

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155502	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2013
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 13, 14, 15, 19, 20, 2013</p> <p>Facility number: 000328 Provider number: 155502 AIM number: 100287960</p> <p>Survey team: Barbara Fowler RN TC Diane Hancock RN Denise Schwandner RN Diana Perry RN August 13, 14, 15, 2013 Anna Villain RN August 19, 2013</p> <p>Census Bed Type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare 8 Medicaid 36 Other 4 Total: 48</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<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 that the plan of correction be considered our allegation of compliance effective September 16, 2013 to the annual licensure survey conducted on August 13th through August 19th, 2013. The facility also request that our plan of correction be considered for paper review compliance. The facility would respectfully submit to you any compliance paper work you would need for review.</p>	

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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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide liability notice and beneficiary appeal rights on approved forms with acknowledgement of receipt to 1 of 1 sampled resident for whom Medicare services were terminated in the sample of 4 reviewed. (Resident #33)</p> <p>Finding includes:</p> <p>During an interview with the facility Administrator, on 8-19-2013 at 10:30 a.m., she provided a type written letter, dated 8-8-13, indicating Resident #33's Medicare services would no longer be covered effective 8-10-13. Appeal rights were not provided. The administrator indicated they required the family to sign the letter when the facility was stopping the services. She was unaware of the required form. The letter provided was not approved, in content or format, by CMS (Centers for Medicare and Medicaid Services) and failed to address appeal rights.</p> <p>3.1-4(a)</p>	F000156	<p>F156 It is the practice of Transcendent Healthcare to assure that residents receive notice and appeal rights when no longer eligible for Medicare benefits. The correction action taken for those residents found to be affected by the deficient practice include: Resident #33 has been provided the proper Medicare form with the appeal rights identified. Other residents that have the potential to be affected have been identified by: All future residents will be notified of ineligibility of Medicare benefits utilizing the appropriate for identifying the appeal rights in accordance with the regulation. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The appropriate form has been obtained related to residents being ineligible for Medicare benefits and their appeal rights. The Business Office Manager has been in-serviced related to the use of the appropriate forms to utilize when the end of Medicare coverage occurs. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) to assure that residents not eligible for</p>	09/16/2013	

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			Medicare receive proper notice and information related to appeal rights. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 16, 2013	

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 resident expressing a desire to go to bed, out of 30 stage 1 sample residents observed, was assisted to bed in a timely manner according to her wishes. (Resident #5)</p> <p>Finding includes:</p> <p>Resident #5 was observed on 8/14/13 at 4:10 p.m. in her room. She was yelling out, "[Unknown woman's name] help me, help me. Help me to bed. Turn down the covers; I want to go to bed."</p> <p>LPN #1 entered the resident's room at 4:18 p.m. She stated to the resident, "If you go to bed, you'll miss supper." The resident continued to yell and scream, wanting to go to bed. The LPN continued to mention supper, indicating it was almost time for supper. The resident continued to yell. LPN #1 eventually asked the</p>	F000246	F246 It is the practice of Transcendent Healthcare to assure that residents are treated in a dignified manner including honoring of wishes. The correction action taken for those residents found to be affected by the deficient practice include: Resident #5 is receiving services in accordance with her wishes. Other residents that have the potential to be affected have been identified by: All residents are receiving services in accordance with their wishes. Please see below for measures implemented to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Reinforcement of the facility policy related assuring that residents receive services in accordance with their wishes. The nursing staff has been in-serviced related to assuring that resident's wishes are honored as part of services provided. The in-service will specify laying residents down upon their request. Please see below for means of monitoring	09/16/2013			

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	<p>resident, "Do you want to eat supper in bed? The resident continued to state she wanted to go to bed.</p> <p>At 4:19 p.m. on 8/14/13, the Director of Nurses [DoN] entered the room. The resident stated, "I want to go to bed; they won't let me." The DoN continued to tell the resident it was time for supper and ask her if she wanted to have supper first. She told the resident supper was in 30 minutes. The resident continued to chant "help me to bed; help me to bed." The DoN repeated, "do you want to lay down now or do you want to have supper first? The resident responded, "I don't know what you said," then stated, "get in bed...I've got to get to bed." The DoN stated, "I think she wants to lay down instead of have supper."</p> <p>At 4:35 p.m. on 8/14/13, the resident was observed laying peacefully in bed.</p> <p>The observations were reviewed with the DoN and Administrator on 8/20/13 at 10:30 a.m. Both indicated if residents wanted to go to bed, they should be allowed to go to bed.</p> <p>3.1-3(v)(1)</p>		<p>through observation to assure that the policy is followed in accordance with the regulation. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents for honoring of residents' wishes and choices. This tool will specifically observe for residents that have request to assure that they are honored. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 16, 2013</p>				

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F000258 SS=E	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on interviews and observations, the facility failed to ensure that sound levels did not interfere with the resident's control over unwanted noise for 7 of 21 residents interviewed for comfort. (Resident #67, #23, #48, #37, #17, #22, and #15)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #67 indicated on 08/13/2013, at 10:52 a.m., that the facility is pretty cool and noisy when trying to sleep and that there is no respect for anyone sleeping.</li> <li>2. Resident #23 indicated on 8/13/2013, at 4:23 a.m., that it is noisy at night.</li> <li>3. Resident #48 indicated on 8/13/2013, at 10:54 a.m., that there is noise in the hallway.</li> <li>4. Resident #37 indicated on 8/14/2013, at 10:00 a.m., that it gets a little noisy at night especially with a full moon.</li> <li>5. Resident #17 indicated on</li> </ol>	F000258	F258 It is the practice of Transcendent Healthcare to assure that residents have a comfortable environment that minimizes noises. The correction action taken for those residents found to be affected by the deficient practice include: Residents #37, #17, #22, #48 and #15 indicate the noise levels have improved. Residents #23 and #67 are unknown to the facility. Other residents that have the potential to be affected have been identified by: All residents able to be interviewed have been questioned related to noise levels. Per this interview process, residents are indicating much improvement in noise levels. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All staff has been in-serviced related to assuring that noise levels are controlled. The in-service specifies assuring that voices are kept at lower levels for the residents' comfort. The charge nurses are responsible for assuring that noise levels are acceptable on their designated shifts. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance	09/16/2013			

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	<p>8/14/2013, at 9:07 a.m., that the facility gets loud at times.</p> <p>6. Resident #22 indicated on 8/14/2013, at 2:06 p.m., that some residents are loud. Resident #22 further indicated 8/19/2013, at 9:28 a.m., that noise in the hallway kept her from sleeping at night. She indicated that staff was making noise.</p> <p>7. Resident #15 indicated on 8/14/2013, at 8:41 a.m., that noise in the facility affects comfort level.</p> <p>8. During an observation on 6/14/13 at 4:10 p.m., Resident #5 was observed to be yelling out, "{Unknown woman's name} help me, help me. Help me to bed. Turn down the covers; I want to go to bed."</p> <p>9. During an observation on 8/20/13 at 9:40 a.m., an unidentified dietary employee pushed cart onto the West unit and yelled down the hall that the "Nourishment Cart" was there.</p> <p>10. Administrator indicated during interview on 8/20/2013, at 10:30 a.m., that she knew staff got noisy at times and needed to be reminded to be quieter.</p> <p>3.1-19(f)</p>		<p>Improvement Tool has been initiated that randomly interviews 5 residents related to noise levels and assuring a comfortable environment. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the results of the PI tools. The date the systemic changes will be completed: September 16, 2013</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the care plan was revised for 1 of 1 resident reviewed for dialysis and 1 of 3 residents reviewed for falls, in the stage 2 sample of 27. (Residents #37, #45)</p> <p>Findings include:</p> <p>1. On 8/14/13 at 8:59 a.m., LPN #1 indicated Resident #37 had fallen on 7/23/13.</p> <p>Resident #37's clinical record was reviewed on 8/19/13 at 10:17 a.m.</p>	F000280	F280 It is the practice of this facility to assure that the all resident care plans are updated and revised to reflect the current services provided to the resident. The correction action taken for those residents found to be affected by the deficient practice include: Resident #37 care plan has been updated to reflect the current fall interventions. Resident #45 care plan has been updated to reflect the proper fluid restrictions. Other residents that have the potential to be affected have been identified by: All residents care plans has been reviewed to assure that they accurately reflect any services related to the resident. Any	09/16/2013			

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	<p>The resident was admitted to the facility on 12/15/10 with diagnoses including, but not limited to, chronic edema, obstructive sleep apnea, venous stasis, chronic kidney disease, atrial fibrillation, diabetes mellitus, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and chronic pain.</p> <p>Nurses' notes, dated 7/23/13 at 3:10 a.m., indicated the following: "Heard res. [resident] calling out. Searched down hall and found res in floor in room. Urine noted in floor..."</p> <p>The resident had a care plan to address falls, initiated 1/16/12. The care plan indicated a "History of falls (list dates) 1/16/12, 5/14/12." The 7/23/13 fall was not listed.</p> <p>There had been no updates or revisions since 5/14/12, when non-skid strips were added under the resident's recliner chair.</p> <p>The Director of Nurses (DoN) was interviewed on 8/19/13 at 4:45 p.m. The DoN indicated the resident had transferred himself to the bed side commode (BSC) and spilled urine and slipped in it. She indicated they had moved the BSC closer to the</p>		<p>discrepancies identified will be corrected to assure the care plan is accurate. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The MDS Coordinator is responsible for revisions on the plan of care. This position has been in-serviced related to assuring that the care plans accurately reflects the resident's condition. The MDS Coordinator will be part of the interdisciplinary team that reviews the 24-hr reports, incidents, new orders, etc each business morning to assist with updated knowledge related to the residents' condition so that the care plan can be updated appropriately. The corrective action taken to monitor performance to assure compliance through quality assurance is: A PI tool has been established that randomly reviews 5 resident care plans for accuracy. The Director of Nursing, or designee, is responsible for completion of the tool. This tool will be completed weekly x3, monthly x3, and then quarterly x3. Any identified issues will be immediately corrected. The quality assurance committee will review the PI tools at the regularly scheduled meetings with additional recommendations if there is any negative outcome on the PI tools. The date the systemic changes</p>	

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	<p>recliner and told the resident to ask for help if needed.</p> <p>The DoN provided an incident/accident report at 4:50 p.m. on 8/19/13. The incident/accident report indicated the resident had spilled urine and slipped in it. Preventive measures indicated an "anti-slip mat to be put under bed side commode."</p> <p>Resident #37 was observed in his room on 4/19/13 at 5:10 p.m. New non-skid strips had been placed in front of the bed side commode. He indicated he thought it would take care of the problem.</p> <p>The care plan had not been revised to include moving the BSC closer, encouraging to ask for help, and any anti-slip mat or strips in front of the BSC.</p> <p>2. Resident #45 was observed on 8/13/13 at 2:05 p.m. sitting in her room. Resident #45 had an area on her right forearm which the resident indicated was a dialysis shunt. Resident #45 indicated she had dialysis on Tuesday, Thursday, and Saturday each week.</p> <p>The clinical record of Resident #45</p>		will be completed: September 16, 2013				

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	<p>was reviewed on 8/15/13 at 9:14 a.m. Resident #45 had a diagnosis including, but not limited to ESRD (End Stage Renal Disease).</p> <p>The clinical record indicated Resident #45 had a physician's order, dated 7/25/13, for a fluid restriction of 1500 ml (milliliter) in a 24 hr (hour) period.</p> <p>A care plan for fluid restriction, dated 1/5/13, indicated Resident #45 had a fluid restriction of 1800 ml/24 hrs. The care plan indicated Resident #45 was to receive 360 ml at meals, 120 ml at the bedside on the night shift, and 300 ml at the bedside on the day and evening shifts. The resident also had Nephro 120 ml bid (twice a day) ordered which was included in her meals.</p> <p>During an interview with the DM (Dietary Manager) on 8/15/13 at 12:55 p.m., the DM indicated she had observed the fluid restriction on Resident #45's meal card and she had questions about it also.</p> <p>During an interview with the DoN (Director of Nursing) on 8/15/13 at 1:45 p.m., the DoN indicated Resident #45 was noncompliant with the diet and fluid restriction that were ordered. The DoN indicated Resident</p>			

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	<p>#45's family would bring in food and fluids from home.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 8/15/13 at 1:15 p.m., the MDS Coordinator indicated the resident's care plan had not been updated to show the order from 7/25/13. The MDS Coordinator indicated she has been doing the nutritional care plans for residents as well as all the nursing care plans.</p> <p>The care plan had not been revised to indicate the change in the fluid restriction which was ordered on 7/25/13.</p> <p>3.1-35(d)(2)(B)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary fluid restriction for 1 of 1 resident receiving dialysis, who was on a fluid restriction. (Resident #45)</p> <p>Findings include:</p> <p>Resident #45 was observed on 8/13/13 at 2:05 p.m. sitting in her room. Resident #45 had an area on her right forearm which the resident indicated was a dialysis shunt. Resident #45 indicated she had dialysis on Tuesday, Thursday, and Saturday each week.</p> <p>Resident #45 was observed on 8/15/13 at 12:20 p.m., eating lunch. Resident #45's meal card indicated the resident had an 1800 ml (milliliter) fluid restriction.</p> <p>The clinical record of Resident #45 was reviewed on 8/15/13 at 9:14 a.m.</p>	F000309	<p>F309 It is the practice of Transcendent Healthcare of Owensville to assure the physicians' orders are followed related to fluid restrictions. The correction action taken for those residents found to be affected by the deficient practice include: Resident #45 is receiving fluids in accordance with the physician's orders. The care plan and the dietary card accurately reflect the current physician's orders. This resident remains non-compliant with this order and the non-compliance is also identified on the plan of care. The resident and family will continue to be educated related to possible negative outcomes related to their decision to be noncompliant. Other residents that have the potential to be affected have been identified by: There are currently no additional residents at the facility that has orders for any type of fluid restriction. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The MDS Coordinator, nursing staff, and</p>	09/16/2013			

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	<p>Resident #45 had a diagnosis including, but not limited to ESRD (End Stage Renal Disease).</p> <p>The clinical record indicated Resident #45 had a physician's order, dated 7/25/13, for a fluid restriction of 1500 ml in a 24 hr (hour) period.</p> <p>The "Consumption Record" for July, 2013, indicated Resident #45 had received greater than 1500 ml's of fluid on July 25 and July 27.</p> <p>The "Consumption Record" for August, 2013, indicated Resident #45 had received greater than 1500 ml's of fluid on August 1, 2, 3, 4, 5, 6, 8, 9, 16, 17, and 18.</p> <p>A care plan for fluid restriction, dated 1/5/13, indicated Resident #45 had a fluid restriction of 1800 ml/24 hrs. The care plan indicated Resident #45 was to receive 360 ml at meals, 120 ml at the bedside on the night shift, and 300 ml at the bedside on the day and evening shifts.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 8/15/13 at 1:15 p.m., the MDS Coordinator indicated the resident's care plan had not been updated to show the order from 7/25/13. The</p>		<p>dietary staff have been in-serviced related to fluid restrictions. It has been reiterated that if a nurse receives a physician's order for fluid restrictions that Director of Nursing, MDS Coordinator, and Dietary Manager are to be notified so that all necessary elements including care plan and dietary card are implemented/ revised to assure compliance. In addition, the interdisciplinary team, which includes DNS, MDS, and DM will review every physician's order each business day so that each appropriate department is aware of any changes in the physician's orders. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) that has orders for fluid restrictions. This tool will review the order, the plan of care, the MAR, the Dietary card, and the CNA assignment sheets to assure that all elements related to fluid restrictions are in place. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed if needed based on any negative outcome the tool</p>	

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	<p>MDS Coordinator indicated she has been doing the nutritional care plans for residents as well as all the nursing care plans.</p> <p>During an interview with the DoN (Director of Nursing) on 8/15/13 at 1:45 p.m., the DoN indicated Resident #45 was noncompliant with the diet and fluid restriction that were ordered. The DoN indicated Resident #45's family would bring in food and fluids from home.</p> <p>3.1-37(a)</p>		would identify. The date the systemic changes will be completed: September 16, 2013	

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure foods were served and stored under sanitary conditions for 1 of 1 kitchens reviewed. This had the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>1. During initial tour of the kitchen on 8/13/13 at 9:15 a.m., the walk-in freezer was observed to have a bag of frozen omelets, a bag of frozen biscuits, a bag of frozen pancakes, and a bag of frozen waffles that were opened but not sealed or dated. The walk-in refrigerator had a tray of jello with no date or covering on it. The bins containing brown sugar, powdered sugar, and potato flakes did not have dates on them.</p> <p>2. During an observation of the kitchen on 8/19/13 at 7:48 a.m., the Dietary Manager (DM) was observed</p>	F000371	F371 It is the practice of this facility to assure that foods are served and stored properly in accordance with facility policy. The correction action taken for those residents found to be affected by the deficient practice include: No specific residents were identified. The food items identified in the walk-in-freezer that were identified as opened and not sealed have been discarded. All dietary staff or any staff that enters the kitchen is wearing hairnets within acceptable infection control parameters. The coffee supplies are no longer stored by the hand-washing sink or paper towel dispenser as the main coffee machine is operational. The paper towel dispensers in the dietary are no longer jammed and work properly. Other residents that have the potential to be affected have been identified by: Potentially all residents could be effected. Because of the corrections that have been implemented, food is sealed and dated properly, hairnets are worn properly, paper towel dispensers are working properly, and all	09/16/2013

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	<p>standing in the kitchen with no cap covering her hair and dietary employee #1 was observed serving breakfast with her hair bangs hanging out of the cap. Two (2) coffee filters with dried ground coffee and a coffee pot with coffee were observed to be sitting on a serving cart beside the handwashing sink and under the paper towel dispenser.</p> <p>3. During an observation on 8/19/13 at 11:35 a.m., the paper towel dispenser at the handwashing sink was observed to be broken. The DM indicated she was going to notify maintenance immediately. At that time, Dietary Employee #2 indicated the paper towel dispenser located by the dishwashing machine did not work properly either.</p> <p>During an interview with the Dietary Manager (DM) on 8/13/13 at 9:15 a.m., the DM indicated all foods should be sealed and dated after they are opened. The DM indicated the staff should be applying a piece of tape to the bins and dating the tape when foods are placed in them.</p> <p>During an interview with Dietary Employee #2 on 8/19/13 at 7:55 a.m., she indicated the main coffee pot had stopped working and they had to use</p>		<p>supplies/equipment is setting/stored in a manner that is within the acceptable parameters of sanitation. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The dietary staff has been in-serviced related to storage, sealing, and dating of opened foods. The in-service also included the proper use of hairnets, and setting/storage of equipment within acceptable sanitation standards. Also, included was the importance of dietary staff notifying maintenance if a piece of equipment such as the towel dispenser is not working properly so that it can be immediately corrected. This will be monitored by the new dietary manager. Please refer to monitoring systems to assure compliance with sanitation within the dietary department The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement tool has been established that randomly reviews for storage, sealing, and dating of food and equipment. The PI tool also observes for hairnets and observes for proper functioning of equipment within the dietary department. The Dietary Manager, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3.</p>		

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	<p>the smaller coffee pot for coffee.</p> <p>A policy, titled "Dietary Sanitation" and obtained from the Adm (Administrator) on 8/20/13 at 11:13 a.m., indicated foods were to be stored properly and dated when opened in accordance with regulatory guidelines.</p> <p>3.1-21(l)(2) 3.1-21(l)(3)</p>		<p>Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcomes of the tool. The date the systemic changes will be completed: September 16, 2013</p>		

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure accounting for controlled drugs was in</p>	F000431	F431 It is the practice of Transcendent Healthcare of Owensville to assure that narcotic count sheets are completed when narcotics are administered and	09/16/2013	

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	<p>order and failed to ensure insulin was disposed of after opened for 28 days, for 2 of 2 medication carts/rooms observed (West Unit and East Unit). This affected 6 of 20 residents' drugs reviewed on the West Unit and 1 of 27 residents reviewed on the East Unit. (Residents #43, #67, #44, #34, #35, #39, #22)</p> <p>Findings include:</p> <p>1. The West Unit medication cart and room were observed with LPN #2 at 2:15 p.m. on 8/19/13. The narcotic count was reviewed, comparing medications in the drawer with the documented count sheets. The following medications had not been signed out during her shift: Resident #43's Lorazepam (antianxiety medication) 0.5 mg (milligrams), ordered three times a day; the 8/19/13 12:00 p.m. dose was not signed out. There were 6 left and the count sheet indicated 7 should be left.</p> <p>Resident #43's Lortab (pain medication) 7.5 mg, ordered four times a day; the 12:00 p.m. dose was not documented. There were 7 left and the count sheet indicated there should have been 8.</p>		<p>insulin is disposed of properly within 28 days of being opened. The correction action taken for those residents found to be affected by the deficient practice include: Residents #43 narcotic sheet accurately reflects the current count for the Lorazepam and the Lortab. Resident #67 narcotic sheet accurately reflects the current count for Lorazepam Resident #44 narcotic sheet currently reflects the count for Clonazepam. Resident #34 narcotic sheet accurately reflects the current count for Oxycodone Resident #35 narcotic count sheet accurately reflects the current count for Clonapepam Resident #39 narcotic count sheet accurately reflects the count for Hydrocodone Resident #22 narcotic count for the Oxycodone is accurate. In addition, this resident's insulin was destroyed. Other residents that have the potential to be affected have been identified by: All residents' narcotic sheets have been reviewed to assure the sheet correlates with the number of pills. No issues have been identified. All residents that have insulin have been reviewed to assure that their insulin is dated and does not exceed 28 days. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for all nurses related to signing</p>				

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	<p>Resident #67's Lorazepam 0.5 mg, ordered twice a day; the 8:00 a.m. dose was not signed out. There were 48 in the drawer and the count sheet indicated there should have been 49.</p> <p>Resident #44's Clonazepam (antianxiety medication) 0.5 mg; ordered twice a day, had 4 left. The count sheet indicated there should be 5.</p> <p>Resident #34's Oxycodone-acetaminophen (pain medication) 10-325 mg; the 8:00 a.m. and 12:00 p.m. doses were not signed out. There were 93 in the drawer; the count sheet indicated there should be 95.</p> <p>Resident #35's Clonazepam 1 mg, there were 75 in the drawer; the count sheet indicated there should be 76.</p> <p>Resident #39's Hydrocodone-acetaminophen 7.5-500 mg; there were 98 in the drawer, the count sheet indicated there were supposed to be 99.</p> <p>During an interview with LPN #2 at 2:30 p.m. on 8/19/13, she indicated she had not signed out her narcotics for her shift.</p>		<p>narcotic count sheets when medication is administered, assuring that when narcotics arrive from pharmacy that all medications are present, and dating insulin when opening and assuring that it is disposed of in a manner that does not exceed 28 days after opening. Each nurse is responsible for assuring that narcotics are signed for on the narcotic sheet appropriately, dating the insulin when opened, and disposing of the insulin within 28 days of opened date. Please see below for means of monitoring. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents related to narcotic counts and utilizing insulin that does not exceed 28 days after opening. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 16, 2013</p>		

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	<p>2. The East Unit medication cart and room were observed on 8/19/13 at 2:45 p.m. with LPN #3.</p> <p>During the review of the narcotic counts for the East Unit, Resident #22 was observed to have Oxycodone hydrochloride 5 mg tablets. The count sheet indicated 30 tablets were delivered on 2/19/13. LPN #4 had signed indicating there were 30 tablets in the package. Observation of the bubble pack type package noted there were only 29 tablets in the package. The space for the number 2 pill was empty with the foil torn. The count sheet, regarding the number 2 pill had documentation, "omitted" with LPN #3's initials.</p> <p>LPN #3 was interviewed. She indicated when the package of 30 pills was delivered on 2/19/13, the nurse who signed must have not seen the number 2 tablet was missing. LPN #3 indicated she had counted the tablets at a later date and the number 2 pill was not in the package and the package was sealed at that time. She indicated over time the foil covering the number 2 slot had torn. She indicated she had just documented the number 2 pill was "omitted" and they only counted the 29 since then.</p>						

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	<p>The nurse receiving the order failed to have an accurate accounting of the delivered medication. There also was no signature of the person who delivered the medication to verify the number of pills delivered.</p> <p>During the review of the East Unit cart, an open bottle of Humalog insulin was observed, belonging to Resident #22. The date opened on the bottle was documented as 7/18/13. LPN #3 indicated it should have been discarded 28 days after opening.</p> <p>3. The policy and procedure for Controlled Substances, dated as revised April 2007, was provided by the Director of Nurses on 8/19/13 at 3:10 p.m. The policy and procedure included, but was not limited to, the following: "Controlled substances must be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, must count the controlled substances together. Both individuals must sign the designated narcotic record. Any empty blister packets must be identified on the accountability sheet as omitted and initialed."</p>						

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	<p>"When a nurse administers a narcotic, it should be identified on the MAR [medication administration record]. It should also be identified on the narcotic count sheet."</p> <p>"Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. Any discrepancies must be investigated."</p> <p>3.1-25(n) 3.1-25(o)</p>			

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F000458 SS=B	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 resident room of 33 resident rooms, measured at least 80 square feet per resident. The room could be used to house 3 residents and measured 15 feet 11 inches long by 13 feet 3 inches wide. This would result in 70.29 feet per resident. (Room #31)</p> <p>Finding includes:</p> <p>* Room #31 (certified for Title 18/19 SNF/NF) was observed on 8/13/13 at 9:05 a.m.</p> <p>The measurement of Room #31 was observed to measure 15 feet 11 inches long by 13 feet 3 inches wide. This resulted in 70.29 square feet per resident, for 3 residents in the room.</p> <p>During an interview with the Adm (Administrator) on 8/20/13 at 7:45 a.m., the Adm provided information regarding the room waiver and indicated the facility wanted to keep the ability to have 3 residents in the</p>	F000458	F458 It is the practice of Transcendent Healthcare of Owensville to assure that all residents' needs are met. The correction action taken for those residents found to be affected by the deficient practice include: Room 31 is identified. There are currently 2 residents that reside in this room. The room is licensed for 3 residents. The facility has submitted a waiver request related to the square footage requirements. Other residents that have the potential to be affected have been identified by: No additional rooms are affected. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The square footage requirements in no way affect the care that is provided to the residents in room #31. These residents receive the highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. The corrective action taken to monitor performance to assure compliance through quality assurance is: There is no specific monitoring. The residents that	09/16/2013			

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	room.  3.1-19(l)(2)		reside in room #31 are observed frequently throughout the day and receive care and services in accordance with the facility standard. The date the systemic changes will be completed:September 16, 2013	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure resident rooms were clean, orderly, and in good condition and bedside equipment in good condition for 9 of 25 rooms observed during stage 1 resident reviews, in that tables were soiled or worn, walls and curtains were soiled, and floors were soiled/stained. (Rooms 26, 32, 28, 14, 23, 21, 22, 10, 4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Room 26 was observed on 8/14/13 at 10:58 a.m. The overbed table was soiled with dried food and debris. The room was observed again on 8/19/13 at 3:30 p.m. and the table was still soiled.</li> <li>2. Room 32 was observed on 8/14/13 at 9:10 a.m. The cove base was loose in the bathroom. The room was observed again on 8/19/13 at 3:30 p.m. and remained the same.</li> <li>3. Room 28 was observed on 8/14/13 at 9:23 a.m. Bed B's overbed table had very rough edges with vinyl</li> </ol>	F000465	<p>F465 It is the practice of Transcendent Healthcare of Owensville to assure that a safe, functional, sanitary, and comfortable environment for residents, staff, and the public is provided. The correction action taken for those residents found to be affected by the deficient practice include: No specific residents were identified. Room #26 over-bed table has been cleaned. Room #32 cove base in bathroom has been repaired. Room #28 over-bed table has been replaced and the cove base in the bathroom cleaned. Room #14 bathroom floor has been cleaned. Room #23 bathroom wall and floor has been cleaned. Room #21 privacy curtain has been laundered. Room #22 toilet has been repaired and the pull cord has been cleaned. The rooms #10 and #31 affecting residents #54 and #31 have been rearranged so that the doors can be closed. Other residents that have the potential to be affected have been identified by: All residents' rooms/bathrooms have been reviewed to assure clean. The review includes over-bed table, privacy curtains, bathroom walls/floors, and call light cords. All toilets have been reviewed to</p>	09/16/2013

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	<p>missing on all sides. The cove base in the bathroom was soiled. The room was observed again on 8/19/13 at 3:30 p.m. and the overbed table and cove base were the same.</p> <p>4. Room 14 was observed on 8/14/13 at 10:00 a.m. The bathroom floor was soiled and stained gray, especially around the toilet. The room was observed again on 8/19/13 at 3:30 p.m. The bathroom floor was the same.</p> <p>5. Room 23 was observed on 8/14/13 at 9:18 a.m. The bathroom wall had a 4 inch brown stain/dried on substance to the right of the toilet. The room was observed again on 8/19/13 at 3:30 p.m. and the stain was still there. Also noted was removable brown dried substance on the floor to the right of the toilet.</p> <p>6. Room 21 was observed on 8/13/13 at 11:41 a.m. The privacy curtain between the beds was soiled with a brown substance on the edge at the height it would be pulled. The room was observed again on 8/19/13 at 3:30 p.m. The privacy curtain continued to be soiled.</p> <p>7. Room 22 was observed on 8/13/13 at 2:25 p.m. The toilet water</p>		<p>assure they are in proper repair. All residents' beds have been checked to assure the door can be closed properly. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for maintenance, nursing staff and housekeeping staff related to cleanliness of resident rooms and bathrooms. Housekeeping is to clean each resident room and bathroom every day for cleanliness. Nursing has the responsibility to notify housekeeping/maintenance if an issue is identified that needs to be immediately resolved. Maintenance is responsible for routinely checking to assure that resident doors can close appropriately. Administration will be making rounds through the facility daily to assure that rooms/bathrooms are clean and equipment operating properly and resident doors can close appropriately The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents rooms/bathrooms related to cleanliness, proper functioning of equipment, and proper closing of doors. The Administration, or designee, will complete these tools weekly x3,</p>		

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	<p>would run for several seconds, then shut off for several seconds, then run again. The pull cord for the call light in the bathroom was soiled brown in color at the distal end, two feet long. The room was again observed on 8/19/13 at 3:30 p.m. The toilet continued to run for several seconds, shut off, and run again. The pull cord continued to be soiled.</p> <p>8. The DoN and Administrator indicated during interview on 8/20/13 at 10:30 a.m., the observations were fair and they would have the issues corrected on that date.</p> <p>9. Room 10 was observed on 8/13/13 at 10:58 a.m. The room door was unable to be closed completely without moving the resident's bed. The room was observed again on 8/15/13 at 9:05 a.m. The foot of Resident 54's bed was too long for the room door to be closed completely.</p> <p>10. Room 4 was observed on 8/14/13 at 8:46 a.m. The room door was unable to be closed completely. The room was observed again on 7/19/13 at 1:15 p.m. The foot of Resident #31's bed was too long for the room door to be closed completely.</p>		<p>monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 16, 2013</p>				

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	<p>During an interview with the Adm (Administrator) on 8/19/13 at 4:00 p.m., the Adm indicated she did not know the beds were too long and the doors could not be shut without moving the beds. The Adm indicated she would have the issues corrected on that date.</p> <p>3.1-19(f)</p>			