

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE HWY 165 W PO BOX 369 OWENSVILLE, IN 47665
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F 000 Bldg. 00	<p>This visit was for a Investigation of Complaint IN00168199.</p> <p>Survey dates: March 13, 2015</p> <p>Complaint number: IN00168199 - Substantiated. Federal/State deficiencies related to the allegations are cited at F247.</p> <p>Facility number: 000328 Provider number: 155502 AIM number: 100287960</p> <p>Survey team: Anna Villain, RN-TC Jodi Meyer, RN</p> <p>Census Bed Type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 12 Medicaid: 41 Other: 3 Total: 56</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings</p>	F 000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 247 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 16, 2015 by Jodi Meyer, RN</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to notify family and /or residents' when a room change was conducted for 3 of 5 residents reviewed for room changes in a total sample of 7. (Resident C, D, F)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 3/13/15 at 11:00 a.m., the record contained a nurses notation of the resident moving on 2/24/15 to another room due to the need for isolation. The record lacked a specific time of the notation and of the transfer. The record did not contain documentation the family was contacted regarding the resident's transfer. The next note on 2/26/15 at 1800 (6:00 p.m.) "N/O (new order) D/C</p>	F 247	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective April 3, 2015 to the state findings of the complaint survey conducted on March 13, 2015.</p> <p>1. The corrective action taken for those residents found to be affected by the deficient practice is that the facility has revised the room change notification form to include a reason for the need to make a room change along with the date and time resident and responsible party received this notification. In the event that it is necessary to change</p>	04/03/2015

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	<p>(discontinue) precautions (isolation) family made aware." The record lacked documentation of the resident's return to their previous room where their personal effects had been stored.</p> <p>On 3/13/15 at 11:30 a.m., Housekeeper #1 was interviewed regarding the resident's move. She indicated the resident was moved across the hall due to infection. She continued, the room in which the resident was moved to was unoccupied due to the current resident was in the hospital . She further described the hospitalized resident's belongings (Resident #B) were placed in the room closet and Resident #C's belongings stayed in the room across the hall.</p> <p>LPN #1 was present during the above interview, she added that when the results of the test came back negative Resident #C was returned across the hall to the original room.</p> <p>Resident #B's clinical record was reviewed on 3/13/15 at 10:30 a.m., the resident was admitted to the hospital on 2/12/15. Documentation indicated the room was on a reserve or bedhold for Resident #B while being hospitalized.</p> <p>Resident #C had documentation of "Room Change" form in the clinical record, dated 12/12/14, from one room to another. The record lacked any documentation of the reason for the move</p>		<p>rooms for the resident identified as resident #C in the future the revised form will be completed. In addition the social service director will document the room change in the social service notes along with the resident's response and adjustment to the room change.</p> <p>2. The corrective action taken for those residents found to be affected by the deficient practice is that the facility has revised the room change notification form to include a reason for the need to make a room change along with the date and time resident and responsible party received this notification. In the event that it is necessary to change rooms for the resident identified as resident #D in the future the revised form will be completed. In addition the social service director will document the room change in the social service notes along with the resident's response and adjustment to the room change.</p> <p>3. The corrective action taken for those residents found to be affected by the deficient practice is that the facility has revised the room change notification form to include a reason for the need to make a room change along with the date and time resident and responsible party received this notification. In the event that it is necessary to change rooms for the resident identified as</p>	

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	<p>or notification of the move with resident and/or family member.</p> <p>2. Resident #D's clinical record was reviewed on 3/13/15 at 11:35 a.m. The record contained documentation of the resident changing rooms four times in less than one year. The "Room Change" form, dated 2/23/15, changed the resident's room from one room to another without documentation of reason and/or discussion with resident and/or family.</p> <p>3. On 3/13/15 at 11:30 a.m., Resident #F was interviewed. Resident #F indicated she had been moved three or four times when she first arrived at the facility. Resident #F further indicated she had been moved because other residents were returning to the facility and had needed the rooms she was in. Resident #F indicated the facility had only asked her if would be okay to move once and had only notified her she would be moving immediately before they had moved her. Resident #F indicated the facility had placed her with a resident who she had been fearful of once and Resident #F indicated she had requested she be moved at that time.</p> <p>On 3/13/15 at 12:00 p.m., Resident #F's clinical record was reviewed. The nursing notes indicated Resident #F had</p>		<p>resident #F in the future the revised form will becompleted. In addition the socialservice director will document the room change in the social service notesalong with the resident's response and adjustment to the room change.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that a house wide audit was completed on allresidents to ensure that the reasons for room change where documented in theclinical record along with the date and time of resident and responsible partynotification.</i></p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for SocialServices and all licensed nurses on the revised room change notificationform. The staff was in-serviced on theirresponsibilities for accurate and thorough completion of the form prior to anyroom changes. In addition SocialServices was in-serviced on their responsibility in documenting the room changetransaction in the social service notes along with the resident'sresponse/adjustment to the room change.</p> <p>The corrective action taken to</p>	

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	<p>been admitted on 2/23/15 to (room number). The Skilled Daily Nursing Notes, dated 2/24/15, indicated Resident #F had been moved to another room (Resident #B's room). The Skilled Daily Nursing Notes, dated 2/25/15, indicated Resident #F had been moved to another room. The clinical record lacked documentation to indicate the circumstances surrounding Resident #F's room changes. The clinical record lacked any social service notes surrounding the circumstances of Resident #F's room changes.</p> <p>On 3/13/15 at 1:50 p.m., the Administrator provided the additional Room Change documentation. The additional documentation lacked information surrounding Resident #F's room change. At that time, the Administrator also provided the Admission MDS (Minimum Data Set) Assessment, dated 3/8/15. The MDS assessment indicated Resident #F was cognitively intact.</p> <p>On 3/13/15 at 2:00 p.m., the Administrator was queried regarding Resident #F's room changes. The Administrator indicated Resident #F had requested to be moved to a different room because Resident #F had not liked the initial room due to its size. The</p>		<p>monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the documentation on room changes. This tool will monitor the documentation to ensure proper notification has been provided to the resident and/or responsible party along with the justifiable reason for the room change. The tool will also monitor the documentation related to social service assessing the resident's adjustment to their new room. This tool will be completed by the Executive Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>	

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	<p>Administrator indicated Resident #F had been moved to another room. The Administrator indicated the facility suggested Resident #F move to another room because the facility thought Resident #F would like that room the best.</p> <p>This Federal tag related to Complaint IN00168199.</p> <p>3.1-3(v)(2)</p>			