons can acc		
	Findings include.				•		
	Događ on obcamietie	ons on 10/24/23 between 2:15			the switch. The switch is in the	e on	
		during a tour of the facility with			position when not in use.	nut.	
					The measures that have been	pui	
		nd Maintenance Supervisor,			into place to ensure that the	:-	
	_	stove/oven in Physical			deficient practice does not rec		
		stove/oven was not being			that a mandatory in-service ha		
		observation and the power to			been provided for the mainten	ance	
		on. Based on interview at the			supervisor on the life safety		
		, the Maintenance Supervisor			cooking facilities regulation an		
		top stove/oven was not			advised of their responsibility t		
		ot in use, furthermore, the			ensure that the regulation is be	-	
	_	visor said he didn't think there			followed. In addition, a manda	•	
		switch for the Physical			in-service has been provided f		
		oven other than unplugging it			therapy staff on the installation	n of	
	from the receptacle				the stove kill switch as well as		

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 10/24/2023
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E I	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	_	viewed with the Administrator apervisor during the exit		their responsibility to ensure the stove kill switch is on whe 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 be developed and implemented the monitor the stove/oven in the gym to ensure that the stove is disengaged when not in use. tool will be completed by the maintenance supervisor and/of their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	n t t t t t t t t t t t t t t t t t t t
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are ready. 9.6.1.3, 9.6.1.5, N Based on record reversiled to maintain 1 accordance with NF Sections 19.3.4.5.1	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K345 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, s	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 59 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155801	B. W	ING		10/24/2	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ctions shall be performed in			and visitors have the potential	to	
	accordance with the schedules in Table 14.3.1, or				be affected by this deficient		
	_	red by the authority having			practice. The facility has now		
	_	14.3.1 states that the following			completed the required		
	-	spected semi-annually:			semi-annual visual inspection		
	a. Control unit troul				the facility's fire alarm devices	and	
	b. Remote annuncia				there is documentation of this		
		(e.g. duct detectors, manual			visual inspection along with th	е	
		eat detectors, smoke detectors,			findings in the facility's		
	etc.)				preventative maintenance bind	der.	
	d. Notification appl				These fire alarm system		
	e. Magnetic hold-op				inspections will continue to be		
	_	ice could affect all occupants			conducted and documented ir		
	in the facility.				accordance with the regulation		
					The corrective action taken for	r the	
	Findings include:				other residents that have the		
					potential to be affected by the		
		view on 10/24/23 between 9:30			same deficient practice is that		
	_	with the Administrator and			residents, staff and visitors ha		
	_	visor present, there was			the potential to be affected by		
	_	vided regarding an annual fire			deficient practice. The facility	has	
		ction dated 11/17/22 by the			now completed the required	,	
	_	inspection vendor, furthermore,			semi-annual visual inspection		
		y inspections available dated			the facility's fire alarm devices	and	
		and 08/02/23 by the facility's			there is documentation of this	_	
	•	n vendor, however, the documents did not provide			visual inspection along with th	e	
		semi-annual visual inspection			findings in the facility's	dor	
		alarm devices. Based on			preventative maintenance bind	der.	
		e of record review, the			These fire alarm system		
		visor agreed the quarterly			inspections will continue to be conducted and documented in		
	_	provide information of a					
		inspection of the facility's fire			accordance with the regulation		
	alarm system device				The measures that have been	ραι	
	aların system devic	Co.			into place to ensure that the deficient practice does not rec	ur is	
	This finding was re	viewed with the Administrator			that a mandatory in-service ha		
		upervisor during the exit			been conducted for the facility		
	conference.	apervisor during the exit			-		
	conference.				maintenance supervisor on the responsibility to ensure all	CII	
	3.1-19(b)				•		
	3.1-19(0)				required tasks are completed	ailu	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 60 of 82

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/17/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801		ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					documented in accordance withe fire alarm system testing a maintenance regulation.  The corrective action taken to monitor to ensure the deficien practice will not recur is that the Executive Director will now be responsible for reviewing the maintenance supervisor's preventative maintenance bind quarterly to ensure there is documentation to support that required inspections of the facility's fire alarm system have been completed and documentation in accordance with the regulational including the semi-annual visual inspection of the facility's fire alarm devices.	t ne der all e nted	
K 0346 SS=C Bldg. 01	services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to 9.6.1.6  Based on record refailed to provide a oprotection of all oct to be followed in the	of Service The alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall be approved fire watch shall be urties left unprotected by the series alarm system has	K 03	346	K346 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, s		11/24/2023

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

more in a twenty four hour period in accordance

affects all occupants in the facility.

with LSC, Section 9.6.1.6. This deficient practice

Event ID:

V2WV21

Facility ID: 000450

If continuation sheet

and visitors have the potential to

practice. The facility fire watch

be affected by this deficient

Page 61 of 82

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	
		155801	B. WING			10/24/	2023
NAME OF F	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATE, ZIP COD		
					ORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH	B	SOONV	'ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
					policy has now been updated		
	Findings include:				include IDOH notification of th		
					implementation of any fire wat	tch	
		view on 10/24/23 between 9:30			conducted as required by		
	1	with the Administrator and			regulation. The policy has als		
	_	visor present, the facility			been updated to reflect that al		
	1 ~	documentation, however, it			staff members will be trained a		
	_	he plan failed to include			least annually on how to prope	-	
	_	ana Department of Health			conduct a fire watch along wit	h the	
	, ,	eb link for contacting the			required documentation of		
		System located on the IDOH			information during the fire wat		
	1	ore, the fire watch did not			The corrective action taken for	r tne	
		tion to indicate the person			other residents that have the		
	_	watch has been properly an interview at the time of			potential to be affected by the		
		Administrator confirmed the fire			same deficient practice is that		
		reviously mentioned			residents, staff and visitors ha		
	_	rmore, the Administrator said			the potential to be affected by		
		vith the gateway web link when			deficient practice. The facility watch policy has now been	IIIE	
	using it in the past.	-			updated to include IDOH		
	using it in the past.				notification of the implemental	tion	
	This finding was re	eviewed with the Administrator			of any fire watch conducted as		
		upervisor during the exit			required by regulation. The pe		
	conference.	upervisor during the exit			has also been updated to refle	-	
					that all staff members will be	301	
	3.1-19(b)				trained at least annually on ho	w 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 red	ur is	
					that a mandatory in-service ha		
					been conducted for all staff or		
					facility's revised fire watch pol	icy.	
					All staff have now been traine	-	
					how to conduct a fire watch as	3	

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

Event ID:

V2WV21

Facility ID: 000450

If continuation sheet

well as what information must be documented during the fire watch

Page 62 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155801	B. WI	NG		10/24/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIEI	₹			IORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOONV	/ILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					per facility policy. This training will be conducted at least annual	-	
					and more often if warranted.	ually	
					The corrective action taken to		
					monitor to ensure the deficien		
					practice will not recur is that the		
					Executive Director will now be		
					responsible for reviewing the		
					documentation of any fire water	ch	
					conducted to ensure that the t	ask	
					has been completed in		
					accordance with facility policy		
					that there is documentation to		
					support the tasks that were		
					completed during the fire watc		
					Additional training will be prov		
					by the Executive Director on the		
					fire watch policy when warran	iea.	
K 0353	NFPA 101						
SS=F	Sprinkler System	- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
		er and standpipe systems					
	are inspected, tes	ted, and maintained in					
		NFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
		sting are maintained in a					
		nd readily available. rsystem last checked					
	a) Date spririkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMA	RKS information on					
	,	non-required or partial					
	automatic sprinkle						
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					

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

Event ID:

 $V2WV21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000450$ 

If continuation sheet

Page 63 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155801	B. WI	NG		10/24	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
TIVAINOU	LINDLINI HEALID	CARL OF BOOMVILLE - NORTH		BOOM	, ILLE, IIN 47 00 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation and interview, the		K 0.	353	K353		11/24/2023
	-	sure 1 of 2 sprinkler system			1.) The corrective action taker	n for	
	gauges on the front lobby sprinkler system riser				those residents found to have		
		5 years or documented as			been affected by the deficient		
		s by comparison with a			practice is that all residents, s		
		JFPA 25, Standard for the			and visitors have the potential	το	
		, and Maintenance of			be affected by this deficient	1	
		Protection Systems, 2011			practice. The identified sprink		
		3.2.1 states gauges shall be			system gauge in the front lobb	у	
		ars or tested every 5 years by			sprinkler riser has now been		
	-	calibrated gauge. Gauges not			replaced. All sprinkler system		
		percent of the full scale shall eplaced. This deficient practice			gauges will now be replaced o	)I	
		dents, staff, and visitors.			documented testing by		
	could affect all fest	ucius, stati, and visitois.			comparison with a calibrated	uired	
	Findings include:				gauge every five years as requ	uileu	
	i manigs include:				by the regulation.  2.) The corrective action taker	for	
	Rased on observativ	ons on 10/24/23 between 2:15			those residents found to have		
		during a tour of the facility with			been affected by the deficient		
		nd Maintenance Supervisor,			practice is that at least 20		
		r gauges on the front lobby			residents, staff and visitors co	uld	
	-	d a date of 2015 which was			be affected by this deficient	aiu	
		st due for replacement or			practice. The identified ceiling	1	
	• •	ecalibration date information			area in the washer room of the	-	
		lry sprinkler system gauge.			laundry has now been repaire		
		at the time of the observation,			and there are no gaps around		
		pervisor confirmed the			water lines and conduits that		
		uge had not been recalibrated			prohibit the sprinkler heads fro	om	
		ent five year period and would			functioning at full capability.		
		aced as soon as possible.			3.) The corrective action taker	n for	
		-			those residents found to have		
	This finding was re	viewed with the Administrator			been affected by the deficient		
		upervisor during the exit			practice is that all residents, s		
	conference.				and visitors have the potential	to	
					be affected by this deficient		
	3.1-19(b)				practice. The spare sprinkler		
					cabinet in the front lobby sprin	kler	
		ration and interview, the			rise room has been straighten	ed	
	facility failed to ens	sure the ceiling in 1 of 4			up and the spare sprinklers ar	е	
	sprinklered smoke	compartments was maintained	l		securely placed in slots to ens	uro	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155801	B. WI	NG		10/24/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
	T		T .		, I		I ~~~
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION eads to function to their full		TAG			DATE
		ficient practice could affect at			they do not become broken or		
		•			damaged.	410 0	
	least 20 residents, s	tarr, and visitors.			The corrective action taken for	rtne	
	Findings include:				other residents that have the		
	Based on observations on 10/24/23 between 2:15				potential to be affected by the		
					same deficient practice is that		
		during a tour of the facility with			residents, staff and visitors ha		
		adding a four of the facility with and Maintenance Supervisor,			the potential to be affected by		
		inch to three inch gaps			deficient practice. The identifi		
		and conduits penetrating the			sprinkler system gauge in the		
		er room of the laundry room.			lobby sprinkler riser has now be		
		e water lines and conduits			replaced. All sprinkler system		
		ire stopped. Based on			gauges will now be replaced o	ונ	
		e of observation, the			documented testing by		
		visor acknowledged the gaps			comparison with a calibrated	uirad	
	_	idry room ceiling and said they			gauge every five years as req		
		ed as soon as possible.			by the regulation. A house wi		
	would be life stopp	ed as soon as possible.			audit of all ceiling areas has b conducted to ensure that all	een	
	This finding was re	viewed with the Administrator			sprinkler heads can function a	.4	
	_	upervisor during the exit			their full capability. No other	ıL	
	conference.	upervisor during the exit			ceiling problems were identifie	\d	
	conference.				The spare sprinkler cabinet is		
	3.1-19(b)				being checked routinely by the		
	J.1-17(0)				maintenance supervisor as pa		
	3 Based on observ	ation and interview, the			the preventative maintenance		
		sure 1 of 2 sprinkler systems			program to ensure the proper		
	1	nets were properly maintained.			storage of the spare sprinklers	2	
		for the Inspection, Testing,			continues.	•	
		f Water-Based Fire Protection			The measures that have been	nut	
		ion, Section 5.4.1.4 states a			into place to ensure that the	Pul	
		nklers (never fewer than six)			deficient practice does not rec	eur is	
		on the premises so that any			that a mandatory in-service ha		
		been operated or damaged in			been provided for the mainten		
		mptly replaced. The sprinklers			supervisor on the required		
		the types and temperature			maintenance and testing of the	e	
	•	the types and temperature the types and temperature. The			sprinkler system. The	-	
		kept in a cabinet located where			maintenance supervisor has b	neen	
		which they are subjected will at			educated on their responsibilit		
	_	degrees Fahrenheit. A special			ensure that the sprinkler syste	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155801	B. W	ING		10/24/	2023
				CTREET	ADDRESS SITE OF THE COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANGO	ENDENT HEALTH	OADE OF BOOM WILE MODELL			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOOM	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	-	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
		all be provided and kept in the			gauges are replaced and/or te	sted	
	_	n the removal and installation			every five years in accordance		
		deficient practice could affect			the regulation. They are also		
	all residents and staff in the facility.  Findings include:				responsible to ensure that there	e	
					are no gaps around water lines		
					conduits that penetrate the cei		
	8	Findings include.			which might allow sprinkler he		
	Based on observation	ons on 10/24/23 between 2:15			to no function to their full		
		during a tour of the facility with			capability and to ensure the sa	ıfe	
		nd Maintenance Supervisor,			storage of the spare sprinkler		
		cabinet in the front lobby			heads to avoid any potential		
		had four spare sprinkler heads			breakage/damage to the spare	2	
	-	osely and not in slots, which			sprinklers.	,	
		ge to the sprinkler heads if			Sprinters.		
	-	ening the cabinet door. Based			The corrective action taken to		
		time of observation, the			monitor to ensure the deficient		
		visor acknowledged there			practice will not recur is that a		
	_	inkler heads in the spare			Quality Assurance tool has be	on	
		ying loose and not secured in			developed and implemented to		
	their own slots.	ying loose and not secured in			ensure that the facility's sprink		
	then own siots.				system is being maintained an		
	This finding was re	viewed with the Administrator			tested in accordance with the l		
	-	upervisor during the exit			safety regulations. The tool w		
	conference.	upervisor during the exit			, , ,		
	conference.				monitor the sprinkler gauges to ensure they are functioning	,	
	3.1-19(b)				properly and being replaced a	ad/or	
	J.1-17(0)				tested in accordance with the	iu/Ui	
					regulations, that ceiling surface		
					are being maintained properly		
					of gaps which allow the sprink	ei	
					heads to function to their full		
					capabilities and to ensure that		
					spare sprinklers are being stor	ea	
					in the appropriate manner to	h -	
					prevent breakage/damage to t		
					spare sprinkler heads. This to	OI	
					will be completed by the		
					maintenance supervisor and/o	r	
					their designee weekly for four		
					weeks, then monthly for three		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 66 of 82

	MEDICAKE & MEDIC	_	_	OMB NO. 0936-039		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155801	B. WING		10/24/2023	
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD		
111111111111111111111111111111111111111	NO VIDEN ON SOLI EIE			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH	BOON	VILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				months and then quarterly for three quarters. The outcome this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	of e	
K 0354 SS=C Bldg. 01	extent and duration been determined, are inspected and recommendations management or durant and the fire depart having jurisdiction the sprinkler system 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1. Based on record revalued to provide a containing procedure protection of all occurrence for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires sprinkler out-of-service for 1 period in accordance 9.7.6 requires accordance 9.7.6 require	er system is impaired, the en of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where em is out of service for more a 24-hour period, the of the building affected are approved fire watch is sprinkler system has been	K 0354	K354 The corrective action taken for those residents found to have been affected by the deficient practice is that all residents, so and visitors have the potential be affected by this deficient practice. The facility fire water policy has now been updated include IDOH notification of the implementation of any fire water conducted as required by regulation. The policy has also been updated to reflect that all staff members will be trained as	taff I to  h to e tch	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet

Page 67 of 82

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLET	ГED
		155801	B. W	ING _		10/24/2	023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
	, _ , 10	C, it is a boot will - not the	_	DOON	, in		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		to fire extinguishers and the			least annually on how to prop	-	
		notify the fire department are			conduct a fire watch along wit	h the	
	_	consider. During the patrol of			required documentation of		
	the area, the person should not only be looking for fire, but making sure that the other fire				information during the fire wat		
	protection features of the building such as egress				The corrective action taken fo	r the	
	_	stems are available and			other residents that have the		
		y. This deficient practice			potential to be affected by the		
		upants in the facility.			same deficient practice is that residents, staff and visitors ha		
		apanto in the facility.			the potential to be affected by		
	Findings include:				deficient practice. The facility		
	i manigs merade.				watch policy has now been		
	Based on record rev	view on 10/24/23 between 9:30			updated to include IDOH		
		with the Administrator and			notification of the implemental	tion	
	•	visor present, the facility			of any fire watch conducted as		
	_	documentation, however, it			required by regulation. The p		
	_	he plan failed to include			has also been updated to refle	-	
	_	ana Department of Health			that all staff members will be		
	(IDOH) with the w	eb link for contacting the			trained at least annually on ho	ow to	
	Incident Reporting	System located on the IDOH			properly conduct a fire watch		
	Gateway, furthermo	ore, the fire watch did not			along with the required		
	include documentar	tion to indicate the person			documentation of information		
	conducting the fire	watch has been properly			during the fire watch.		
		an interview at the time of			The measures that have been	n put	
		Administrator confirmed the fire			into place to ensure that the		
	_	reviously mentioned			deficient practice does not red		
		rmore, the Administrator said			that a mandatory in-service ha		
		ith the gateway web link when			been conducted for all staff or	I .	
	using it in the past.				facility's revised fire watch pol	-	
	TD1 ' C' 1'	t dad Attitue			All staff have now been traine		
		viewed with the Administrator			how to conduct a fire watch as		
		upervisor during the exit			well as what information must		
	conference.				documented during the fire wa		
	3.1-19(b)				per facility policy. This training	~	
	3.1-17(0)				will be conducted at least ann and more often if warranted.	ually	
					The corrective action taken to		
					monitor to ensure the deficien		
					practice will not recur is that the	· .	
					Executive Director will now be		
	1		1		LYGORING DIECTOL MILLION DE	,	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 68 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		A. BUILDING  B. WING	01	COMPLETED 10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST /ILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible covering is not except to a complying wife provided with a containing of the door closed whapplied. There is a closing of the door release when the copermitted. Nonrate	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain		responsible for reviewing the documentation of any fire watch conducted to ensure that the translation to support the tasks that were completed during the fire watch Additional training will be proviby the Executive Director on the fire watch policy when warrant to the support that there is documentation to support the tasks that were completed during the fire watch Additional training will be proviby the Executive Director on the fire watch policy when warrant the support of the s	ask and h. ided

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

Event ID:

 $V2WV21 \quad \ \ {\rm Facility\ ID:} \quad \ 000450$ 

If continuation sheet

Page 69 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155801	B. W	NG		10/24	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
11011100	·	Office of Boothviller - Northi		BOOM	1122, 114 47 00 1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		6 are permitted. Door					
	frames shall be labeled and made of steel or other materials in compliance with 8.3,						
	unless the smoke						
	-	I fire window assemblies are					
	· ·	n sprinklered compartments					
		ictions in area or fire					
	resistance of glas assemblies.	s or frames in window					
	assemblies.						
	10363 /2 CER	Parts 403, 418, 460, 482,					
	483, and 485	1 413 400, 410, 400, 402,					
	· ·	(S details of doors such as					
		ngs, automatics closing					
	devices, etc.	nge, automaties sissing					
		vation and interview, the	K 0	363	K363		11/24/2023
		sure 1 of 26 resident room	11 03 03		1.) The corrective action taken for		11/2 // 2020
		ld close completely and latch,			those residents found to have		
	and resist the passa	ge of smoke. This deficient			been affected by the deficient		
	practice could affect	et at least 20 residents, as well			practice is that at least 20		
	as staff and visitors				residents, staff and visitors ha	ve	
					the potential to be affected by	this	
	Findings include:				deficient practice. The resider	nt's	
					room door identified as room 2		
		ons on 10/24/23 between 2:15			has now been adjusted by the		
		during a tour of the facility with			maintenance department and		
		and Maintenance Supervisor,			door closes completely, latche		
		oor did not close fully and latch			securely into the door frame a		
		The door was hitting the top			resists the passage of smoke.		
		latching side leaving a half			2.) The corrective action taker		
		p along the entire length of the			those residents found to have		
		o its fullest. Based on			been affected by the deficient		
		ne of observation, the			practice is that at least 30	l	
		visor acknowledged resident			residents have the potential to		
	room 22 corridor door did not close completely and latch and was not smoke resistant when				affected by this deficient pract		
		ioi smoke resistant when			The rooms identified as rooms		
	closed fully.				and 10 have now had the was		
	This finding was	wigwad with the Administrator			baskets removed and there are		
		viewed with the Administrator			objects impeding the doors fro		
	i and iviaintenance S	upervisor during the exit	1		closing. The residents and sta	<b>411</b>	1

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 70 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155801	B. W	NG		10/24/2	2023
		<u> </u>		CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TDANCO	SENDENT HEALTH	CARE OF BOOM /// LE NORTH					
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOONV	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.				members have been reminded	d to	
					not place any objects in from o	of	
	3.1-19(b)				the doors that could potentially	y	
					prevent them from closing.		
					The corrective action taken fo	r the	
	2. Based on observation and interview, the				other residents that have the		
	facility failed to en	sure 2 of 26 resident room			potential to be affected by the		
	corridor doors had	no impediment to closing.			same deficient practice is that	all	
	This deficient pract	tice could affect at least 30			residents, staff and visitors ha	ve	
	residents.				the potential to be affected by	this	
					deficient practice. A housewid	de	
	Findings include:				audit has been conducted on	all	
					corridor doors to ensure that t	hey	
	Based on observati	ons on 10/24/23 between 2:15			close completely, latch into the	e	
	p.m. and 5:00 p.m.	during a tour of the facility with			door frame securely and resis	t the	
	the Administrator a	and Maintenance Supervisor,			passage of smoke. The doors	s	
	resident room door	s 22 and 10 were both held			have also been checked to en	sure	
	wide open with wa	ste baskets. Based on			no objects have been placed i	in	
	interview at the tim	ne of each observation, the			front of the doors to prevent the	ne	
		visor acknowledged resident			doors from closure. All corride	or	
	room doors 22 and	10 were being held wide open			doors are now closing securel	ly to	
	with waste baskets.				resist the passage of smoke.		
					The measures that have been	put	
	_	eviewed with the Administrator			into place to ensure that the		
		upervisor during the exit			deficient practice does not red		
	conference.				that a mandatory in-service ha		
					been provided for all staff on t	he	
	3.1-19(b)				regulation regarding the closu		
					corridor doors to ensure that t	hey	
					close securely to resist the		
					passage of smoke and that no		
					objects are placed in front of t	he	
					doors at any time to prevent		
					proper closure.		
					The corrective action taken to		
					monitor to ensure the deficien	-	
					practice will not recur is that a		
					Quality Assurance tool has be		
					developed and implemented t	0	
					monitor the proper closure of		

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155801			JILDING	nstruction  01	(X3) DATE S COMPLI 10/24/2	ETED	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH		305 E N	DDRESS, CITY, STATE, ZIP COD ORTH ST ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0372	NFPA 101				corridor doors. This tool will monitor to ensure each door closes completely, latches securely into the door frame at resists the passage of smoke. The tool will also monitor to ensure that there are no object placed in front of the door that might impede secure closure. This tool will be completed by maintenance supervisor and/of 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.	ts the r	
SS=F Bldg. 01	Subdivision of Bui Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smoke in duct penetration systems where and is installed for smoto to the smoke barri 19.3.7.3, 8.6.7.1(1) Describe any medicates and me	nall be constructed to a tance rating per 8.5. Smoke permitted to terminate at an act dampers are not required ans in fully ducted HVAC approved sprinkler system oke compartments adjacent iter.  1) Chanical smoke control RKS. on and interview, the facility	K 03	372	K372		11/24/2023
		f 3 smoke barrier walls was in the smoke resistance of the			The corrective action taken for those residents found to have		

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 72 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		,	LDING	INSTRUCTION 01	(X3) DATE COMPL 10/24	ETED	
		100001	B. Wh	_		10/2-1/	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			IORTH ST /ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	smoke barrier. LS0	C Section 19.3.7.5 requires			been affected by the deficient		
	smoke barriers to b	e constructed in accordance			practice is that all residents, s	taff	
	with LSC Section 8	3.5 and shall have a minimum ½			and visitors have the potential	to	
	hour fire resistive r	ating. This deficient practice			be affected by this deficient		
	could affect all resi	dents, as well as staff and			practice. The smoke barrier w	vall	
	visitors.				above the smoke barrier doors	S	
					between the west corridor and	the	
	Findings include:				front lobby center has been		
					repaired. The dry wall has be	en	
	Based on observati	ons on 10/24/23 between 2:15			replaced and the smoke barrie	er	
	p.m. and 5:00 p.m.	during a tour of the facility with			walls are now protected to		
	the Administrator a	and Maintenance Supervisor,			maintain smoke resistance.		
	the smoke barrier wall above the smoke barrier				The corrective action taken for	r the	
	doors between the	west corridor and the front			other residents that have the		
	lobby/center hall as	rea had an approximately three			potential to be affected by the		
	foot by four foot se	ection of the dry wall missing.			same deficient practice is that	all	
	Based on interview	at the time of observation, the			residents, staff and visitors ha	ve	
	Maintenance Super	visor said he did not know the			the potential to be affected by	this	
	opening in the smo	ke barrier wall existed, but			deficient practice. A house wi		
	would have it repai	red as soon as possible.			review of all smoke barrier wa		
					has now been conducted and	no	
	This finding was re	eviewed with the Administrator			additional issues have been		
	and Maintenance S	upervisor during the exit			identified that could affect the		
	conference.				resistance of smoke.		
					The measures that have been	put	
	3.1-19(b)				into place to ensure that the		
					deficient practice does not rec	ur is	
					that a mandatory in-service fo		
					maintenance supervisor on the	е	
					regulation on smoke barrier w	alls	
					was conducted to ensure their	r	
					knowledge level of the regulat	ion	
					and to remind them of their		
					responsibility to ensure smoke	•	
					barrier walls are maintained in	1	
					accordance with the regulation	n.	
					The corrective action taken to		
					monitor to ensure the deficien	t	
					practice will not recur is that		
					Inspections of the smoke barr	ier	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  10/24/2023	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				walls will now be routinely conducted as part of the preventative maintenance pro and the findings documented ithe preventative maintenance binder. The results of these inspections will be reviewed quarterly by the Executive Director to ensure on-going compliance.	ector
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills al routine. Where dr 9:00 PM and 6:00	ay be used instead of			
	1. Based on record facility failed to produce documentation for 2 quarters. Furthermore provided with fully of drills, and 4 of 4 performed during the frame. This deficie residents, as well as facility.  Findings include:  Based on review of	review and interview, the vide quarterly fire drill 2 of 3 shifts during 2 of 4 ore, 4 of 12 fire drills were not detailed information for times third shift fire drills were not be dedicated third shift time ant practice could affect all staff and visitors in the the facility's fire drill reports in 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, so and visitors have the potential be affected by this deficient practice. The facility has now completed fire drills on each so The documentation of these find drills is complete and reflects are required documentation include the specific times that the drills were conducted and the transmission of the fire alarm	taff to hift. re all ing

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 74 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED		
		155801	B. WI	B. WING			10/24/2023	
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	R			NORTH ST			
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601			
	T		T		· 		(V.f.)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)	
	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION  nd Maintenance Supervisor		TAG			DATE	
	present, the following	•			signal to the fire department.  The corrective action taken for	r tha		
	•	ed fire drill documentation for			other residents that have the	rune		
		t) of the second quarter (April,			potential to be affected by the			
	, -	2023, and the first shift (day) of			same deficient practice is that	all		
		lly, August, and September) of			residents, staff and visitors ha			
	2023.	1, 11 agust, and september) of			the potential to be affected by			
		11/19/22 at 8:00, 12/18/22 at			deficient practice. The facility			
		30, and 06/26/23 at 3:45 did not			now completed fire drills on ea			
		to verify the actual time of day			shift. The documentation of the			
	the drills were perfe				fire drills is complete and refle			
	_	11/19/22 at 8:00, 03/10/23 at			all required documentation	ClS		
		at 6:30 p.m., and 09/29/23 at 7:30			including the specific times that	at		
	_	as third shift fire drills. When			the drills were conducted and			
	•	trator said the third shift time			transmission of the fire alarm	uic		
	•	was supposed to be between			signal to the fire department.			
	10:00 p.m. and 6:00				The measures that have been	nut		
	_	at the time of record review,			into place to ensure that the	ραι		
		nd Maintenance Supervisor			deficient practice does not rec	ur is		
		of a fire drill report during the			that a fire drill schedule has be			
		of the second and third			prepared by the Executive Dir			
		us the lack of a.m. and p.m. on			to ensure that fire drills are be			
	four fire drill report				conducted in accordance with			
	•				regulation. A mandatory in-se			
	This finding was re	viewed with the Administrator			has been provided for the			
	_	upervisor during the exit			maintenance supervisor on the	е		
	conference.	- <del>-</del>			regulation related to fire drills			
					ensure their knowledge level a			
	3.1-19(b)				when the fire drills are to be			
	3.1-51(c)				conducted and what information	on		
					must be documented with eac	:h		
	2. Based on record	review and interview, the			fire drill including the specific t	ime		
	facility failed to ens	sure 1 of 12 fire drill reports			of the drill as well as the			
	included complete	documentation of the			transmission of the fire alarm			
	transmission of a fir	re alarm signal to the			signal to the fire department.	The		
	monitoring compan	y/fire department during the			newly developed fire drill sche	dule		
	past twelve months.	LSC 19.7.1.4 requires fire			has been reviewed with the			
		occupancies shall include the			maintenance supervisor to en	sure		
	transmission of the	fire alarm signal and			that fire drills are being condu	cted		
		gency conditions. This			as required			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	ETED	
		155801	B. WING			10/24/	10/24/2023	
			<del></del>	CTD FET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				ORTH ST			
TDANCO		CARE OF BOONIVILLE MORTH			'ILLE, IN 47601			
TRANSCI	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		воопу	ILLE, IN 47601			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	deficient practice co	ould affect all residents.			The corrective action taken to			
					monitor to ensure the deficient	•		
	Findings include:				practice will not recur is that th	ie		
	C				Executive Director will now rev			
	Based on review of	the facility's fire drill reports			monthly the fire drill			
		n 9:30 a.m. and 2:15 p.m. with			documentation to ensure that t	fire		
		nd Maintenance Supervisor			drills are being conducted in			
		drill reports performed during			accordance with the regulation	1		
	-	eriod were not provided with			and that detailed information is			
		he transmission of the alarm to			documented with each fire drill			
	the monitoring com	pany. This drill was dated			required. Additional education	will		
	10/21/22 at 1:00 p.n	n. Based on interview at the			be provided by the Executive			
	time of record revie	w, the Maintenance Supervisor			Director when warranted.			
		was no information on the						
	_	eport to verify that the						
		alarm was received by the						
	monitoring company	-						
	This finding was rev	viewed with the Administrator						
	and Maintenance Su	pervisor during the exit						
	conference.	-						
	3-1.19(b)							
	3.1-51(c)							
K 0761								
SS=C								
Bldg. 01								
	Based on observation	on, record review, and	K 07	61	K761		11/24/2023	
	interview; the facilit	ty failed to ensure an annual			The corrective action taken for			
	inspection and testir	ng of 1 of 1 oxygen room fire			those residents found to have			
	door assembly was	completed in accordance with			been affected by the deficient			
	LSC 19.1.1.4.1.1. C	Communicating openings in			practice is that all residents, st	aff		
	dividing fire barrier	s required by 19.1.1.4.1 shall be			and visitors have the potential			
	permitted only in co	orridors and shall be protected			be affected by this deficient			
	•	osing fire door assemblies.			practice. The fire door asseml	bly		
		3.) LSC 8.3.3.1 Openings			to the oxygen storage room ha	-		
	•	ire protection rating by Table			now been inspected and teste			
	-	ected by approved, listed,			The documentation of this			
	_	semblies and fire window			inspection is on file in the			
l			1	l	•			

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 76 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
		155801	B. WING			10/24/2023	
			<u> </u>		PPPPGG CHW	. 5, = 1,	
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
TDANSO	ENDENT HEALTH	CADE OF BOONVILLE MODELL			IORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		ВООМУ	'ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		r accompanying hardware,			preventative maintenance bind	der.	
	_	s, closing devices, anchorage,			The corrective action taken for	r the	
		nce with the requirements of			other residents that have the		
	·	for Fire Doors and Other			potential to be affected by the		
		s, except as otherwise			same deficient practice is that		
	_	de. NFPA 80 5.2.1 states fire			residents, staff and visitors ha		
		all be inspected and tested not			the potential to be affected by		
	_	and a written record of the			deficient practice. The fire do		
	-	signed and kept for inspection			assembly to the oxygen storag	-	
	_	80, 5.2.4.1 states fire door			room has now been inspected		
		visually inspected from both			tested. The documentation of	this	
		overall condition of door			inspection is on file in the		
	assembly.				preventative maintenance bind		
					In addition, all fire door assem		
	·	tates as a minimum, the		have been inspected annually an			
	following items sha				the documentation of these		
		or breaks exist in surfaces of			inspections and testings are o	n	
	either the door or fr				file in the preventative		
		light frames, and glazing beads			maintenance binder.		
		ely fastened in place, if so			The measures that have been	put	
	equipped.				into place to ensure that the		
		e, hinges, hardware, and			deficient practice does not rec		
		eshold are secured, aligned,			that a mandatory in-service ha	IS	
		er with no visible signs of			been conducted for the		
	damage.				maintenance supervisor on the	9	
	(4) No parts are mis				regulation related to the		
	` '	do not exceed clearances			maintenance, inspection and		
	listed in 4.8.4 and 6				testing of fire doors. The		
		device is operational; that is,			maintenance supervisor was	. 1114	
		pletely closes when operated			re-educated on their responsib	-	
	from the full open p				to ensure that these inspection		
	closes before the ac	is installed, the inactive leaf			and testings are completed at		
					least annually and to ensure the	IE	
	door when it is in the	are operates and secures the			documentation of such		
		vare items that interfere or			inspections in maintained at the	i <del>C</del>	
	•				facility in the preventative		
	frame.	are not installed on the door or			maintenance binder.		
		Sections to the deer assembly			The corrective action taken to		
		ications to the door assembly			monitor to ensure the deficient		
	nave been performe	ed that void the label.			practice will not recur is that T	ne	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155801	B. WING 10/24/2023			2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				IORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
T				L	122, 11 11 33 1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		edge seals, where required, are			Executive Director will review		
	-	their presence and integrity.			semi-annually the preventative		
	-	ice could affect all residents,		maintenance binder to ensure fire			
	as well as staff, and	visitors.			door assemblies are inspected		
					and tested at least annually ar		
	Findings include:				that there is documentation on		
	<b>D</b> 1 1	10/04/02 1			to support these inspections a	nd	
		riew on 10/24/23 between 9:30			testing.		
	•	with the Administrator and					
		visor present, the facility was					
	-	ocumentation for an annual					
	•	ygen transfilling room fire					
	•	sed on interview at the time of					
		Maintenance Supervisor said					
		entation of an annual					
	-	ygen transfilling room fire					
	-	sed on observations during a					
	-	with the Administrator and visor between 2:15 p.m. and					
	_	s one oxygen transfilling room					
	-	noted in the facility in the same					
	smoke compartmen						
	smoke compartmen	t as the front lobby.					
	This finding was rev	viewed with the Administrator					
	-	apervisor during the exit					
	conference.	ipervisor during the exit					
	conference.						
	3.1-19(b)						
	3.1 17(0)						
K 0781	NFPA 101						
SS=F	Portable Space He	eaters					
Bldg. 01	Portable Space He						
Ü	•	eating devices shall be					
	·	ealth care occupancies,					
	•	ed in nonsleeping staff and					
	•	here the heating elements					
		2 degrees Fahrenheit (100					
	degrees Celsius).	3					
	18.7.8, 19.7.8						
		view, observation, and	K 0'	781	K781		11/24/2023
			ı - ´	-			

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 78 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155801	B. WI	ING		10/24	/2023
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
			T		, 		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION ity failure to ensure portable	<del>                                     </del>	TAG		.r	DATE
	· ·	not used in health care			The corrective action taken fo those residents found to have		
	_	ling to current written policy					
	_	the facility which prohibited			been affected by the deficient practice is that all residents, s		
		cient practice could affect all			and visitors have the potential		
		l visitors in the facility.			be affected by this deficient	0	
	1001dellio, buili, allu	. violeolo in the lucinty.			practice. The heating elemen	t	
	Findings include:				was promptly removed from the		
	- manage morado.				faux fire place located in the	.5	
	Based on record rev	view on 10/24/23 between 9:30			facility lobby.		
		with the Administrator and			The corrective action taken fo	r the	
	-	visor present, the facility's			other residents that have the		
	policy was that portable space heaters were not				potential to be affected by the		
		ity. Based on observations			same deficient practice is that		
		and 5:00 p.m. during a tour of			residents, staff and visitors ha		
	the facility with the				the potential to be affected by		
	-	visor, a faux fire place was			deficient practice. A house wi		
	observed in the from	nt entrance lobby. The fire			audit was conducted througho		
	place was not affixed	ed to the wall or floor at the			the facility for the use of porta		
	time of observation	, and was not turned on at the			space heaters. No other porta		
	time of observation	either. When the			space heaters were located.		
		visor turned the fire place on			The measures that have been	n put	
		t blew hot air out of the front			into place to ensure that the		
	vent. This was ack				deficient practice does not red	cur is	
	_	visor who said the fire place			that a mandatory in-service w		
		luring his time working in the			conducted for the maintenanc	e	
		would remove the heat			supervisor on the regulation		
	element as soon as	possible.			related to the use of portable		
					space heaters. The maintena		
	_	eviewed with the Administrator			supervisor was instructed to a		
		upervisor during the exit			to the preventative maintenan	ce	
	conference.				program that during routine		
	2.1.10/13				rounds, any portable space		
	3.1-19(b)				heaters that may be identified		
					to be promptly removed from	the	
					facility.		
					The corrective action taken to		
					monitor to ensure the deficien		
					practice will not recur is that a		
					i pau oi me iacillivs preventativ	<b>√</b> ⊢	

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

Event ID:

V2WV21 Facility ID: 000450

If continuation sheet Page 79 of 82

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COM	E SURVEY PLETED 24/2023
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E	ADDRESS, CITY, STATE, ZIP NORTH ST VILLE, IN 47601	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				maintenance program maintenance supervis monitor during routine ensure that no portab heaters are being util accordance with facili Any identified space I be promptly removed maintenance supervis	sor will e rounds to ole space ized in ity policy. heaters will by the	
K 0918 SS=C Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test und a complete simula automatic or manual loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours. der load conditions include				

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

Event ID:

V2WV21

Facility ID: 000450

.50 If continuation sheet

Page 80 of 82

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155801	B. Wl	WING		10/24/2023	
		_		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		305 E N	NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH	_	BOON	VILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ble. EES electrical panels					
		arked, readily identifiable,					
		n normal power circuits.					
		ssibility of damage of the r source is a design					
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1	•					
		view and interview, the facility	K <sub>0</sub>	918	K918	11	1/24/2023
		omplete documentation for the	IX U	710	The corrective action taken fo		1/24/2023
	•	nergency Power Standby			those residents found to have		
	_	ace with NFPA 110, Standard			been affected by the deficient		
		Standby Power Systems,			practice is that all residents, s		
	Section 8.4.9, as re-	quired by NFPA 99 Health Care			and visitors have the potential		
	Facilities Code, Sec	etion 6.4.1.1.6.1. NFPA 110			be affected by this deficient		
	Section 8.4.9 states	that all Level 1 Emergency			practice. The facility has now		
	Power Systems sha	ll be tested at least once within			completed the required four-h	our	
	every three years.	Where the assigned class is			load test on the facility's		
	greater than 4 hours	s, it shall be permitted to			emergency generator.		
	terminate the test at	fter 4 hours. NFPA 99 Section			Documentation of this testing	has	
		at Type 1 and Type 2 essential			been retained in the facility's		
		ower sources shall be classified			preventative maintenance bin	der.	
		X, Level 1 generator sets. This			This test will be completed at		
	_	ould affect all building			least every 36 months and the		
	occupants.				supportive documentation of t	his	
	F: 1:				test will be placed in the		
	Findings include:				preventative maintenance bin		
	Događ or ""	view on 10/24/22 h-+ 0.20			The corrective action taken fo	r tne	
		view on 10/24/23 between 9:30			other residents that have the		
	_	with the Administrator and			potential to be affected by the		
		visor present, the facility was ocumentation of a four hour			same deficient practice is that residents, staff and visitors ha		
	_	ergency generator conducted			· ·		
		month period. This was			the potential to be affected by deficient practice. The facility		
	_	faintenance Supervisor at the			now completed the required	ııaə	
	time of record revie				four-hour load test on the facil	itv's	
	line of feedia fevic				emergency generator.	ity 3	
	This finding was re	viewed with the Administrator			Documentation of this testing	has	
	_	upervisor during the exit			been retained in the facility's	1145	
	conference.				preventative maintenance bin	der	

PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155801	B. WING			10/24/	2023
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	30	05 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST IILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		)	PROVIDENCE NAVIOE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
					This test will be completed at		
	3.1-19(b)				least every 36 months and the	:	
					supportive documentation of tl	nis	
					test will be placed in the		
					preventative maintenance bind	der.	
					The measures that have been	put	
					into place to ensure that the		
					deficient practice does not rec		
					that a mandatory in-service for		
					maintenance supervisor has b	een	
					conducted on the regulation		
					related to the testing of the		
					emergency generator which		
					includes a 4-hour load test of t		
					emergency generator every 36	5	
					months. The maintenance		
					supervisor has been instructed		
					retain a copy of this testing in		
					facility's preventative maintena	ance	
					binder.		
					The corrective action taken to		
					monitor to ensure the deficient		
					practice will not recur is that the		
					Executive Director will review	uie	
					maintenance supervisor's	dere	
					preventative maintenance bind at least annually to ensure the		
					required documentation is	:	
					available related to the inspec	tion	
					testing and maintenance of the		
					facility's emergency power sys		
					including the 4-hour load test		
					the emergency generator ever		
					months.	, 00	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: V2WV21 Facility ID: 000450 If continuation sheet Page 82 of 82