

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 14, 15, 16, 20, and 21, 2014</p> <p>Facility number: 000328 Provider number: 155502 AIM number: 100287960</p> <p>Survey team: Anna Villain, RN-TC Barbara Fowler, RN Denise Schwandner, RN Diana Perry, RN Diane Hancock, RN October 14, 15, 21, 2012</p> <p>Census Bed Type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 8 Medicaid: 34 Other: 10 Total: 52</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		

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.

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000242 SS=D	<p>Quality review completed on October 24, 2014 by Jodi Meyer, RN</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide showers based on the residents preference for 1 of 30 residents reviewed during Stage 1. (Resident #64)</p> <p>Finding includes:</p> <p>On 10/15/14 at 9:27 a.m., Resident #64 was observed lying in bed. Resident #64 indicated she was unable to choose how many times a week she received a shower.</p> <p>On 10/20/14 at 10:19 a.m., Resident #64 was observed receiving a bed bath.</p> <p>On 10/16/14 at 8:37 a.m., Resident #64's</p>	F000242	<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 November 14, 2014 to the state findings of the Recertification and State licensure survey conducted on October 14, 15, 16, 20 and 21, 2014.</p> <p>F - 242</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 64 has been</p>	11/14/2014

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 10/21/2014
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>clinical record was reviewed.</p> <p>The Care plans included, but were not limited to, requires assistance to complete bathing, dressing and grooming tasks. The interventions included, but were not limited to, provide showers two times weekly.</p> <p>The CNA Treatment Record, indicated Resident #64 received no showers from 9/23/14 through 9/30/14. The CNA Treatment record indicated Resident #64 received no showers 10/1/14 through 10/15/14. The Treatment Record indicated Resident #64 had refused a shower one time.</p> <p>On 10/21/14 at 2:10 p.m., the DON (Director of Nursing) indicated the resident had not received showers because the resident and her family member preferred bed baths.</p> <p>On 10/21/14 at 3:10 p.m., the Administrator provided the "Activities of Daily Living" policy, no date. The policy included, but was not limited to, upon admission the resident is interviewed related to their personal preferences as it relates to daily care and the resident will be offered a minimum of two showers and/or bed baths weekly.</p>		<p>re-interviewed related to her personal preference related to bathing. The ADL record has been up-dated along with the CNA assignment sheet to reflect the resident's choice of bed baths versus showers. The resident is now receiving bed baths in accordance with her personal preference and her care plan has been up-dated to reflect her choice. The resident is now receiving her baths in accordance with her personal preference.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been completed to reflect each resident's personal preference related to bathing/showers. The residents were also advised that they could change their preference at any time. The ADL records have all been up-dated to reflect each resident's current personal preference related to bathing /showers along with the CNA assignment sheets. The residents' care plans have all been reviewed and up-dated related to their personal preferences related to bathing/showers. Each resident is now receiving their baths/showers in accordance with their personal preferences.</i></p>		

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 10/21/2014
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-3(u)(3)		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 reviewed their practice as it relates to honoring the residents' personal preferences related to bathing/showers. Each resident will be offered a bed bath/shower at least twice a week or more often if requested. Upon admission a personal preference form is being completed to determine the residents' choice at it relates to bathing/showers. The facility will honor the residents' choice and up-date their ADL record and the CNA assignment sheet to reflect those choices. The residents' care plans will also be up-dated to reflect the residents' personal choices related to bathing/showers. The residents have and will continue to be advised on admission that they can change their personal preference at any time during their stay at the facility. A mandatory in-service was conducted for all nursing staff on the importance of honoring the residents' choices as it relates to bathing/showers. The staff was also instructed that at any time a resident chooses to change their personal		

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000246 SS=D	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		<p>preference that they are to report this information to nursing administration immediately so that the necessary changes can be made to accommodate the resident. The staff have also been re-educated on their responsibility in documenting each bed bath and/or shower on the ADL record as well as any refusals of care.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that each resident is receiving their bath/showers in accordance with their personal preferences. The tool will also monitor the documentation of the bed baths and/or showers along with documenting any refusals. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and the quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>would be endangered.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 30 stage 1 residents had the ability to request assistance, in that, call lights were out of reach. (Resident #13, Resident #68)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #13 was observed on 10/14/14 at 11:42 a.m. to be sitting in her wheelchair in her room. The call light was positioned under the bed between the wall and the resident's bed. Resident #13 was unable to reach the call light. Resident #13 indicated she did not know where the call light was located. 2. Resident #68 was observed on 10/15/14 at 9:15 a.m. sitting in a recliner. The call light was lying on the resident's bed out of the reach of the resident. 3. Call lights being out of reach was reviewed with the Director of Nursing and the Assistant Director of Nursing on 10/21/14 at 9:27 a.m.; both indicated call lights should be in reach of the residents. 4. During an interview on 10/21/14 at 2:17 p.m., the Maintenance Supervisor indicated he had applied a clip to the call light for Resident #13. 	F000246	<p>F - 246 The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as resident # 13 and # 68 have their call lights within reach at all times. There residents are alert and oriented residents who are independently ambulatory. The residents were advised of the importance of keeping their call light with them as they move from one location to another in their rooms. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was completed and each resident had their call light within their reach. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all staff on the importance of checking the location of the residents call lights with each resident contact. It was also stressed that even if the resident is alert and independent it is still each employee's responsibility to ensure that the residents call lights are always within their reach. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality</i></p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000309 SS=D	<p>5. A policy titled, "Resident Call Systems" and obtained from the Administrator on 10/21/14 at 3:10 p.m., indicated resident call lights are to be in reach of residents at all times while residing in their rooms.</p> <p>3.1-3(v)(1)</p> <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, record review, and interview, the facility failed to ensure an assessment was provided in 1 of 4 residents reviewed for hospitalization in a total sample of 13 who met the criteria and 1 of 1 resident reviewed for dialysis, in that, the facility failed to assess a resident's vital signs during a significant change and a thrill and bruit were not assessed for a dialysis resident. (Resident</p>	F000309	<p>Assurance tool has been developed and implemented to ensure that each resident has their call light within reach at all times. This tool will be completed by Social Services and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The tool will also be completed on each shift according to the above identified schedule. The outcome of this tool will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.</p> <p>F - 309</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 64 now has an assessment documented daily related to thrill and bruits.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as #65 is no longer a resident at the facility. The lack of</p>	11/14/2014

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 10/21/2014
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#65, Resident #64)</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident #65 was reviewed on 10/16/14 at 8:17 a.m. Resident #65 had diagnoses including, but not limited to, CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), morbid obesity, peripheral edema, pernicious anemia, hypertension, and diabetes. Resident #65's admission MDS (Minimum Data Set) assessment, dated 7/22/14, indicated Resident #65 had a score of 15 which indicated no cognitive impairment.</p> <p>Resident #65 had a physician' order, dated 7/16/14, for O2 (oxygen) at 3 liter per minute via nasal cannula.</p> <p>A "Skilled Nurse's Note", dated 8/3/14 at 7:00 a.m., indicated the resident had requested the bedpan several times with no results.</p> <p>A "Skilled Nurse's Note", dated 8/3/14 at 2 p.m., indicated Resident #65 had remained in bed all day and had nausea and vomiting in the a.m. The note indicated Resident #65's physician had been contacted and the facility was "still waiting response."</p>		<p>documenting the assessment onthis resident's clinical record was discussed with the nurse responsible andcounseling was given to that nurse with re-education on proper documentation in assessing a resident's condition including the documentation of vital signs.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the same deficientpractice is that all residents on dialysis were reviewed and now have documented assessment related to thrills and bruits daily on their clinicalrecords. A housewide audit was conductedon all residents and no other resident lacked documentation of the nurses'assessment of the residents' condition when a medical decline occurred.</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 was provided for all licensednurses on documentation of dialysis residents to ensure that the thrills andbruits are assessed each day and the results of that assessment documented onthe medication record. In addition theirn-service included proper documentation of assessments of residents who have adecline in their medical condition which is to include documentation of theresident's vital signs.</p> <p><i>The corrective actiontaken to</i></p>		

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A "Skilled Nurse's Note", dated 8/3/14 at 10:00 p.m., indicated Resident #65 had 2 loose mucous stools but no nausea. The note indicated Resident #65 had slept most of the shift. The note further indicated Resident 65's O2 (oxygen) saturation (a measurement of the amount of oxygen in the blood) was 78%. The note indicated Resident #65 indicated she was not having any respiratory distress.</p> <p>A "Skilled Nurse's Note", dated 8/4/14 from 11-7 indicated Resident #65 had a T (temperature) of 97.8, P (pulse) 70, R (respirations) 18, and B/P (blood pressure) 116/72. The note indicated Resident #65 had an O2 saturation of 96% on 3 liters of oxygen.</p> <p>The "Skilled Nurse's Notes", dated 8/4/14 at 7:00 a.m., indicated Resident #65 had been "feeling bad since Sunday (8/3/14) a.m." The note indicated the resident had several loose stools, had become nauseated, and had vomited early Sunday (8/3/14). The note indicated the physician had been contacted and the facility had received an order for Phenergan (a medication used for nausea and/or vomiting) 25 mg (milligram) orally every 4 hours as needed for nausea or vomiting.</p>		<p><i>monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to audit the documentation of assessments of thrills and bruits as well as the documentation of the assessments documented including vital signs for any decline in a residents' medical condition. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the audit tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A nurse's notes, dated 8/4/14 at 9:30 a.m., indicated Resident #65 had diarrhea x (times) 3 and had been given Imodium (an antidiarrheal medication) with her 8:00 a.m. medications. The note further indicated the resident had vomited undigested food and the Phenergan tablet which had been given to the resident. The note indicated the physician had been sent a fax for a request of the Phenergan to be given I.M. (intramuscularly) and to update the physician.</p> <p>A nurse's note, dated 8/4/14 at 10:00 a.m., indicated Resident #65's nails were blue and her lips were cyanotic. Resident #65's O2 saturation was 67%. The resident's vital signs were: B/P 106/62, T 96.9, P 60, R 16. The note further indicated the resident was confused.</p> <p>A nurse's note, dated 8/4/14 at 10:05 a.m., indicated the physician was called but had not returned the call.</p> <p>A nurse's note, dated 8/4/14 at 10:30 a.m., indicated Resident #65's husband requested Resident #65 be transferred to the emergency room and an ambulance was notified.</p> <p>A nurse's note, dated 8/4/14 at 10:45 , indicated Resident #65 was transferred to</p>			

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the hospital.</p> <p>The "Resident Transfer Form", dated 8/4/14 indicated Resident #65 was transferred to the hospital due to cyanosis of the hands, feet, and lips, an O2 saturation of 67% on 4 liters of oxygen , and the time of transfer was "12 noon."</p> <p>The clinical record lacked any documentation of any assessment for Resident #65 for 12 (twelve) hours. Follow up to the low oxygen level of 78% was lacking.</p> <p>During an interview on 10/16/14 at 10:02 a.m., the ADON (Assistant Director of Nursing) indicated Resident #65's vital signs should have been obtained and the physician should have been notified when the O2 saturation was 78%. The ADON further indicated Resident's 65's vital signs should have been obtained throughout the night and day shift prior to 10:00 a.m. The ADON indicated the "Resident Transfer Form" was probably incorrect.</p> <p>A policy titled, "Documentation" and obtained from the Administrator on 10/21/14 at 3:10 p.m., indicated the staff should be thorough in their assessment of the resident's condition. The policy indicated if there is an occasion when</p>			

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>there is a change in a resident's condition, the physician was notified and the staff is not receiving an appropriate response, the DON (Director of Nursing) is to be notified. The policy further indicated the Medical Director may be notified if necessary.</p> <p>2. On 10/20/14 at 10:19 a.m., Resident #64 was observed receiving a bed bath.</p> <p>On 10/16/14 at 8:37 a.m., Resident #64's clinical record was reviewed. Resident #64's diagnoses included, but were not limited to, Acute Renal Failure.</p> <p>The Care Plans included, but were not limited to, is receiving dialysis services....interventions included, but were not limited to, assess access site for bruit and thrill and report any changes.</p> <p>The Daily Skilled Nurses Notes, indicated, on 9/27/14 through 9/29/14, 10/2/14, 10/6/14, 10/7/14, 10/8/14, 10/11/14, 10/12/14 there was no documentation that the thrill and bruit was assessed.</p> <p>The TAR (Treatment Administration Record) lacked documentation regarding the assessment of a thrill and bruit.</p> <p>On 10/21/14 at 11:07 a.m., the DON (Director of Nursing, provided a policy</p>			

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000323 SS=D	<p>regarding the assessment of a thrill and bruit, no date. The policy indicated the presence of a thrill and bruit should be monitored daily.</p> <p>On 10/16/14 at 10:53 a.m., the DON indicated the nurses should chart the assessment of the thrill and bruit on the Daily Skilled Nurses Notes.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were kept out of resident areas for 3 of 30 residents observed during stage 1 sample review. (Resident #19, Resident #57, Resident #17)</p> <p>Findings include:</p> <p>1. Resident #19's room was observed on 10/14/14 at 11:05 a.m. There were 2 (two) containers of "Mary's Butt cream" (a medicated barrier cream used for the buttocks) in the bathroom in a medicine</p>	F000323	<p>F – 323</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the two containers of Mary's Magic butt cream have been removed from the resident identified as resident # 19's room and are stored in the treatment cart.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the two containers of Mary's Magic butt cream have been removed from the resident identified as resident # 57's room. Resident identified as #57 is</p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cabinet.</p> <p>2. Resident #57's room was observed on 10/14/14 at 2:36 p.m. There were 2 (two) containers of "Mary's Butt cream" (a medicated barrier cream used for the buttocks) in the bathroom in a medicine cabinet.</p> <p>3. Resident # 17's room was observed on 10/14/14 at 3:19 p.m. There was a container of "Lantaseptic" Skin Protectant on the back of the commode with another resident's name on it.</p> <p>4. During an interview on 10/14/14 at 9:30 a.m., the DON (Director of Nursing) indicated medicated creams are not to be left in a resident's room.</p> <p>3.1-45(a)(1)</p>		<p>no longer a resident at the facility.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the container of Lantaseptic Skin Protectant was immediately removed from the resident identified as resident #17's room. The resident's treatments are now being stored in the treatment cart.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was conducted to ensure that no other treatments were stored at the resident's bedside unless they had a specific physician's order and were stored in a locked drawer.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all nursing staff on the safety of the residents as it relates to the proper storage of treatments/creams/ointments, etc.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that each resident's room does not contain any treatment supplies unless specifically ordered by the physician and stored</i></p>	

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 10/21/2014
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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</p>		<p>in a secured area. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the audit tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</p>		

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 the disposal of medications with shortened expiration dates for 4 of 4 residents on 2 of 2 medication carts.</p> <p>Findings include:</p> <p>1. On 10/20/14 at 10:08 a.m., the medication cart was checked on the East hall and was observed to have three Advair Diskus Inhalers opened, in plastic bags. One Diskus for Resident # 28, had an open date of 9/11/14, but no expiration. Two other Advair Diskus for residents # 2 and #17 were opened, with no open or expiration date on them, and the foil pouch was missing.</p> <p>On 10/20/14 at 10:10 a.m., LPN #1 indicated the Advair Diskus was good for 90 days after opening. LPN #1 presented a policy which was used by the facility indicating the Advair Diskus was good for 90 days.</p> <p>On 10/20/2014 at 12:02 p.m., the DON (Director of Nursing) indicated the facility policy was to discard the Advair</p>	F000431	<p>F – 431</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the Advair diskus for the resident's identified as resident # 28, #2, #32 and #17 have been destroyed. New Advair diskus have been obtained for each of these residents. The inhalers were dated when opened and also include an expiration date. The inhalers are being stored in their foil pouches.</i></p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of each med cart was completed to ensure that all inhalers and other appropriate medications were dated when opened. All inhalers include an expiration date and are stored in accordance with their manufacturer guidelines.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility's practice of following the manufacturer guidelines related to</p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000441 SS=D	<p>Diskus after 90 days. The DON also indicated a call to the Pharmacy indicated the Advair Diskus were good until the expiration date.</p> <p>2. On 10/21/2014 9:24 a.m., the medication cart on West hall was observed and Advair Diskus for resident #32, had no open date.</p> <p>On 10/21/2014 8:56 a.m., review of the Nursing 2014 Drug Handbook indicated the patient should discard the device 1 month after removal from the moisture-protective overwrap pouch.</p> <p>On 10/21/14 the Manufacturers Instructions for the Advair Diskus, indicated the Diskus should be discarded 30 days after taken out of the foil pouch.</p> <p>On 10/21/14 at 11:00 a.m., interview with DON about the manufacturer's recommended disposal date. DON indicated the policies would be changed.</p> <p>3.1- 25(0)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease</p>		<p>medication storage. The nurses were instructed on the practice of dating medications/inhalerswhen opened. The nurses were alsoinstructed on placing the expiration dates on the inhalers and storing theinhalers in accordance with the manufacturer guidelines.</p> <p><i>The corrective actiontaken to monitor to assure performance to assure compliance through qualityassurance is a Quality Assurance tool has been developed and implemented tomonitor the storage of medications. The tool will include the proper storage of each medication in accordance with themanufacturer guidelines, including date of opening the medication and theexpiration dates being recorded. This tool will be completed by the Director of Nursing and/or her designee weeklyfor four weeks, then monthly for three months and then quarterly for threequarters. The outcome of the audit toolwill be reviewed at the facility Quality Assurance meetings to determine if anyadditional action is warranted.</i></p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to maintain infection control procedures, for 2 of 3 residents observed during care, in that, gloves were not changed between dirty and clean tasks, hand hygiene was not completed, and catheter care was not completed. (Resident #64, Resident #65)</p>	F000441	<p>F - 441</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #64 is now receiving personal care and treatments in accordance with acceptable standards of infection control practices. The resident</p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>1. On 10/20/14 at 10:19 a.m., CNA #1 was observed to provide a bed bath for Resident #64. CNA #1 was observed to cleanse the resident's buttocks. CNA #1 then assisted the resident to turn from side to side to remove the soiled bed linens. LPN #2 entered the room to provide a treatment to the residents abdominal wound. CNA#1 was then observed to remove the right hand glove and replace it with a new one. LPN #2 applied gloves. LPN #2 and CNA #1 were observed to remove the soiled linens. LPN #2 removed the gloves and applied new gloves. LPN #2 applied a triple antibiotic ointment to an open area on the residents abdominal wound. LPN #2 removed her gloves and completed hand hygiene using hand sanitizer. LPN #2 applied a new pair of gloves and applied a pad to the residents abdominal fold. LPN #2 hand washed for six seconds. CNA#1 removed her gloves and assisted the resident dressing. CNA #1 hand washed for nine seconds.</p> <p>On 10/21/14 at 3:10 p.m., the Administrator provided the "Handwashing/Hand Hygiene" policy, dated 2009. The policy included, but was not limited to, employees must wash their</p>		<p>identified as#65 is no longer a resident at the facility.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. Each resident is now receiving personal care in accordance with acceptable infection control standards of practice. In addition a house wide audit was conducted related to Foley catheter care. Each resident is now receiving Foley catheter care in accordance with acceptable standards of infection control practices.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all certified nursing assistants on the facility policies on hand washing, glove usage and catheter care. Each certified nursing assistant has successfully demonstrated knowledge of acceptable standards of practice in hand washing, glove usage and catheter care by the completion of a skills test.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor</i></p>	

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 10/21/2014	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>hands for at least twenty seconds and after handling soiled or used linens, dressings, bed pans, catheters and urinals.</p> <p>2. Resident # 65's closed record was reviewed on 10/16/14 at 8:17 a.m. The closed record indicated Resident #65 had a Foley catheter inserted on 7/16/14 for urinary retention.</p> <p>The chart lacked any documentation regarding catheter care being completed.</p> <p>3. During an interview on 10/21/14 at 8:15 a.m., the Assistant Director of Nursing indicated catheter care should be provided whenever the resident has an indwelling catheter.</p> <p>4. During an interview on 10/21/14 at 9:35 a.m., the DON (Director of Nursing) indicated the facility policy is to have the staff wash their hands if visibly contaminated and change their gloves between clean and dirty tasks.</p> <p>A policy titled, "Catheter Daily Care and obtained from the DON on 10/21/14 at 10:00 a.m., indicated catheter care was to be provided every shift and as often as needed thereafter.</p> <p>3.1-18(b) 3.1-18(l)</p>		<p>compliance in the acceptable standards of infection control practices related to hand washing, glove usage and catheter care. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the audit tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</p>				

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. Based on observation, interview, and record review, the facility failed to ensure 1 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 square feet per resident. (Room #31)</p> <p>Findings include:</p> <p>On 10/14/14 at 9:27 a.m., the Administrator provided a room size waiver from the state survey agency.</p> <p>On 10/20/14 at 10:00 a.m., the Administrator was interviewed. The Administrator indicated the facility wanted to keep the ability to have 3 residents in the room.</p> <p>*Room #31 (certified for Title 18/19 SNF/NF) was observed on 10/20/14 at 3:30 p.m. 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</p>	F000458	<p>November 7, 2014 Program Director-Provider Services Indiana State Department of Health Division of Long Term Care, Section 4B Indianapolis, IN</p> <p>RE: Request for Room Waiver To whom it may Concern: The following correspondence is being submitted in relation to a request for a square footage room waiver at Transcendent Healthcare of Owensville located at 7336 W. St. Rd. 165 Owensville, IN. Transcendent Healthcare of Owensville was cited on the annual SBH Survey for F458 related to square footage of a resident's room. A waiver request has been incorporated in the plan of correction for this survey. The room identified is room #31 (see attached floor plan). The room is dually licensed under the Medicare/Medicaid for three beds. The room measures 70.29 sq. ft/ resident. The health and safety of the residents that reside in that room has not been jeopardized and their</p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000465 SS=E	<p>resident, for 3 residents in the room.</p> <p>On 10/21/14 at 3:10 p.m., the Administrator provided the "Physical Environment Policy". The policy indicated Room #31 had a room waiver in effect.</p> <p>3.1-19(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT 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 provide a safe, functional, sanitary, and comfortable environment for 13 of 24 rooms observed, in that, doors were marred with paint chipped, walls were scuffed with paint chipped, caulking around commodes and bath tubs were cracked and stained, electrical power strips were near sinks and had multiple items plugged into them, bathroom tiles were cracked, bathroom floor grout was dirty, an electric razor was sitting in the corner</p>	F000465	<p>needs are being met as evidence by the following:</p> <p>The staff is easily able to facilitate the resident care needs in a safe and private environment.</p> <p>Resident's personal items are available and easily reached as needed by the resident.</p> <p>Based on the above information, Transcendent Healthcare of Owensville, is requesting that a waiver be granted to continue to operate the facility as it is licensed bed capacity of 68 beds.</p> <p>Sincerely, Vanessa Johnson, HFA</p> <p>F – 465 The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room #1 has had the bathroom door frame repaired and is free of any scraped or marred areas. The bathroom heater has been repaired and no longer has any scraped areas on it. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 2 has had the surge protector removed from the sink area. The corrective action taken for those</p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on the sink, a commode extender had stool smeared on it, the corners and edges of the bathroom floor had ground in dirt, and cobwebs were observed behind a bedroom entrance door. (Rooms 1, 2, 5, 6, 8, 10, 11, 18, 20, 22, 23, 24, 33)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 10/14/14 at 11:36 a.m., Room 1 was observed to have the bathroom door frame scraped and marred and the bathroom heater scraped. The same was observed on 10/21/14 at 11:15 a.m. 2. During an observation on 10/14/14 at 11:02 a.m., Room 2 was observed to have a surge protector plugged into an outlet under the paper towel holder lying on a sink. The same was observed on 10/21/14 at 11:16 a.m. 3. During an observation on 10/15/14 at 9:39 a.m., Room 5 was observed to have unlabeled and uncovered toothbrushes in the bathroom. The same were observed on 10/21/14 at 11:17 a.m. 4. During an observation on 10/15/14 at 9:06 a.m., Room 6 was observed to have the doors chipped and marred. The same was observed on 10/21/14 at 11:18 a.m. 		<p>residents found to be affected by the deficient practice is that the room identified as room # 5 has had the two unlabeled and uncovered toothbrushes removed. Each resident has been provided with a new labeled and appropriately covered toothbrush.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 6 has had the doors repaired and are now free of any chipped and/or marred areas. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 8 has had the doors repaired and are now free of any marred paint chipped areas. The commode extender has been sanitized and is free of dried stool. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 10 has had the grab bars in the bathroom replaced and are now secure. The walls in the bathroom which were scuffed have been repainted and are now free of scuffmarks. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 11 has had the multiple power strips removed. The corrective action taken for those residents found to be</p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>5. During an observation on 10/15/14 at 9:01 a.m., Room 8 was observed with the doors marred paint chipped off and a commode extender with dried stool on it. The doors were marred and paint was chipped off again on 10/21/14 at 11:20 a.m.</p> <p>6. During an observation on 10/14/14 at 2:39 a.m., Room 10 was observed to have the grab bars in the bathroom loose and the walls in the bathroom scuffed. The walls in the bathroom remained scuffed on 10/21/14 at 11:22 a.m.</p> <p>7. During an observation on 10/14/14 at 11:10 a.m., Room 11 was observed to have multiple electrical power strips in the room with multiple items plugged in.</p> <p>8. During an observation on 10/14/14 at 11:33 a.m., Room 18 was observed to have the bathroom door and frame scuffed, caulking around the commode was cracked and stained, a bottle of liquid hand soap was sitting on the sink with no name on it, a holder with a toothbrush, toothpaste, and a cup in it was on the sink with no name name on it. During an observation on 10/21/14 at 11:25 a.m., the bathroom door and frame remained scuffed, the caulking around the commode remained cracked and stained, and the bottle of liquid hand soap</p>		<p>affected by the deficient practice is that the room identified as room # 18 has had the bathroom door and frame repaired and is now free of scuff marks. The caulking around the commode has been replaced and is now free of cracks and/or stains. The bottle of liquid hand soap, a holder with a toothbrush, the toothpaste and cup has been removed from the room. A new bottle of liquid hand soap, a new toothbrush with holder and new tube of toothpaste along with a new cup have been obtained and properly labeled for the resident. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 20 has had the caulking around the tub replaced. The bag containing, body wash, briefs, petroleum jelly and periwash that was on the shelf over the tub has been discarded. The resident has been provided with personal care items which are appropriately labeled and properly stored. The commode that was identified as being dirty with stool has been cleaned and sanitized. The dirty Kleenex has been removed from the bathroom floor. The two toothbrushes and tube of toothpaste that were on the back of the sink have been removed. The resident has been provided with personal care items which are appropriately labeled and properly stored. The cracked</p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>remained on the back of the sink.</p> <p>9. During an observation on 10/14/14 at 11:05 a.m., Room 20 was observed to have cracked caulking around the base of the tub, a baggy with body wash, briefs, petroleum jelly, and periwash were on the shelf over the tub with no name on them, a wet washcloth was on the shelf over the tub, the commode was dirty with stool, dirty Kleenex was on the bedroom floor, 2 (two) toothbrushes, a tube of toothpaste were on the back of the sink with no names on them, cracked tile were on the bathroom floor, and a pink toothbrush, a container of powder, plastic cups, and a plastic spoon were in a medicine cabinet with no names on them. During an observation on 10/21/14 at 11:30 a.m., the caulking remained cracked around the base of the tub, cracked tile remained on the bathroom floor, and a container of powder, plastic cups, and a plastic spoon remained in the medicine cabinet with no name on them.</p> <p>10. During an observation on 10/14/14 at 3:19 p.m., Room 22 was observed to have the caulking around the commode stained, a white bar with 4 (four) holes in it across the back of the commode, the bathroom door and frame was scuffed, 4 (four) bedpans were on the tub shelf with no names on them, a bag of Poise pads</p>		<p>floor tile on the bathroom floor has been replaced. The pink toothbrush, container of powder, plastic cups and plastic spoon that were in the medicine cabinet has been removed. The resident has been provided with personal care items which are appropriately labeled and properly stored.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 22 has had the caulking replaced around the commode. The white bar with four holes in it across the back of the commode, the bathroom door and frame has been repaired and is free of any scuff marks. The four unidentified bedpans and bag of Poise pad that were on the tub shelf have been removed. The bedpan which was in a wash basin with deodorant, powder, barrier cream, lip balm, periwash and lotion which were on the tub shelf have been removed. The wash basin with the incontinence pads, periwash and a stuffed animal that were on the tub shelf has been removed. The pair of gripper socks that were on the floor has been removed. Each resident residing in Room # 22 has been provided with new personal care items that are appropriately labeled and properly stored. The grout along the bathroom floor has been replaced. The toilet has been repaired and no longer has the water continuously running.</p>	

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 10/21/2014
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	(pad used for incontinence) was on the tub shelf with no name on it, a bedpan was in a wash basin with no name on it, a wash basin with deodorant, powder, barrier cream, lip balm, periwash, and lotion was on the tub shelf with no names on them, a wash basin with incontinence pads, periwash and a stuffed animal was on the tub shelf with no name on them, a pair of blue gripper socks were on the floor with no names on them, the grout on the bathroom floor was dirty, the toilet was continuously running, the quarter-round across the bottom of the bathtub had dirt on it, the room heater had paint chipped, and wax build-up was on the floor by the bed. During an observation on 10/21/14 at 11:34 a.m., the caulking around the commode remained stained, the white bar remained on the back of the commode, the bathroom door and frame remained scuffed, the 4 wash basins remained on the tub shelf with no names on them, the Poise pads remained on the tub shelf with no name on them, the wash basin with deodorant, powder, barrier cream, lip balm, periwash, and lotion remained on the tub shelf with no name on them, the wash basin with the incontinence pad, wipes, stuffed animal, periwash remained on the tub shelf with no names on them, the quarter-round across the bottom of the bathtub remained dirty, the room		The quarter-round across the bottom of the bathtub has been cleaned. The room heater has been repainted and no longer has chipped paint on it. The floor has been completely stripped and re-waxed and is free of any wax build-up. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 23 has had the wall above the "A" bathroom painted and is free of any chipped areas. The electric razor has been removed from the sink and is now stored properly and is identified by the owner's name. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 24 has had the bathroom door repainted and is free of any paint chipped areas. The floor next to "B" bed has been thoroughly cleaned and is no longer sticky. The corrective action taken for those residents found to be affected by the deficient practice is that the room identified as room # 33 has had the commode extenders thoroughly cleaned and sanitized and is free of smeared stool. The floor has been stripped and re-waxed and is free of dirt. The cobwebs behind the bedroom door have been removed.		

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>heater had paint chipped, wax build-up remained on the floor next to the bed, and the bathroom floor grout remained dirty.</p> <p>11. During an observation on 10/15/14 at 9:12 a.m., Room 23 was observed to have chipped paint on the wall above the "A", the bathroom and bedroom doors had chipped paint, and an electric razor was in the corner of the sink with no name on it. The same was observed on 10/21/14 at 11:45 a.m.</p> <p>12. During an observation on 10/15/14 at 9:16 a.m., Room 24 was observed to have the bathroom door with chipped paint and the floor next to the "B" bed was sticky. During an observation on 10/21/14 at 11:48. the bathroom door remained with chipped paint.</p> <p>13. During and observation on 10/15/14 at 9:24 a.m., Room 33 was observed to have the commode extender with stool smeared on it, the corners and edges of the floor had dirt ground in them, and cobwebs were observed behind the bedroom door near the bottom of the door. During and observation on 10/21/14 at 11:50 a.m., the commode extender continued to have stool smeared on it and the corners and edges of the floor had dirt ground in them.</p>		<p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was completed of each resident's room to ensure all personal care items were properly labeled and stored. A house wide audit was also conducted related to each resident's room environment to ensure each room was in good condition. Any environmental concerns that were identified have been repaired.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the proper labeling and storage of resident's personal equipment. The preventative maintenance schedule has been revised to include the proper placement of power surge strips, door and door frame inspections for chipped or marred areas, inspections of heating units, secure condition of grab bars, cleanliness of commodes, inspection of grout around tubs, commodes and sinks, wall conditions for chipped paint or marred walls, and the cleanliness of floors including the build-up of wax. A mandatory in-service has been provided for the</p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000514 SS=D	<p>During an interview on 10/21/14 at 9:00 a.m., Housekeeping Supervisor #1 indicated the facility had a schedule for total room cleaning. Housekeeping Supervisor #1 indicated if there were any problems in the facility that required the maintenance department, the maintenance supervisor would be notified and the problem would be corrected.</p> <p>A policy titled, "Physical Environment Policy" and obtained from the Administrator on 10/21/14 at 3:10 p.m., indicated the facility was maintained to protect the health and safety of residents, personnel, and the public. The policy further indicated a safe, functional, sanitary, and comfortable environment would be provided for all residents, staff, and the public.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES SIBLE The facility must maintain clinical records on</p>		<p>maintenanceand housekeeping staff on the revised preventative maintenance schedule andtheir responsibility in maintaining a clean safe environment for each resident.</p> <p><i>The corrective actiontaken to monitor to assure performance to assure compliance through qualityassurance is a Quality Assurance tool has been developed and implemented toensure that each resident is provided a clean and safe environment. The tool will include the monitoring of theproper storage of resident's personal equipment as well as monitor thecondition of the resident's room and bathroom as it relates to condition ofwalls, floor tiles, doors, door frames,floors, bathrooms (clean commodes, cleancaulking around tubs, clean quarter-round ,commodes and sinks). The tool will also monitor the proper use ofpower surge protectors. This tool willbe completed by the Executive Director and/or her designee weekly for fourweeks, then monthly for three months and then quarterly for threequarters. The outcome of this tool willbe reviewed at the facility Quality Assurance meeting to determine if anyadditional action is warranted.</i></p>	

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview the facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for accidents in a total sample of 30, who met the criteria, in that, documentation was lacking for falls. (Resident #57, Resident #72)</p> <p>Findings include:</p> <p>1. During an observation on 10/14/14 at 2:35 p.m., Resident #57 was observed with a hematoma to her left forehead and a bruise on the left side of her face.</p> <p>During an interview on 10/14/14 at 3:54 p.m., LPN #2 indicated Resident #57 had had several falls.</p> <p>The clinical record for Resident #57 was reviewed on 10/16/14 at 3:55 p.m. Resident #57 had diagnoses including, but not limited to, dementia with</p>	F000514	<p>F - 514</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as resident # 57 and #72 have had their falls investigated to obtain additional information. An interdisciplinary note has been added to the clinical record to give a thorough account of the fall on 09-24-14 and the fall of 10-08-14 for resident #57. An interdisciplinary note has been added to the clinical record to give a thorough account of the fall 10-06-14 for resident # 72.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that each resident identified as a high fall risk has the potential to be affected by this deficient practice. The facility has reviewed its fall documentation protocol. A new fall documentation tool has been developed and implemented to ensure that all appropriate information is</i></p>	11/14/2014

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 10/21/2014
--	---	--	---

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
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>behavioral disturbances, psychosis, dysphagia, expressive aphasia, depression, anxiety, cerebrovascular disease, and cerebral vascular accident. A quarterly MDS (Minimum Data Set) assessment, dated 7/9/14, indicated Resident #57 had a BIMS (Brief Interview for Mental Status) assessment score of 15, indicating no cognitive impairment. The MDS indicated Resident #57 was an extensive assist of 1 person for transfers and a limited assist of 1 person for ambulation in the room. The MDS further indicated Resident #57 had one fall since her admission to the facility or since her last MDS assessment.</p> <p>A "72 Hr. Fall Follow Up" form, starting 9/26/14, 3-11 shift, was observed to be located in Resident #57's clinical record.</p> <p>The clinical record of Resident #57 lacked any documentation regarding a fall on 9/26/14.</p> <p>2. During the clinical record review for Resident #57 on 10/16/14 at 3:55 p.m., the clinical record indicated the resident had a "72 Hr. Fall Follow Up" form starting 10/8/14, night shift.</p> <p>The clinical record for Resident #57 lacked any documentation regarding a fall on 10/8/14.</p>		<p>documented in the clinical record at the time any fall occurs.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility's new fall documentation form. The nurses have been educated on their responsibility of the accurate completion of this documentation tool.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented related to the monitoring of the documentation of each resident's fall. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the audit tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p> <p>Facility will be in compliance: November 14, 2014</p>	

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 10/21/2014	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3. During an interview on 10/14/14 at 4:05 p.m., LPN #2 indicated Resident #72 had sustained a fall in the past 30 days.</p> <p>During an observation on 10/14/14 at 4:00p.m, Resident #72 was observed to be ambulating with assist of 1 person in the hall.</p> <p>The clinical record for Resident #72 was reviewed on 10/20/14 at 9:28 a.m. Resident #72 had diagnoses including, but not limited to Alzheimer's disease, insomnia, hypertension, osteoarthritis, depression, history of falls, and diabetes. An Admission MDS (Minimum Data Set) assessment, dated 10/7/14, indicated a score of 3, which indicated severe cognitive impairment.</p> <p>During the clinical record review for Resident #72, a "72 (seventy-two) Hr (hour) Fall Follow Up" form, dated 10/6/14, day shift, was located.</p> <p>The clinical record lacked any documentation regarding a fall on 10/6/14.</p> <p>4. During an interview on 10/21/14 at 10:15 a.m., the ADON (Assistant Director of Nursing) indicated she was</p>						

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 10/21/2014	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>unable to locate any documentation regarding Resident #57's falls on 9/26/14 or 10/8/14 or Resident #72's fall on 10/6/14.</p> <p>During an interview on 10/21/14 at 11:20 a.m., the ADON indicated all falls should be documented in the nurse's notes along with and assessment of the resident.</p> <p>A policy titled, "Documentation" and obtained from the Administrator on 10/21/14 at 3:10 p.m., indicated all nursing documentation is extremely important.</p> <p>3.1-50(a)(2)</p>						