STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		IDENTIFICATION NUMBER: 155502	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 11/14/	ETED		
	NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE		
Bldg. 00	Complaint IN00 Federal/State de allegations are of Survey dates: No Facility number Provider number AIM number: 1 Census Bed Typy SNF/NF: 49 Total: 49 Census Payor Total: 49 Census Payor Total: 49 These deficience cited in accordate 16.2-3.1.	2240842 - Substantiated. eficiencies related to the eited at F278 and F514. Fovember 14, 2017 1000328 155502 100287960 100287960	F 0000					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155502		(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 11/14.	LETED	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				HWY 16	DDRESS, CITY, STATE, ZIP CODE 5 W PO BOX 369 VILLE, IN 47665		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
F 0278 SS=D Bldg. 00	(g) Accuracy of As assessment must resident's status. (h) Coordination A registered nurse coordinate each a appropriate partic professionals. (i) Certification (1) A registered nurse coordinate each a appropriate partic professionals. (i) Certification (1) A registered nurse coordinate each assessment accuracy of that the assessment accuracy of that publication (ii) Penalty for Fals (1) Under Medical individual who will (ii) Certifies a material are sident assessment in a resident assessment (iii) Causes another material and false assessment is sulfaterial.	e must conduct or assessment with the aipation of health urse must sign and certify ent is completed. If who completes a portion to the assessment and certify the ortion of the assessment. Sification are and Medicaid, an and Medicaid, an and Medicaid, an and fully and knowingly- erial and false statement in ment is subject to a civil not more than \$1,000 for					

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Event ID:

7GKW11 Facility ID: 000328

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLI	ETED
		155502	B. WING 11/14/2			2017	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			•	HWY 16	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	assessment.						
	(2) Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure the comprehensive assessment was accurate for 1 of 3 residents reviewed. The MDS (Minimum Data Set) assessment was incorrectly assessed for a resident medications. (Resident C) Findings include:		F 02	278	By submitting the enclosed material are not admitting the truth or accurate 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 requests the plan of correction be considered our allegation of compliance effective December 8, 2017 to the state findin of the Complaint Survey conducted on November 14, 2017.	cy s y	12/08/2017
	was reviewed on Resident C was a on 9/6/17. Diag not limited to, manxiety disorder kidney disease. An admission Massessment, date resident had recemedication, and medication, and 7 days. On 11/14/17 at 2 Coordinator indiassessment was at the medications	a diuretic medication for 2:39 p.m., the MDS icated Resident C's MDS entered incorrectly for and she would be making			The corrective action taken for those residents found to be affected by the deficient practice is that the MDS for resident identified as resident C was immediately corrected by the MDS coordinator upon identifying the mistake. The corrective action taken for the oresidents having the potential to be affected by the same deficient praction is that a housewide audit of all the more recent MDSs has been completed to ensure the accuracy of all MDSs.	et the state of th	
	a correction imn	_			The measures or systematic change that have been put into place to ens		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155502	B. Wl	B. WING			/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			65 W PO BOX 369		
TRANSC	TRANSCENDENT HEALTHCARE OF OWENSVILLE				SVILLE, IN 47665		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ted documentation of a			that the deficient practice does not r is that the facility does have a policy		
	policy for MDS	inaccuracy.			procedure on the accuracy of the MI		
					A mandatory in-service has been		
	On 11/14/17 at 3	3:53 p.m., the			provided for all members of the interdisciplinary team on the facility		
	Administrator in	ndicated the facility			policy related to accuracy of the MD	S.	
		AI (Resident Assessment					
		egard to the MDS					
	assessment.	-8			The corrective action taken to monit	or to	
	assessinent.				assure performance to assure		
	This Fodoral tog	relates to Complaint			compliance through quality assurant a Quality Assurance tool has been	ce is	
	IN00240842.	relates to Complaint			developed and implemented to moni	itor	
	INUU24U842.				the accuracy of the content of the M	DS.	
					This tool will be completed by the Director of Nursing Services and/or	her	
	3.1-31(c)(13)				designee weekly for four weeks, the		
					monthly for three months and then		
					quarterly for three quarters. The outcome of this tool will be reviewed	at	
					the regularly scheduled Quality	~.	
					Assurance meeting to determine if a	ny	
					additional action is warranted.		
					The date the systemic		
					changes will be complete	:d	
					is December 8, 2017.		
F 0514	483.70(i)(1)(5)						
SS=D	RES						
Bldg. 00	RECORDS-COM	PLETE/ACCURATE/ACCE					
_	SSIBLE						
	(i) Medical record						
	(1) In accordance	•					
		dards and practices, the tain medical records on					
	each resident that						
	(i) Complete;						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		155502	B. WI	B. WING 11/1			2017
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				HWY 16	ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369 SVILLE, IN 47665		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(ii) Accurately documented;						
	(iii) Readily acces	sible; and					
	(iv) Systematically	y organized					
	(5) The medical re	ecord must contain-					
	(i) Sufficient inforr resident;	mation to identify the					
	(ii) A record of the resident's assessments;					ļ	
	(iii) The comprehensive plan of care and services provided;						
	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;						
	(v) Physician's, nu professional's pro	urse's, and other licensed gress notes; and					
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.		F.0.5	1.4	F – 514		12/00/2017
	D 1		F 05	14	- J 		12/08/2017
		review and interview,					
	the facility failed				The corrective action taken for those	e e	
		vas complete for 1 of 3			residents found to be affected by the		
		red. Social Service			deficient practice is that the social service designee had originally		
	_	was lacking in the clinical			documented on the events of the		
	record.				resident identified as resident C however the electronic charting systems	em	
	(Resident C)				failed to save the information. The	J111	
	Findings include	2:			social service designee has since re-entered the information in the electronic record and it is now a part the clinical record.	: of	
	The closed clinic	cal record for Resident C			are cillical record.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE S	
11.12.12.11.	or conduction	155502	B. W.		00	11/14/	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE HWY 165 W PO BOX 369 OWENSVILLE, IN 47665				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	was reviewed on 11/14/17 at 9:47 a.m. Resident C was admitted to the facility on 9/6/17. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, and stage 3 chronic kidney disease. An admission MDS (Minimum Data Set) assessment, dated 9/9/17, indicated the resident had a BIMS (Brief Interview for Mental Status) assessment of 15 (fifteen), indicating no cognitive impairment. A nursing progress note, dated 9/7/17 at 1:23 p.m., indicated Resident C had increased anxiety and 1 on 1 care was provided. A nursing progress note, dated 9/5/15 at 5:03 p.m., indicated Resident C had anxiety and was exit seeking. The note indicated redirection was unsuccessful. The note indicated the physician and Power of Attorney were notified. A wanderguard (a safety device) was applied to the resident. A nursing progress note, dated 9/8/17 at 2:19 p.m., indicated Resident C had removed the wanderguard and refused to have the device reapplied. A nursing progress note, dated 9/8/17 at 3:20 p.m., indicated the resident had been agitated throughout the day over the			TAG	The corrective action taken for the cresidents having the potential to be affected by the same deficient practises that a housewide audit of all social service documentation has been completed to ensure that all social service issues have been document in the resident's clinical records. The measures or systematic change that have been put into place to ensure that the deficient practice does not is that a mandatory in-service has be provided for the social service design to ensure her knowledge level on documenting all social service relateresident events/information in the clinical record.	tice al ted es sure recur een inee	DATE
					The corrective action taken to moniassure performance to assure compliance through quality assuranta Quality Assurance tool has been developed and implemented to mor social services documentation of resident's psychosocial needs/even the clinical record. This tool will be completed by the Director of Nursir Services and/or her designee week four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool we reviewed at the regularly schedu Quality Assurance meeting to deterif any additional action is warranted.	nce is nitor ts in ng ly for vill led mine	
					The date the systemic changes will be complete is December 8, 2017.	ed	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2017 FORM APPROVED OMB NO. 0938-0391

· ´		X1) PROVIDER/SUPPLIER/CLIA	, ,		INSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155502					11/14/2017	
100002		<i>D.</i> ,,,		A PARAGO CITY OT LIFE ZIA CORE	11/14/2017			
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 65 W PO BOX 369			
TRANSCENDENT HEALTHCARE OF OWENSVILLE				1	SVILLE, IN 47665			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLET DATE		
TAG		for pain and antianxiety		IAG	,	DATE		
	1 * *	e note further indicated						
		ysician was notified and						
		sident transported to						
	_	tal] for evaluation.						
	Li milio or mospie							
	A nursing progre	ess note, dated 9/9/17 at						
		ted Resident C wanted to						
		The note further						
	1	ident signed out of the						
	facility against n	•						
	On 11/14/17 at 2	2:27 p.m., the Social						
	Services (SS) pe	rson indicated she had						
	been involved th							
	incidents and had	d documented on the						
	resident but was	unable to locate the						
	documentation in	n the resident's clinical						
	record.							
	A policy, dated 2	2010 and obtained from						
	the Administrate	or on 11/14/17 at 5:11						
	p.m., indicated tl	he SS Coordinator or						
	designee would	document significant						
	events in the resi	ident's life. The policy						
	indicated change	es in the resident's						
	emotional needs would be documented.							
	_	relates to Complaint						
	IN00240842.							
	3.1-50(a)(1)							

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