STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 00 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE	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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates : November 18, 19, 23, & 24, 2015. Facility number: 000328 Provider number: 155502 AIM number: 100287960 Census bed type: SNF/NF: 57 Total: 57 Census payer type: Medicare: 7 Medicaid: 40 Other: 6 Total: 57 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on December 1, 2015.	F 0000		
F 0241 SS=D	483.15(a) DIGNITY AND RESPECT OF			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Bldg. 00	INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure dignity was provided to 2 of 3 residents observed eating in the East dining room and 1 of 30 residents reviewed during stage 1. Resident's were not served their food at the time of their tablemate's, and staff entered a resident's room without knocking and announcing themselves before entering. (Resident #7, Resident #62, Resident #51) Findings include: 1. During an observation on 11/18/15 at 12:05 p.m., Resident #7 and Resident #62 were observed to be sitting at the dining room table on the east side with Resident #10. Staff was observed to deliver Resident #10's tray to her at 12:05 p.m., and the resident began eating her lunch. The staff were observed to deliver trays to residents seated at the table next to them before delivering trays to Resident #7 and Resident #62. Resident #7 and Resident #62 received their trays at 12:11 p.m. and staff began feeding the residents at 12:13 p.m.	F 0241	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the right to contest the findingsor allegations as part of any proceedings and submit these responses pursuantto our regulatory obligations. Thefacility request the plan of correction be considered our allegation ofcompliance effective December 24, 2015 to the state findings of theRecertification and State Licensure Survey conducted on November 18, 19, 23 and24, 2015. F - 241 1). The corrective action taken for those residents foundto be affected by the deficient practice is that theresidents identified as resident # 7 and resident # 62 and now being servedeach meal at the same time as their tablemates. 2). The corrective action taken for those residents foundto be affected by the deficient practice is that nostaff member enters the room of theresident identified as resident # 51 without knocking and announcing who isentering the room. *The corrective actiontaken for the*	12/24/2015

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	2. During an observation on 11/18/15 at 10:25 a.m., Resident #51 was observed to be lying in bed with her room door closed. Helping Hands #1 was observed to open the resident's door, walked into the room and obtain the resident's water cup. The helping hands personnel did not knock nor announce themselves before entering the resident's room. On 11/18/15 at 10:38 a.m., CNA #1 was observed to knock on Resident #51's door. CNA #1 opened the door and entered the room without announcing who was entering. During an interview on 11/24/15 at 10:03 a.m., CNA #1 indicated before entering a room, the staff should knock and announce themselves to the resident. During an interview on 11/24/15 at 1:54 p.m., CNA #1 indicated when delivering trays to residents eating in the dining room, the entire table should be served before serving another table. A policy titled, "Routine Resident Checks," obtained from the Administrator on 11/24/15 at 2:05 p.m., indicated the person entering the resident's room should knock before entering the room and introduce themselves.		*other residents having the potential to be affected by the samedeficient practice is that* all residents have the potential to be affectedby this deficient practice. Allresidents in the dining rooms are being served their meal trays at the sametime as there tablemates before serving the next table. In addition no staff members enters anyresident's room without first knocking and announcing who they are beforeentering. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory all staff meeting has been provided onthe facility practices related to resident dignity. The in-service included instructions on thefacility practice of ensuring that each resident at the dining room tables areserved at the same time as theirtablemates before starting to serve the next table. The instructions also included a review ofthe facility practice of affording each resident their privacy by knocking ontheir room door and announcing who they are before entering the resident'sroom. *The corrective action willbe monitored to ensure the deficient practice will not recur through thequality assurance program by* the development and implementation of aQuality Assurance tool. This tool willmonitor to ensure that residents at the same dining room table are served atthe same time and that all	

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	3.1-3(t)		staff knocks on the doors of the residents' room andannouncement themselves before entering. This tool will be completed by the Social Service Director and/or herdesignee daily for one week, then weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's regularlyscheduled Quality Assurance meetings to determine if any additional action iswarranted.	
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide activities on the weekend to meet the residents needs for 3 of 6 residents reviewed in a total sample of 19 residents. (Resident #18, Resident #23, Resident #11) Findings include: 1. During an observation on 11/18/15 at 3:29 p.m., Resident #18 was observed to be sitting in her room with her television on. Resident #18 indicated the facility	F 0248	F – 248 1.)The corrective action taken for those residents foundto be affected by the deficient practice is that the resident identified as resident # 18 hasbeen interviewed by the Activity Director to up-date her activitypreference/interest list. The ActivityDirector has up-dated the activity calendar to include activities of interestfor the resident on the weekends and in the evenings. 2.)The corrective action taken for those residents foundto be affected by the deficient practice is that the resident identified as resident # 23	12/24/2015

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	did not have many activities on the weekends or in the evenings. Resident #18 indicated the facility would offer church services on Sunday but she had quit attending the services as another resident would yell loudly throughout the service. Upon query, Resident #18 indicated the other resident was very disruptive and the facility had indicated to the resident the other resident had the right to attend the church service also. Resident #18 indicated she usually just stayed in her room as the facility did not have many activities in which she was interested. The clinical record for Resident #18 was reviewed on 11/23/15 at 9:04 a.m. Resident #18 had diagnoses including, but not limited to, hypertension, depressive disorder, anemia, congestive heart failure, and atrial fibrillation. An admission MDS (Minimum Data Set) assessment, dated 4/16/15, indicated Resident #18 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated no cognitive impairment. The MDS indicated the following activities were important to Resident #18: having books, newspapers, and magazines to read, keeping up with the news, doing things with groups of people, and doing her favorite activities.		hasbeen interviewed by the Activity Director to up-date her activitypreference/interest list. The Activity Directorhas up-dated the activity calendar to include activities of interest for theresident on the weekends and in the evenings. 3.)The corrective action taken for those residents foundto be affected by the deficient practice is that theresident identified as resident # 11 has been interviewed by the ActivityDirector to up-date his activity preference/interest list. The Activity Director has up-dated theactivity calendar to include activities of interest for the resident on theweekends and in the evenings. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* all residents have the potential to be affectedby the deficient practice. The facilityhas reviewed its current activity program and calendar. Based on interviews ofthe residents additional activities have been added to the activity calendarwhich include evening and weekend activities. The Activity Director has modified her working schedule as well as hasenlisted volunteers to assist with the additional activity functions. The measures or systematic changes that have been put intoplace to ensure that the deficient practice	

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	An activity care plan, dated 9/3/15, indicated the following: invite and assist the resident to activities as needed, encouraged to socialize with peers provide room visits as necessary post an activity calendar in the resident's room praise the resident for participating ensure activities are appropriate for the resident's cognitive status encourage the resident to participate in activities of interest provide one-on-one activities as needed Beauty shop, Bingo, watching television in room A "Potential Activity Deficient" care plan, dated 8/18/15, indicated the following: television would be within easy view of resident reading materials would be offered to resident prn resident would be encouraged to participate in group activities of choice activity assessment as needed modify activities if activity needed change offer needed activity supplies as needed An activity progress note, dated 8/14/15 at 12:41 p.m., indicated Resident #18 was alert and overall oriented to their name		does not recur is that a mandatory in-service has been provide for all staffon the importance of providing activity programs that meet the needs of ourresidents and that all staff should encourage residents to attend activityfunctions as well as assist those residents to and from the activities. Additional education was also provided to theactivity director on the importance of having activities that are of interestto the residents and the scheduling of activities on the weekends and in theevenings. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool. This tool willmonitor resident attendance and satisfaction of the activity programs. It will monitor to ensure that activities areprovided in the evenings and on the weekends to meet the resident's needs. This tool will be completed by the ExecutiveDirector and/or their designee daily for one week, then weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the facility's regularly scheduledQuality Assurance meetings to determine if any additional action is warranted.	

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	and surroundings. The progress note indicated the resident liked preferred to have verbal cues to remind them of activities of possible interest. The note indicated the resident would attend many activities such as Bingo, special events, cooking class, and going to the beauty shop. The note further indicated the resident received family visit 2 (two) or 3 (three) times a month. The note further indicated the staff would encourage socialization and participation to enhance the resident's quality of life. During a review of the October, 2015, activity calendar, the calendar indicated the facility offered "Let's Warm Up" (an exercise activity) at 9:30 a.m. on Saturday mornings and 2 (two) church service on Sundays in October (one on the first Sunday at 9:00 a.m., and one on the fourth Sunday at 4:00 p.m.) The calendar indicated the facility offered "Let's Warm Up" every Sunday morning. The calendar also indicated a resident's birthday party was held on the third Sunday of the month. During a review of the November, 2015, calendar, the calendar indicated the facility offered "Let's Warm Up" and "Activity Cart" every Saturday morning and "Let's Warm Up" and church services every Sunday.			

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During a review of the October and November, 2015, calendars, the calendars indicated no activities were offered to the residents after 3:15 p.m. during the weekdays.

During a review of Resident #18's monthly activity attendance calendar, the October, 2015, calendar indicated the resident had attended 1 (one) activity daily at the facility but had not attended any activities on the weekends.

During a review of Resident #18's November, 2015, activity calendar, indicated the resident had had attended 1 (one) activity during the day but had not attended any activity offered on the weekends.

2. During an observation on 11/18/15 at 2:00 p.m., Resident #23 was observed to be sleeping in a chair in her room.

During an interview on 11/18/15 at 3:13 p.m., Resident #23 indicated the facility did not offer any activities in the evenings and did not offer many activities on the weekends.

The clinical record of Resident #23 was reviewed on 11/19/15 at 1:09 p.m. Resident #23 had diagnoses, including

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	but not limited to, acute and chronic respiratory failure, chronic airway obstruction, congestive heart failure, hypertension, osteoarthritis, cardiomegaly, and hypothyroidism. An admission MDS (Minimum Data Set) assessment, dated 6/18/15, indicated Resident #23 had a BIMS (Brief Interview for Mental Status) score of 8, which indicated moderate cognitive impairment. The MDS further indicated the following activity preferences were important to Resident #23: having books, magazines, newspaper to read, keeping up with the news, doing things with groups of people, doing their favorite activities, going outside to get fresh air when the weather is good, and to participate in religious services or practices. An activity care plan, dated 8/30/15, indicated the following: invite and assist to activities encourage to socialize with peers provide room visits as necessary praise for participation ensure activities are appropriate to cognitive status encourage participation in activities of interest provide one-on-one activities as needed Bingo, manicures, special events			

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	An activity evaluation, dated 11/12/15, indicated the resident's current interests included, but were not limited to, arts, crafts, and hobbies, reading or listening to books, watching television or listening to the radio, watching movies, and talking or conversing. An activity progress note, dated 10/19/15 at 11:24 a.m., indicated the resident was alert and oriented to her surroundings. The note indicated the resident needed assistance to and from activities. The note indicated the resident enjoyed watching television, movies, and playing Bingo. The note further indicated the resident was very social with other residents and with staff and enjoyed visits from several family members several days a week. The note also indicated the activity department would continue to encourage socialization as well as participation in activities to increase the residents quality of life. During a review of the October, 2015, activity calendar, the calendar indicated the facility offered "Let's Warm Up" (an exercise activity) at 9:30 a.m. on Saturday mornings and 2 (two) church service on Sundays in October (one on the first Sunday at 9:00 a.m., and one on the fourth Sunday at 4:00 p.m.) The calendar indicated the facility offered			

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	"Let's Warm Up" every Sunday morning. The calendar also indicated a resident's birthday party was held on the third Sunday of the month. During a review of the November, 2015, calendar, the calendar indicated the facility offered "Let's Warm Up" and "Activity Cart" every Saturday morning and "Let's Warm Up" and church services every Sunday. During a review of the October and November, 2015, calendars, the calendars indicated no activities were offered to the residents after 3:15 p.m. during the weekdays. During a review of Resident #23's October, 2015, activity attendance calendar, the calendar indicated the resident had attended activities on 17 out of 31 days. During a review of Resident #23's November, 2015, activity attendance calendar, the calendar indicated the resident had attended activities on 11 out of 18 days. The calendar indicated the resident had not attended any activities on the weekends. During an interview with the ADON (Assistant Director of Nursing) on			

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	11/23/15 at 3:25 p.m., the ADON indicated the restorative nursing assistant would do the exercise class on the weekend. The ADON indicated the class was called "Let's Warm Up." During an interview on 11/24/15 at 9:13 a.m., the Activity Director indicated the facility did not have activities scheduled in the evening or on the weekends. The Activity Director indicated the facility would occasionally have an activity in the evening but it was not listed on the activity calendar. A policy titled, "Activity Programs," obtained from the Administrator on 11/24/15 at 2:05 p.m., indicated individualized and group activities were to be provided on hours convenient to the residents, including evenings, holidays, and weekends. 3. On 11/18/15 at 3:10 p.m., during Stage 1 initial resident interview, Resident #11 indicated there were not many activities on evenings or weekends On 11/19/15 at 1:49 p.m., review of the clinical record by the activities director on 11/5/15 at 9:48 a.m., indicated the resident enjoyed therapy, socializing in dining room, and participating in activities of his choice, daily, such as, trivia.			

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	An activity evaluation completed on 10/6/15, indicated it was very important for the resident to read books, newspapers, and magazines, loved music, and kept up with news. On 11/19/15 at 2:14 p.m., trivia was being played. Resident #11 was not observed to be present. Resident # 11 was observed in his room in his wheelchair on 11/19/2015 at 2:00 p.m. On 11/23/15 at 10:01 a.m., the resident was in Occupational Therapy at the present time. In the afternoon he was in Physical Therapy. On 11/23/15 at 9:32 a.m., Resident #11 was not in his room or on the floor, possibly in therapy. Care Plan : Activities: dated 9/25/15 resident will participate in at least 2 group activities per week invite and assist to activities as needed encourage to socialize with peers provide room visits as necessary post activity calendar praise participation in activities such as TV, exercise, movie, and music sociable with roommate			

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	out to meals visits with family Minimum Data Set, dated 10/2/15, indicated it was very important to Resident #11 to listen to music, read newspapers and books, be outside, and very important to do things with other people. On 11/19/15 at 3:00 p.m., the activity calendar indicated on Saturday and Sunday they had " Pump Me Up" and church on Sunday. On 11/23/15 at 1:26 p.m., the activities calendar was received from the Activities Director which indicated : No activities listed after 3:15 p.m. On Saturdays at 9:30 was Let's Warm Up On Sunday was Lets Warm Up and Church On 11/23/15 at 1:42 p.m., an interview with the Activities Director indicated she did not come in on the weekends. She left her activities cart here with a list of things to do. The activities were completed by whomever had time on the weekends. No one was assigned to do activities. 3.1-33(c)			

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(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
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 0272	F – 272	12/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 00 B. WING	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

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	Based on observation, interview, and record review, the facility failed to ensure a comprehensive assessment was accurate for 1 of 29 residents reviewed as a resident's MDS (Minimum Data Set) assessment was incorrectly entered. (Resident #10) Findings include: During an observation on 11/18/15 at 10:00 a.m., Resident #10 was observed to be lying in bed, with her upper dentures partially out of her mouth. . During an interview on 11/18/15 at 10:25 a.m., Resident #10 indicated her teeth were loose and she had not seen a dentist in a long time. The resident indicated she had no natural teeth and had a full set of dentures. The clinical record of Resident #10 was reviewed on 11/19/15 at 1:52 p.m. Resident #10 had diagnoses including, but not limited to hypokalemia, diabetes, dementia with delusions, and diarrhea. Resident #10 had a physician's order, dated 8/20/15, for Lexapro (an antidepressant) 10 mg (milligrams) orally daily. An annual MDS, dated 9/18/15. indicated		The corrective action taken for those residents found tobe affected by the deficient practice is that theresident identified as resident # 10 has had a corrected comprehensiveassessment completed and submitted. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* all residents have the potential to be affectedby the deficient practice. A house wideaudit of all current comprehensive assessments has been completed to ensurethat all comprehensive assessments are accurate and have been correctly markedto reflect the resident's current condition. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for the MDScoordinator on the importance of ensuring that the information recorded on thecomprehensive assessment accurately reflects the resident's condition/status. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool. This tool willmonitor to ensure the accuracy of the information entered into thecomprehensive assessment	

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	155502	A. BUILDING 00 B. WING	11/24/2015

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	the resident had no issues with her teeth. The MDS further lacked documentation the resident received an antidepressant medication. A care plan for dental care related to no teeth was dated 11/13/15. The care plan indicated the following: assess the resident's ability to care for her dentures assist as needed for mouth care and hygiene refer to OT (Occupational Therapy) for adaptive equipment as needed monitor for loose, poorly fitting equipment as needed monitor mouth, tongue, and gums for odor, redness swelling. coating, sores, cracking, or fissures arrange for dental consult yearly and as needed During an interview with the MDS Coordinator on 11/23/15 at 11:08 a.m., the MDS Coordinator indicated the MDS had not been marked correctly. She indicated she thought if the resident had dentures, she would not need to enter the issue regarding a resident being edentulous. The MDS Coordinator indicated the antidepressant had not been marked and she would need to send a		matches the resident's current condition/status. This tool will be completed by the Directorof Nursing and/or her designee daily for one week, then weekly for four weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the facility's regularly scheduledQuality Assurance meetings to determine if any additional action is warranted.	

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	correction for the dental issue and the antidepressant medication. A policy titled, "MDS Assessment Completion", obtained from the Administrator on 11/24/15 at 2:05 p.m., indicated the MDS Coordinator would be responsible for completion of sections L (dental) and N (medications). 3.1-31(c)(9) 31.-31(c)(13)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the			

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	resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to ensure care plans were developed based on the comprehensive assessment. The facility lacked care plans for urinary incontinence and PICC (Peripherally Inserted Central Catheter). (Resident #54, Resident #56, Resident #73) Findings include: 1. On 11/23/15 at 9:26 a.m., Resident #54"s clinical record was reviewed. The physician's recapitulation orders, signed 11/5/15, indicated the resident had a PICC. The TAR (Treatment Administration Record) indicated nursing staff was changing the dressing to the PICC weekly. The Admission MDS (Minimum Data Set) Assessment, dated 11/17/15, indicated Resident #54 was receiving intravenous medications. The clinical record lacked a care plan regarding Resident #54's PICC.	F 0279	F – 279 1.) The corrective action taken for those residents foundto be affected by the deficient practice is that thecare plan for the resident identified as resident # 54 has been reviewed andrevised to include a care plan to address the resident's PICC line. 2.) The corrective action taken for those residents foundto be affected by the deficient practice is that thecare plan for the resident identified as resident # 56 has been reviewed andrevised to include a care plan to address the resident's frequent urinaryincontinence. 3.) The corrective action taken for those residents foundto be affected by the deficient practice is that thecare plan for the resident identified as resident # 73 has been reviewed andrevised to include a care plan to address the resident's urinary incontinenceproblem. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* all residents have the potential to be affectedby the deficient practice. A housewideaudit has been conducted of the residents' care plans. Each residents care plan has been reviewed andrevised as	12/24/2015

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	On 11/23/15 at 9:49 a.m., Resident #54 was observed with a PICC in place. On 11/23/15 at 10:07 a.m., the MDS Coordinator indicated the resident's care plan related to the PICC was: Altered Skin Integrity, related to operative site. 2. On 11/19/15 at 1:01 p.m., Resident #56's clinical record was reviewed. Resident #56's diagnoses included, but were not limited to, dementia. The Quarterly MDS (Minimum Data Set) Assessment, dated 9/14/15, indicated Resident #56 was frequently incontinent of urine. The clinical record lacked a care plan and interventions related to Resident #56's urinary incontinence. On 11/23/15 at 8:57 a.m., CNA #2 indicated Resident #56 was occasionally incontinent of urine. On 11/23/15 at 8:58 a.m., the MDS Coordinator was unable to locate a care plan related to Resident #56's urinary incontinence. 3. On 11/23/15 at 8:57 a.m., CNA #2 indicated Resident #73 was always incontinent.		warranted to ensure that all areas of concern have been care plannedto meet the current needs of each resident. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for theinterdisciplinary team on the facility policy related to the development andimplementation of resident care plans to ensure that all problems have beenidentified and interventions put in place in an effort to assist the residentin attaining or maintaining their highest practicable physical, mental andpsychosocial needs. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool. This tool willmonitor the content of the resident's care plan to ensure that allproblems/concerns have been identified and interventions implemented in aneffort to assist the resident in attaining or maintaining their highestpracticable physical, mental and psychosocial needs. This tool will becompleted by the Director of Nursing and/or her designee daily for one week, then weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility's regularly	

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	On 11/23/15 at 10:26 a.m., Resident #73 clinical record was reviewed. The Quarterly MDS (Minimum Data Set) Assessment, dated 10/12/15, indicated Resident #73 was occasionally incontinent. The clinical record lacked a care plan related to Resident #73's urinary incontinence. On 11/24/15 at 2:21 p.m., the Administrator provided the "Assessments and Plan of Care" policy, dated 3/4/15. The policy included, but was not limited to: It is the facility policy to complete the core nursing assessments upon admission, with any significant change in condition and at least quarterly. The facility will then proceed to develop the plan of care based on the information provided by the core nursing assessments along with the identified triggers on the MDS. 3.1-35(a)		scheduled Quality Assurance meetings to determine ifany additional action is warranted.	
F 0323 SS=E Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident			

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	hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and record review, the facility failed to provide an environment free from accident hazards. Water temperatures were measured greater than 120 degrees Fahrenheit for 7 of 24 rooms reviewed during Stage 1 of the survey. (Room #4, Room #5, Room #7, Room #18, Room #22, Room #23, Room #25) Findings include: 1. On 11/18/15 at 3:30 p.m., Room #4's water temperature was measured at 128 degrees Fahrenheit. 2. On 11/18/15 at 3:30 p.m., Room #5's water temperature was measured at 125 degrees Fahrenheit. 3. On 11/18/15 at 3:30 p.m., Room #7's water temperature was measured at 124 degrees Fahrenheit. 4. During an observation on 11/18/15 at 11:39 a.m., Room 18 was observed to have a water temperature of 129.7 degrees Fahrenheit (F). 5. During an observation on 11/18/15 at 9:55 a.m., Room 22 was observed to have a water temperature of 128 degrees Fahrenheit (F).	F 0323	F – 323 1.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room # 4 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 2.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room # 5 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 3.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room # 7 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 4.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room #18 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 5.) The corrective action taken for those residents foundto be affected by the	12/24/2015

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	6. During an observation on 11/18/15 at 3:24 p.m., Room 23 was observed to have a water temperature of 132.5 degrees Fahrenheit (F). 7. During an observation on 11/18/15 at 3:41 p.m., Room 25 was observed to have a water temperature of 130.5 degrees Fahrenheit (F). During an interview on 11/18/15 at 4:27 p.m., the Administrator (Adm) indicated water temperatures were checked weekly in 1 (one) to 2 (two) resident rooms on each hall and in a random bathroom. The Administrator indicated the last temperature check was completed on 11/7/15. A copy of the water temperatures for November was provided by Maintenance #1 and the temperatures was observed to be done weekly as indicated. During an interview on 11/19/15 at 8:15 a.m., the Adm indicated the facility had tankless water heaters. The Adm indicated the temperatures had been lowered on 11/18/15 and had been checked throughout the late evening, during the night and throughout the morning hours. The Adm indicated the temperatures had remained below 120 degrees F.		deficient practice is that thewater temperatures have been lowered. The room identified as room # 22 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 6.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room # 23 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. 7.) The corrective action taken for those residents foundto be affected by the deficient practice is that thewater temperatures have been lowered. The room identified as room # 25 is now consistently running a watertemperature of less than 120 degrees Fahrenheit. *orrective action takenfor the other residents having the potential to be affected by the samedeficient practice is that* a housewide audit of each resident's rooms,bathrooms and shower rooms has been conducted. The water temperatures have been adjusted and all water temperatures inresident areas are now consistently running less than 120 degrees Fahrenheit. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatoryin-service has been	

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	A policy titled, "Water Temperatures, Safety of," obtained from the Adm on 11/24/15 at 2:05 p.m., indicated tap water in the facility should be kept within a temperature range to prevent the scalding of residents. The policy further indicated the waters heaters that service the resident's rooms, bathrooms, common areas, and the tub/shower areas should be set to a temperature of no more than 120 degrees. 3.1-19(r)(1) 3.1-19(r)(2)		conducted for the staff in the maintenance and housekeepingdepartments on the facility policy related to water temperatures. The staff has been educated on the safewater temperatures for the residents and understands the importance on ensuringthat the proper water temperatures are maintained. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool to monitor the water temperatures in residentareas. This tool will measure the actualwater temperatures in resident rooms, bathrooms and shower rooms. The tool will also monitor to ensure that ifa temperature is identified above 120 degrees that appropriate action has beentaken to correct the issue immediately. This tool will be completed by the Executive Director and/or theirdesignee daily for one week, thenweekly for four weeks, then monthly for three months and then quarterly forthree quarters. The outcome of this toolwill be reviewed at the facility's regularly scheduled Quality Assurancemeetings to determine if any additional action is warranted.	
F 0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS			

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Bldg. 00	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, the facility failed to ensure proper care for a PICC (Peripherally Inserted Central Catheter) was completed. The dressing for the PICC was not changed according to physicians orders. (Resident #54) Findings include: On 11/23/15 at 9:26 a.m., Resident #54's clinical record was reviewed. The physician's recapitulation orders, signed on 11/5/15, included, but was not limited to: change PICC, sterile, on Thursdays. The TAR (Treatment Administration Record) indicated the dressing was to be changed on 11/12/15, 11/19/15, and 11/26/15. The TAR indicated the dressing had not been changed on 11/19/15.	F 0328	F – 328 The corrective action taken for those residents found tobe affected by the deficient practice is that theresident identified as resident # 54 is receiving PICC line dressing changes inaccordance with the physician's orders. There have been no omissions in providing the dressing changes asordered by the physician. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* any resident with special needs has thepotential to be affected by this deficient practice. A housewide audit was completed. All other residents with special needs arereceiving treatments including dressing changes in accordance with theirphysician's orders. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for alllicensed nurses. The nurses have	12/24/2015

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	On 11/23/15 at 9:36 a.m., the DON was interviewed. The DON indicated she was unable to locate documentation related to the PICC dressing change that had been scheduled for 11/19/15. On 11/23/15 at 9:49 a.m., Resident #54 was observed. The PICC dressing was dated 11/22/15. Resident #54 indicated the dressing had been changed on the previous day. On 11/23/15 at 9:50 a.m., LPN #1 indicated she had been working on 11/19/15. LPN #1 indicated the PICC dressing must be changed by a registered nurse. LPN #1 further indicated there had been another LPN working on 11/19/15. LPN #1 indicated the other LPN was to notify the oncoming registered nurse working on 11/19/15 that the PICC dressing needed to be changed. On 11/24/15 at 2:05 p.m., the Administrator provided the "Central Venous Catheter Dressing Changes" policy, undated. The policy included, but was not limited to, the purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. 3.1-47(a)(2)		beeneducated on the care of PICC lines as well as other special needs. The nurses have been in-serviced on theirresponsibility to ensure that the residents' special needs are met inaccordance with the physician's orders. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool. This tool willmonitor to ensure that those residents with special needs are receiving thenecessary care and services to meet those special needs in accordance withtheir physician's orders. This tool willbe completed by the Director of Nursing and/or her designee daily for one week, then weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility's regularly scheduled Quality Assurance meetings to determine ifany additional action is warranted.	

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F 0458 SS=B Bldg. 00	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 15 feet 11 inches long by 13 feet 3 inches wide. This would result in 70.29 square feet per resident. (Room #31) Findings include: On 11/18/15 at 9:00 a.m., the Administrator indicated the facility would like to maintain the ability to have 3 residents in the room. On 11/24/15 at 1:15 p.m., *Room #31 (certified for Title 18/19 SNF/NF) was observed. 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. On 11/24/15 at 2:05 p.m., the Administrator provided the "Physical	F 0458	December 14, 2015 Program Director-Provider Services Indiana State Department of Health Division of Long Term Care, Section 4B Indianapolis, IN RE: Request for Room Waiver To whom it may Concern: The following correspondence is being submitted in relationto a request for a square footage room waiver at Transcendent Healthcare ofOwensville located at 7336 W. St. Rd. 165 Owensville, IN. Transcendent Healthcare of Owensville was cited on theannual SBH Survey for F458 related to square footage of a resident's room. Awaiver 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. Theroom measures 70.29 sq. ft/	12/24/2015

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	155502	A. BUILDING 00 B. WING	11/24/2015

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	Environment" policy, undated. The policy indicated the facility had a Room Waiver for Room #31. The policy further indicated, bedrooms measure at least 80 square feet per residents. 3.1-19(l)(2)		resident. The health and safety of the residents that reside in thatroom has not been jeopardized and their needs are being met as evidence by thefollowing: Thestaff is easily able to facilitate the resident care needs in a safe andprivate environment. Resident'spersonal items are available and easily reached as needed by the resident. Based on the above information, Transcendent Healthcare ofOwensville, is requesting that a waiver be granted to continue to operate thefacility as it is licensed bed capacity of 68 beds. Sincerely, Vanessa Johnson, HFA	
F 0463 SS=B Bldg. 00	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and record review, the facility failed to ensure call lights were functional for 1 of 24 rooms reviewed during Stage 1 of the survey. (Room #2) Findings include: On 11/18/15 11:26 a.m., Room #2 was	F 0463	F – 463 The corrective action taken for those residents found tobe affected by the deficient practice is that thecall light in the bathroom identified as room # 2 has been repaired and nowfunctions properly. *The corrective actiontaken for the other residents having the potential*	12/24/2015

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	observed. The bathroom call light was observed to be malfunctioning. The call light was pressed three separate times and each time had not functioned. The bathroom services up to four residents. On 11/18/15 at 12:00 p.m., the DON was notified the call light was malfunctioning. On 11/24/15 at 2:05 p.m., the Administrator provided the "Answering Call Lights" policy, dated 4/15/15. The policy included, but was not limited to, report all defective call lights to the nurse and/or maintenance director promptly. 3.1-19(u)(2)		*to be affected by the samedeficient practice is that* all residents have the potential to be affectedby this deficient practice. A housewideaudit has been completed for each resident's room, bathroom and in both showerrooms. All call lights are functioningproperly. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for allstaff on the facility policy related to call lights. The staff was re-educated on theirresponsibility to ensure that all call light malfunctions are immediatelyreported to the nurse and/or the maintenance director. The staff has been instructed that if themaintenance director cannot or is not available to immediately repair the calllight that the resident will receive a hand call bell and instructed on theproper use of the hand call bell until the call light can be properly repaired. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by* thedevelopment and implementation of a Quality Assurance tool. This tool will monitor the proper functioningof call lights in resident rooms, bathrooms and shower rooms. The tool will also monitor to ensure that thefacility policy is being	

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			followed if a call light malfunctions and cannot beimmediately repaired. This tool will be completed by theExecutive Director and/or their designee daily for one week, then weekly for four weeks, thenmonthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed atthe facility's regularly scheduled Quality Assurance meetings to determine ifany additional action is warranted.	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 6 of 24 rooms. Dirt and debris were along edges and in corners, commode screws were uncapped and soiled, a hole was behind a commode, and a commode lid was too small. (Room 18, Room 20, Room 22, Room 23, Room 25, Room 26) Findings include: 1. During an observation on 11/18/15 at 11:35 a.m., Room 18 was observed to have dirt and debris in the corners and along the edges of the cove base. The	F 0465	F - 465 1.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 18 has been cleaned. There is no longer any dirt and debris in the corners and along theedges of the cove base. 2.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 20 has been cleaned. There is no longer any dirt and debris in the corners and along theedges of the cove base. The screws onthe base of the toilet have been capped and are no longer exposed. The hole behind the commode in the bathroomhas been repaired. The wall beside thesink has been repainted and is free of	12/24/2015

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	same was observed on 11/19/15 at 12:58 p.m. 2. During an observation on 11/19/15 at 9:55 a.m., Room 20 was observed to be in the corners and along the edges of the cove base. Screws on the base of the commode were uncapped and exposed. A hole was observed behind the commode in the bathroom and paint was observed to be chipped off the wall beside of the sink. The same was observed on 11/23/15 at 3:00 p.m. 3. During an observation on 11/18/15 at 10:25 a.m., Room 22 was observed to have dirt and debris in the corners and along the edges of the cove base. The commode screws were uncapped and exposed and had a brownish-yellow substance on them. The commode lid did not fit the commode. The same was observed on 11/19/15 at 1:00 p.m. 4. During an observation on 11/18/15 at 3:24 p.m., Room 23 was observed to have dirt and debris in the corners and along the edges of the cove base. The commode screws uncapped, exposed, and covered with a brownish-yellow substance. 5. During an observation on 11/18/15 at 3:24 p.m., Room 25 was observed to		chipped paint. 3.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 22 has been cleaned. There is no longer any dirt and debris in the corners and along theedges of the cove base. The commodescrews have been cleaned and are now capped. The commode lid has been replaced and now has a commode lid that is thecorrect size for the commode. 4.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 23 has been cleaned. There is no longer any dirt and debris in the corners or along the edgesof the cove based. The commode screwshave been cleaned and are now capped. 5.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 25 has been cleaned. There is no longer any dirt and debris in the corners or along the edgesof the cove based. 6.) The corrective action taken for those residents foundto be affected by the deficient practice is that theroom identified as room # 26 has been cleaned. There is no longer any dirt and debris in the corners or along the edgesof the cove based. The commode basescrews are now	

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	have dirt and debris in the corners and along the edges of the cove base. The same was observed on 11/19/15 at 1:07 p.m. 6. During an observation on 11/18/15 at 3:45 p.m., Room 26 was observed to have dirt and debris in the corners and along the edges of the cove base. One side of the commode base had an uncapped, exposed screw. Paint was chipped from around the room and bathroom door frames and the doors. The same was observed on 11/19/15 at 3:01 p.m. During an interview on 11/24/15 at 9:46 a.m., Housekeeper (Hskg) #1 indicated every room was cleaned daily. Hskg #1 indicated the department had a deep cleaning schedule and a list for deep cleaning a room that is marked. Hskg #1 further indicated if a room required painting or some other issue, the staff would notify the maintenance department or document it in the maintenance log book. A policy titled, "Cleaning and Disinfecting Resident's Rooms", obtained from the Administrator on 11/24/15 at 2:05 p.m., indicated housekeeping surfaces would be cleaned on a regular basis.		all capped and there are no exposed screws. The areas around the room door and thebathroom door frames have been painted and are free of any chipped paint. *The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that* all resident rooms and bathrooms have thepotential to be affected by this deficient practice. A housewide audit has been conducted of allresident rooms and bathrooms. Allcorners and areas along the cove base of each room are clean and free of dirtand debris. All commode screws arecapped with no exposed screws. There areno holes in the wall surfaces and all wall surfaces and door frames are free ofchipped paint. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for allmaintenance and housekeeping staff. Thestaff has been instructed on the facility's practice to provide a safe,sanitary and comfortable environment for the residents. The staff has been instructed on propercleaning expectations and the process whereby all environmental concerns suchas missing commode caps, chipped paint and damages wall surfaces are to bereported to maintenance as well as maintenances' responsibility for the repairof facility structure and	

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	3.1-19(f)		equipment. *The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program* by the development and implementation of aQuality Assurance tool. This tool will monitor the resident's environment toensure it is clean and free of dirt and debris, specifically along the corners andedges of the cove base. The tool will also monitor for proper maintenance ofcommodes including the use of caps to cover exposed screws and ensuring thatthe commode lids fit properly. The toolwill also monitor wall surfaces to ensure that they are free of damage andchipped paint. This tool will be completed by the Executive Director and/ortheir designee daily for one week, thenweekly for four weeks, then monthly for three months and then quarterly forthree quarters. The outcome of this toolwill be reviewed at the facility's regularly scheduled Quality Assurancemeetings to determine if any additional action is warranted.	