PRINTED: 03/23/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155502	B. W		<del></del>	COMPLETED 03/06/2018		
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE		HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665			
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OVVEIN	SVILLE, IN 47005			
(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	DEFICIENCY		DATE	
E 0000 Bldg	An Emergency Prej conducted by the Ir Health in accordance Survey Date: 03/06 Facility Number: 0 Provider Number: 100 At this Emergency Transcendent Healt found in compliance Preparedness Requirements Medicaid Participat CFR 483.73. The facility has 68 the survey, the cens	paredness Survey was adiana State Department of the with 42 CFR 483.73.  6/18  100328 155502 287960  Preparedness survey, heare of Owensville, LLC was the with Emergency irements for Medicare and thing Providers and Suppliers, 42  certified beds. At the time of	E 00		March 16, 2018  Matthew Foster, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204  RE: Transcendent Healthcare Owensville Survey Event ID TK9R2  Dear Mr. Foster;  By submitting the enclosed material, 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 t responses pursuant to our regulatory obligations. The fa	the fic e of hese cility		
					requests the plan of correction considered our allegation of compliance effective March16 2018 to the state findings of the Life Safety Code and Emerge Preparedness Survey conduction March 6, 2018.	i, ne ncy		

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

TITLE

Code with Emergency

On March 6, 2018 a Life Safety

(X6) DATE

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

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CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/06/2018
	ROVIDER OR SUPPLIE	R CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 ISVILLE, IN 47665	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
IAG	REGULATORY O	R LSC IDEN HE YING INFORMATION	IAG	Preparedness Survey was conducted at our facility. By submitting the enclosed mater we are not admitting the truth accuracy of any specific findin or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact request that the plan of correct be considered our allegation of compliance effective March 162018 to the State findings of the Life Safety Code with Emerger Preparedness Survey conduct on March 6, 2018.  We respectfully request a desireview to validate the facility's compliance to the findings of the Life Safety Code with Emerger Preparedness Survey conduct on March 6, 2018. We CAN submit supportive documentate to validate facility compliance supporting this plan of correctifor your review.  Transcendent Healthcare of Owensville annual Licensure survey was Jan 28th through facility with a date of alleged compliance being March 2nd and PSR March 8th. Although all citations were cleared the WINDOW remains open due to with the support of the will be wi	ial or gs e cility tion of S, ne ncy red k he ncy red ion oneb
			1	Life Safety survey March 6th v	vith

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Event ID:

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a date of alleged compliance being

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	
		155502	B. WING 03/06/2018				
NAME OF T	DOLUDED OF GUIDAL TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			HWY 16	65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENSVILLE, IN 47665			
(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)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	March 16th.		DATE
					March folh.		
					Please feel free to contact the	:	
					facility is any additional		
					information is needed.		
					Respectfully submitted,		
					Troopconding Submitted,		
					Robert O'Niones, HFA		
					Executive Director		
					Transcendent Healthcare of		
					Owensville		
K 0000							
D. 1 04							
Bldg. 01	A Life Safety Code	Recertification and State	IZ O	000	March 16, 2019		
	-	as conducted by the Indiana	K 0	000	March 16, 2018		
	-	f Health in accordance with 42			Matthew Foster, Director		
	CFR 483.90(a).				Long Term Care Division		
					Indiana State Department of		
	Survey Date: 03/06	5/18			Health		
					2 North Meridian Street		
	Facility Number: 0				Indianapolis, IN 46204		
	Provider Number:						
	AIM Number: 100	287960			RE: Transcendent Healthcare	e of	
	At this Life Sefety	Code survey, Transcendent			Owensville	1	
		sville, LLC was found not in			Survey Event ID TK9R2	ļ	
		equirements for Participation in					
	^	, 42 CFR Subpart 483.90(a),			Dear Mr. Foster;		
		re and the 2012 edition of the					
	-	ction Association (NFPA) 101,					
		SC), Chapter 19, Existing			By submitting the enclosed		
	Health Care Occupa	ancies and 410 IAC 16.2.			material, we are not admitting	the	
					truth or accuracy of any specif	fic	
	_	ity was determined to be of			findings or allegations. We		
		ruction and was fully			reserve the right to contest the		
	sprinklered. The fa	cility has a fire alarm system			findings or allegations as part	of	

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	OF CORRECTION	IDENTIFICATION NUMBER  155502	A. BUILDING B. WING	01	COMPLETED 03/06/2018
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and spaces open to to operated smoke alar rooms. The facility census of 57 at the to All areas where the access were sprinkle facility services were	residents have customary ered and all areas providing		any proceedings and submit the responses pursuant to our regulatory obligations. The fair requests the plan of correction considered our allegation of compliance effective March16 2018 to the state findings of the Life Safety Code and Emerger Preparedness Survey conduct on March 6, 2018.  On March 6, 2018 a Life Safety Code with Emergency Preparedness Survey was conducted at our facility. By submitting the enclosed mater we are not admitting the truth accuracy of any specific findin or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fair request that the plan of correct be considered our allegation of compliance effective March 16 2018 to the State findings of the Life Safety Code with Emerge Preparedness Survey conduct on March 6, 2018.  We respectfully request a desireview to validate the facility's compliance to the findings of the Life Safety Code with Emerge Preparedness Survey conduction March 6, 2018. We CAN submit supportive documentates.	cility a be  pe ncy ded  y  ial or gs e  cility tion of s, ne ncy ded  k  he ncy ded

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/06/2018	
	PROVIDER OR SUPPLIE	R ICARE OF OWENSVILLE		HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  TO VOLIDATE FACILITY COMPRISED OF	D BE COMPLETION DATE		
				to validate facility compliance supporting this plan of correcti for your review.	on			
					Transcendent Healthcare of Owensville annual Licensure survey was Jan 28th through I 1st with a date of alleged compliance being March 2nd a PSR March 8th. Although all citations were cleared the WINDOW remains open due to Life Safety survey March 6th ward a date of alleged compliance to March 16th.  Please feel free to contact the facility is any additional information is needed.	and o vith		
					Respectfully submitted,  Robert O'Niones, HFA Executive Director Transcendent Healthcare of Owensville			
K 0324 SS=E Bldg. 01	accordance with							

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19.3.2.5.2

Commercial Cooking Operations, unless: \* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **HWY 165 W PO BOX 369** TRANSCENDENT HEALTHCARE OF OWENSVILLE **OWENSVILLE, IN 47665** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE \* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or \* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 K 0324 K 324 03/16/2018 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen range hood extinguishing system was The corrective action taken for maintained in proper working order. This deficient those residents found to be practice was not in a resident area but could affect affected by the deficient practice kitchen staff is that no specific residents were identified however the kitchen staff Findings include: could be affected by the deficient practice, therefore the Based on review of the semi annual kitchen range extinguishing nozzle in the range hood inspection reports on 03/06/18 at 10:00 a.m. hood dedicated to the deep fryer with the Maintenance Supervisor present, the has now been properly positioned 12/08/17 report stated "Need swivel on nozzle for over the deep fryer. deep fryer". Based on observation of the kitchen range hood at 12:08 p.m. during a tour of the The corrective action taken for the facility with the Maintenance Supervisor, the extinguishing nozzle in the range hood dedicated other residents having the to the deep fryer was not properly positioned over potential to be affected by the the deep fryer, but, pointing to the left of the deep same deficient practice is that fryer. Based on interview at the time of no residents have the potential to observation, the Maintenance Supervisor agreed be affected by the deficient the nozzle was not properly positioned over the practice however the kitchen staff deep fryer. could be affected by the deficient practice, therefore the 3.1-19(b) extinguishing nozzle in the range

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hood dedicated to the deep fryer has now been properly positioned

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) M	III TIDI E CO	ONSTRUCTION	_	IB NO. 0938-039
			ľ			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		155502	B. W	ING		03/06	/2018
NAME OF I	DDOWNED OD CLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	NAME OF PROVIDER OR SUPPLIER			HWY 1	65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWEN	SVILLE, IN 47665		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					The measures or systematic changes that have been put i place to ensure that the defic practice does not recur is that facility has hired a new Maintenance Supervisor. The Maintenance Supervisor has in-serviced on the facility's expectation of compliance in accordance with NFPA 96 Standard for Ventilation Contand Fire Protection of Comme Cooking Operations.	ient t the e new been rol ercial	
K 0353 SS=E Bldg. 01		- Maintenance and Testing - Maintenance and Testing			monitor to assure performance assure compliance through q assurance is as part of the fare Preventative Maintenance Preventative Maintenance Supervisor of the Maintenance Supervisor of t	ce to uality cility ogram will d good eas of ected	

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Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER HWY 165 W PO BOX 369 TRANSCENDENT HEALTHCARE OF OWENSVILLE **OWENSVILLE, IN 47665** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the K 0353 K 353 03/16/2018 facility failed to ensure the ceiling in 2 of 4 sprinklered smoke compartments was maintained 1 a) The corrective action taken to allow sprinkler heads to function to their full for those residents found to be capability. This deficient practice could affect affected by the deficient practice residents, as well as staff and visitors while in the is that no specific residents were Physical Therapy gym and the Social Services identified however all residents. office. visitors and staff could be affected by the deficient practice. The Findings include: four-inch circular hole in the ceiling attic access panel in the social Based on observations on 03/06/18 between 11:15 service office has been repaired. a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was 1 b) The corrective action taken noted: for those residents found to be a. There was a four inch circular hole in the affected by the deficient practice ceiling attic access panel in the Social Services is that no specific residents were office identified however all residents. b. There was a one inch gap around a wire bundle visitors and staff could be affected that penetrated the ceiling into the attic space in by the deficient practice. The the Physical Therapy gym storage area hall above one-inch gap around the wire the electrical panel bundle that penetrated the ceiling Based on interview at the time of observations, into the attic space in the physical

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the Maintenance Supervisor acknowledged the

Social Services office and the one inch gap in the

four inch hole in the attic access panel in the

ceiling of the Physical Therapy gym.

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therapy gym storage area hall

above the electrical panel has

been repaired/sealed.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155502	B. WING			03/06/	2018
				CTDEET A	ADDRESS OF A STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANGO		OADE OF OMENOVILLE			65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENSVILLE, IN 47665			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN GE 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'	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'	DATE
					2) The corrective action taken	for	
	3.1-19(b)				those residents found to be		
	,				affected by the deficient practi	ce	
	Based on observ	ration and interview, the			is that no specific residents we		
		sure 1 of over 200 sprinkler			identified however all residents		
	-	was free of corrosion. NFPA			visitors and staff could be affect		
	-	e Inspection, Testing, and			by the deficient practice. The	otou	
		ter-Based Fire Protection			sprinkler head above the dish		
		I requires sprinklers to be free			washing machine in the kitche	n l	
	-	on. 5.2.1.1.2 requires any			has been replaced and is free		
	-	s signs of paint or corrosion			signs of paint and corrosion.	•	
	_	This deficient practice could			oigne or paint and contolion		
	_	f plus all residents, as well as			The corrective action taken for	the	
		hile in the adjacent dining			other residents having the		
	room.	e uuguve ug			potential to be affected by the		
	100				same deficient practice is that	a	
	Findings include:				housewide audit of all ceiling		
				areas in the facility and all			
	Based on observation	on on 03/06/18 at 12:14 p.m.			sprinkler heads has been		
		facility with the Maintenance			conducted to ensure that all		
	-	inkler head above the			ceiling areas are maintained to	,	
	_	ne in the kitchen was covered			allow sprinkler heads to function		
		n. Based on interview at the			their full capacity and that all		
	_	, the Maintenance Supervisor			sprinkler heads in the facility w	ere l	
		head was covered with green			free of corrosion. No other		
	corrosion.	5			deficiencies were identified du	rina	
					this housewide audit.	9	
	3.1-19(b)						
	(-)				The measures or systematic		
					changes that have been put in	to	
					place to ensure that the deficie		
					practice does not recur is that		
					facility has hired a new		
					Maintenance Supervisor. The	new	
					Maintenance Supervisor has b		
					in-serviced on the facility's		
					expectation of compliance in		
					accordance with NFPA 25,		
					Standard for the Inspection,		
					Testing and Maintaining of		
			1		1 county and maintaining of		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTI A. BUILD B. WING	IPLE CONSTRUCTION DING 01	(X3) DATE SURVEY COMPLETED 03/06/2018
	PROVIDER OR SUPPLIER	CARE OF OWENSVILLE	H	FREET ADDRESS, CITY, STATE, ZIP C NWY 165 W PO BOX 369 NWENSVILLE, IN 47665	COD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)  Water-based Fire Prote	HOULD BE APPROPRIATE COMPLETION DATE
				Systems.  The corrective action to monitor to assure perfect assure compliance through assurance is as part of Preventative Maintenathe Maintenance Superinspect all ceiling areas sprinkler heads to ensure sprinkler heads are about function to their full capt that all sprinkler heads facility are free of correctionity are free of correctionity corrected to expendent of the control of the contro	aken to ormance to ough quality f the facility nce Program ervisor will s and ure that all le to opacity and is in the osion. Any ocern will be
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Constructic 2012 EXISTING Smoke barriers sh 1/2-hour fire resist barriers shall be p atrium wall. Smok in duct penetration systems where ar is installed for smoth to the smoke barri 19.3.7.3, 8.6.7.1(1) Describe any med system in REMAR	nall be constructed to a tance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.	K 0372	0 K 372	03/16/2018

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failed to ensure 1 of 2 smoke barrier walls was protected to maintain the smoke resistance of the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **HWY 165 W PO BOX 369** TRANSCENDENT HEALTHCARE OF OWENSVILLE **OWENSVILLE, IN 47665** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE smoke barrier. LSC Section 19.3.7.5 requires The corrective action taken for smoke barriers to be constructed in accordance those residents found to be with LSC Section 8.5 and shall have a minimum ½ affected by the deficient practice hour fire resistive rating. This deficient practice is that no specific residents were could affect up to 32 residents, as well as staff and identified however 32 residents on visitors in the west hall. the west hall as well as staff and visitors could be affected by the Findings include: deficient practice. The smoke barrier wall in the attic above the Based on observation on 03/06/18 at 12:49 p.m. smoke barrier doors in the west during a tour of the facility with the Maintenance hall which had the 2 – 3 inch gap Supervisor, the smoke barrier wall in the attic through the wall on the bottom half above the smoke barrier doors in the west hall had of the four-inch sprinkler main has a 2 to 3 inch gap through the wall on the bottom now been repaired and meets the half of the four inch sprinkler main that was not ½ hour fire resistive rating. properly fire stopped. Based on interview at the time of observation, the Maintenance Supervisor The corrective action taken for the said he just started the job and was not aware of other residents having the the gap that penetrated the smoke barrier wall in potential to be affected by the the west hall. same deficient practice is that a housewide audit of all smoke 3.1-19(b) barrier walls has been conducted to ensure that there are no other breaches in the smoke barrier walls. No other areas were identified. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has hired a new Maintenance Supervisor. The new Maintenance Supervisor has been in-serviced on the facility's expectation of compliance in accordance with LSC Section 19.3.7.5 related to smoke barrier walls being maintained to ensure a

minimum of 1/2 hour fire resistive

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EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING <u>01</u>	COMPLETED
	155502	B. WING		03/06/2018
			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER			HWY 165 W PO BOX 369	
TRANSCENDENT HEALTHCARE OF OWENSVILLE			OWENSVILLE, IN 47665	

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	DROVIDENC NEAR OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0511 SS=C Bldg. 01	NFPA 101  Utilities - Gas and Electric  Utilities - Gas and Electric  Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas  Code, electrical wiring and equipment complies with NFPA 70, National Electric  Code. Existing installations can continue in service provided no hazard to life.  18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  Based on record review and interview the facility failed to ensure 1 of 1 emergency generator had a current letter from their gas company to ensure a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS):  (1) Liquid petroleum products at atmospheric pressure	K 0511	rating.  The corrective action taken to monitor to assure performance to assure compliance through quality assurance is as part of the facility's Preventative Maintenance Program the Maintenance Supervisor will inspect all smoke barrier walls monthly to ensure on-going compliance. Any areas of concern identified will be promptly corrected.  K 511  The corrective action taken for those residents found to be affected by the deficient practice is that no specific residents were identified however all residents, visitors and staff could be affected by the deficient practice. A letter signed by the gas company representative with a current date was obtained by the Executive Director during the Life Safety Survey and is maintained in the emergency generator log	03/16/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **HWY 165 W PO BOX 369** TRANSCENDENT HEALTHCARE OF OWENSVILLE **OWENSVILLE, IN 47665** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE withdrawal) (3) Natural or synthetic gas The corrective action taken for the Exception: For Level 1 installations in locations other residents having the where the probability of interruption of off-site potential to be affected by the fuel supplies is high, on-site storage of an same deficient practice is that all alternate energy source sufficient to allow full residents, visitors and staff have output of the EPSS to be delivered for the class the potential to be affected by the specified shall be required, with the provision for deficient practice. A letter signed automatic transfer from the primary energy source by the gas company to the alternate energy source. representative with a current date A.5.1.1 states examples of probability of was obtained by the Executive interruption could include the following: Director during the Life Safety earthquake, flood damage, or a demonstrated Survey and is maintained in the utility unreliability. This deficient practice could emergency generator log affect all residents, staff and visitors. information. Findings include: The measures or systematic changes that have been put into Based on record review on 03/06/18 at 10:50 a.m. place to ensure that the deficient with the Administrator present, the emergency practice does not recur is that the generator log information identified the fuel facility has developed a calendar source for the emergency generator was natural whereby the natural gas provider gas. Additionally, the facility did have a letter will be contacted by the from their natural gas provider indicating the Maintenance Supervisor to obtain natural gas was from a reliable source, however, a letter from the natural gas the date on the letter was 09/23/14, and provider which is dated at least furthermore, the letter was not signed by the gas annually and signed by a gas company representative, and was not current company representative. The within the past twelve months. Based on letter will be maintained in the interview at the time of record review, the emergency generator log. The Administrator said the letter presented was the facility has hired a new most recent letter on file at the facility. Maintenance Supervisor and he has been in-serviced on the new 3.1-19(b) facility practice. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/06/2018
	PROVIDER OR SUPPLIEF	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				implemented to ensure that a current and valid letter from th natural gas provider is on file i emergency generator log. Thi tool will be completed by the Executive Director every three months which and will be on-g to ensure continued compliant Any areas of concern will be immediately addressed with the Maintenance Supervisor.	n the s
K 0712 SS=C Bldg. 01	alarm signal and some conditions. Fire draw and unexpected tite conditions, at least The staff is familia aware that drills a routine. Where draw and 6:00 announcement mandible alarms.	ay be used instead of			
	failed to ensure fire for 3 of 3 employee LSC 19.7.1.6 requir quarterly on each sl furthermore, the fact at unexpected times 10 of 12 fire drills. affect all residents in Findings include:	riew and interview, the facility drills were held at varied times a shifts during 4 of 4 quarters. The drills to be conducted and under varied conditions, will be facility failed to conduct fire drills ander varying conditions for This deficient practice could in the facility.	K 0712	The corrective action taken for those residents found to be affected by the deficient practi is that no specific residents we identified however all resident could be affected by this defic practice. The facility has prep a fire drill calendar which stag the week, day of the week and time of the fire drills to ensure	ice ere s ient ared gers

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>01</u>			ETED
		155502	B. W	ING		03/06/	/2018
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			65 W PO BOX 369		
TRANSC	ENDENT HEALTH	CARE OF OWENSVILLE		OWENSVILLE, IN 47665			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		.m. with the Maintenance			the fire drills are being conduc		
		ten of twelve fire drills			at unexpected times and unde	er	
	1 -	he past twelve months were			varying conditions. A new		
	_	he last four days of the month.			calendar will be developed		
	_	v at the time of record review,			annually to ensure the week,	-	
		upervisor acknowledged that			of the week and time varies ea	ach	
		were performed during the last			year. Only the Maintenance		
	four days of the mo	onth.			Supervisor and the Executive		
					Director will have knowledge	of the	
	3-1.19(b)				fire drill calendar.		
					The corrective action taken fo	r the	
					other residents having the		
					potential to be affected by the		
					same deficient practice is that		
					all residents have the potentia		
					be affected by this deficient		
					practice. The facility has prep	ared	
					a fire drill calendar which stag		
					the week, day of the week and	-	
					time of the fire drills to ensure		
					the fire drills are being conduc	ted	
					at unexpected times and unde		
					varying conditions. A new		
					calendar will be developed		
					annually to ensure the week,	day	
					of the week and time varies ea	ach	
					year. Only the Maintenance		
					Supervisor and the Executive		
					Director will have knowledge of	of the	
					fire drill calendar.		
					The measures or systematic		
					changes that have been put ir	nto	
					place to ensure that the defici		
					practice does not recur is that		
					facility has hired a new		
					Maintenance Supervisor. The	<b>;</b>	
					Executive Director has in-serv		
					the new Maintenance Supervi		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155502		A. BUILDING 01  B. WING		COMPLETED 03/06/2018	
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re	ent - Power Cords and ent - Power Cords and eatient care vicinity are only ents of movable d electrical equipment		of the facility's new practice in development of a fire drill cale and his responsibility in conducting fire drills in accord with the facility calendar.  The corrective action taken to monitor to assure performance assure compliance through quassurance is the Executive Director will be responsible for reviewing/monitoring the monifire drill logs to ensure that the facility fire drill calendar is being followed. Any areas of conceidentified will be immediately addressed with the Maintenar Director for additional action if warranted.	the endar ance e to vality r thly eng rn

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155502		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/06/2018		
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD HWY 165 W PO BOX 369 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	cords are not used wiring of a structure temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on record revinterview; the facilistrips, extension cowere not used as a sleast 5 of 32 resider LSC 19.5.1.1 requires Section 9.1. LSC 9 and equipment to confect the strips of a structural fect over 10 resideres shall not be wiring of a structural fect over 10 resideres as well as southwest sitting are Findings include:  Based on observation and 1:30 p.m. the Maintenance Sunoted:  a. There were two mounted light pluggadapter in the south Beauty Shop.  b. Room 13 had a locord c. Room 9 had a rean extension cord	precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 view, observation, and ty failed to ensure power rds, and multi plug adapters substitute for fixed wiring in at nt rooms, plus one other area. res utilities to comply with v.1.2 requires electrical wiring omply with NFPA 70, National FPA 70, Article 400-8 requires, permitted, flexible cords and used as a substitute for fixed e. This deficient practice could ents in sleeping room, plus staff and visitors while in the ea.  Ons on 03/06/18 between 11:15 during a tour of the facility with apervisor, the following was evending machines and a wall ged into a multi plugged west sitting area outside the ord plugged into an extension frigerator and fan plugged into	K 0920	a). The corrective action taken those residents found to be affected by the deficient practise that no specific residents widentified however all resident visitors and staff have the pote to be affected by the deficient practice. The vending machin on the southwest sitting area outside the Beauty Shop are replugged into the appropriate electrical outlet in accordance NFPA 101 power cord and extensions safety code requirements.  b). The corrective action taken those residents found to be affected by the deficient practise that no specific residents widentified however all resident visitors and staff have the pote to be affected by the deficient practice. Room 13 has had additional hard wired electrica outlet installed and/or an upgrepower strip added in accordar with the regulation.	ice ere ess, ential nes now with ice ere ess, ential	03/16/2018

into two separate power strips

c). The corrective action taken for

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155502		B. W	B. WING		03/06/	/2018	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	e. Room 3 had a re	frigerator and lamp plugged			those residents found to be		
	into a power strip				affected by the deficient practi	ce	
	f. Room 19 had a T	TV and lamp plugged into a			is that no specific residents we		
	power strip				identified however all residents		
		L rating on the power strips			visitors and staff have the pote	ential	
		meet the power strip			to be affected by the deficient		
	_	1363A or UL 60601-1 for			practice. Room 9		
	rooms.	or UL 1363 for resident care			has had additional hard wired electrical outlet installed and/o	r on	
		dged by the Maintenance			upgraded power strip added in		
		me of each observation.			accordance with the regulation		
	Supervisor at the th	or cum coop varion			accordance with the regulation	••	
	3.1-19(b)				d). The corrective action taken	for	
	,				those residents found to be		
					affected by the deficient practi	ce	
					is that no specific residents we	ere	
					identified however all residents	S,	
					visitors and staff have the pote	ential	
					to be affected by the deficient		
					practice. Room 5 has had		
					additional hard wired electrical		
					outlet installed and/or an upgra		
					power strip added in accordan	ce	
					with the regulation.		
					a) The correction action to be	for	
					e). The corrective action taken those residents found to be	1 101	
					affected by the deficient practi	co.	
					is that no specific residents we		
					identified however all residents		
					visitors and staff have the pote	•	
					to be affected by the deficient	Ji iti Gi	
					practice. Room 3		
					has had additional hard wired		
					electrical outlet installed and/o	r an	
					upgraded power strip added ir	1	
					accordance with the regulation		
					f). The corrective action taken	for	
					those residents found to be		

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  155502	A. BUILDING B. WING	01	COMPLETED 03/06/2018
	ROVIDER OR SUPPLIER	CARE OF OWENSVILLE	HWY 1	ADDRESS, CITY, STATE, ZIP COD 65 W PO BOX 369 SVILLE, IN 47665	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				affected by the deficient practic is that no specific residents we identified however all residents visitors and staff have the pote to be affected by the deficient practice. Room 19 has had additional hard wired electrical outlets installed and/an upgraded power strip adde accordance with the regulation.  The corrective action taken for other residents having the potential to be affected by the same deficient practice is that a housewide audit has been conducted to identify any othe areas in need of fixed electrica outlets. In addition, all power strips and/or extension cords to do not meet the requirements.  UL 1363A, or UL 60601-1 for medical equipment or UL 1363 resident care rooms have bee removed and replaced with eit fixed electrical outlets or power strips that meet the LSC requirements.  The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur is that facility has hired a new Maintenance Supervisor. The facility has provided the new Maintenance Supervisor with a mandatory in-service on the	ere s, ential  for d in n. r the  r al hat of s for n her er tr tto ent tto ent tthe
				requirements of NFPA 101 Po	wer

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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF OWENSVILLE			HWY 1	STREET ADDRESS, CITY, STATE, ZIP COD HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE			
K 0923 SS=F Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ecceptors and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enconcombustible of	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.		Cords and Extensions.  The corrective action taken monitor to assure performa assure compliance through assurance is that as part of facility Preventative Mainte Program the Maintenance Supervisor will conduct rou least monthly to identify an correct any areas of non-compliance of NFPA 1 Power Cords and Extensio Any areas of non-complian identified by any staff mem be promptly reported to the Maintenance Supervisor for correction	ance to a quality f the nance ands at d 01 ns. ce ber will			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155502 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **HWY 165 W PO BOX 369** TRANSCENDENT HEALTHCARE OF OWENSVILLE **OWENSVILLE, IN 47665** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA Based on observation and interview, the facility K 0923 K 923 03/16/2018 failed to ensure 3 of 6 cylinders of nonflammable gases such as oxygen were properly secured from The corrective action taken for falling in the oxygen storage/transfilling room. those residents found to be NFPA 99, Health Care Facilities Code, 2012 affected by the deficient practice Edition, Section 11.3.2 states storage for is that no specific residents were nonflammable gases greater than 8.5 cubic meters identified however all residents, (300 cubic feet) but less than 85 cubic meters visitors and staff have the potential (3000 cubic feet) shall comply with 11.3.2.1 to be affected by the deficient through 11.3.2.3. NFPA 99, Section 11.3.2.6 states practice. The three E type oxygen cylinder or container restraints shall comply with cylinders identified during the 11.6.2.3. Section 11.6.2.3(11) states freestanding survey are now storage securely in cylinders shall be properly chained or supported proper cylinder carts.

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in a proper cylinder stand or cart. This deficient practice could affect all residents, staff and

visitors while in the dining room which was

adjacent to the oxygen storage room.

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The corrective action taken for the

other residents having the

potential to be affected by the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/06/2018	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD HWY 165 W PO BOX 369 OWENSVILLE, IN 47665			
TRANSC  (X4) ID  PREFIX  TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Findings include:  Based on observation on 03/06/18 at 12:03 p.m. during a tour of the facility with the Maintenance Supervisor, there were three 'E' type oxygen cylinders standing upright on the floor in the oxygen storage/transfilling room that were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Supervisor said he was not aware the oxygen cylinders were freestanding.  3.1-19(b)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  same deficient practice is that a housewide audit was conduct throughout the facility to ensure that there were no other oxyge cylinders that were not proper secured. No other cylinders widentified.  The measures or systematic changes that have been put in place to ensure that the deficie practice does not recur is that mandatory in-service has been provided for all nursing, housekeeping, laundry and maintenance staff on the facili practice of safe oxygen storage	cted re en lly vere  nto ent a n	
				The staff was directed that any that identifies an oxygen tank is not stored securely is to immediately ensure that the tais placed in a secure cylinder stand or cart.  The corrective action taken to monitor to assure performance assure compliance through quassurance is that as part of the facility Preventative Maintenar Program the Maintenance Supervisor will check monthly oxygen cylinders to ensure that they are being stored in a program that storage stand or cart.	yone that  e to uality e nce all at per	

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