| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155502 | A. BUILDING 00<br>B. WING | 11/14/2017 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00240842.<br><br>Complaint IN00240842 - Substantiated. Federal/State deficiencies related to the allegations are cited at F278 and F514.<br><br>Survey dates: November 14, 2017<br><br>Facility number: 000328<br>Provider number: 155502<br>AIM number: 100287960<br><br>Census Bed Type:<br>SNF/NF: 49<br>Total: 49<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 33<br>Other: 7<br>Total: 49<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 15, 2017. | F 0000 | | |

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

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| F 0278<br>SS=D<br>Bldg. 00 | 483.20(g)-(j)<br>ASSESSMENT<br>ACCURACY/COORDINATION/CERTIFIED<br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each | | | |

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| | assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br><br>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)<br><br>Findings include:<br><br>The closed clinical record for Resident C 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.<br>An admission MDS (Minimum Data Set) assessment, dated 9/9/17, indicated the resident had received an antianxiety medication, an antidepressant medication, and a diuretic medication for 7 days.<br><br>On 11/14/17 at 2:39 p.m., the MDS Coordinator indicated Resident C's MDS assessment was entered incorrectly for the medications and she would be making a correction immediately. | F 0278 | 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 requests the plan of correction be considered our allegation of compliance effective December 8, 2017 to the state findings of the Complaint Survey conducted on November 14, 2017.<br><br>F – 278<br><br>*The corrective action taken for those residents found to be affected by the deficient practice is that* the MDS for the resident identified as resident C was immediately corrected by the MDS coordinator upon identifying the mistake.<br><br>*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit of all the most recent MDSs has been completed to ensure the accuracy of all MDSs.<br><br>*The measures or systematic changes that have been put into place to ensure* | 12/08/2017 |

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| | The facility lacked documentation of a policy for MDS inaccuracy.<br><br>On 11/14/17 at 3:53 p.m., the Administrator indicated the facility followed the RAI (Resident Assessment Instrument) in regard to the MDS assessment.<br><br>This Federal tag relates to Complaint IN00240842.<br><br>3.1-31(c)(13) | | *that the deficient practice does not recur is that* the facility does have a policy and procedure on the accuracy of the MDS. A mandatory in-service has been provided for all members of the interdisciplinary team on the facility policy related to accuracy of the MDS.<br><br>*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 the accuracy of the content of the MDS. This tool will be completed by the Director of Nursing Services and/or her designee weekly for four weeks, then 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 any additional action is warranted.<br><br>The date the systemic changes will be completed is December 8, 2017. | |
| F 0514<br>SS=D<br>Bldg. 00 | 483.70(i)(1)(5)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete; | | | |

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| | (ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. | | | |
| | Based on record review and interview, the facility failed to ensure documentation was complete for 1 of 3 residents reviewed. Social Service documentation was lacking in the clinical record.<br>(Resident C)<br><br>Findings include:<br><br>The closed clinical record for Resident C | F 0514 | F – 514<br><br>*The corrective action taken for those residents found to be affected by the deficient practice is that* the social service designee had originally documented on the events of the resident identified as resident C however the electronic charting system failed to save the information. The social service designee has since re-entered the information in the electronic record and it is now a part of the clinical record. | 12/08/2017 |

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| | was reviewed on 11/14/17 at 9:47 a.m.<br>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.<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A nursing progress note, dated 9/8/17 at 3:20 p.m., indicated the resident had been agitated throughout the day over the | | *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit of all social service documentation has been completed to ensure that all social service issues have been documented in the resident's clinical records.<br><br>*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 the social service designee to ensure her knowledge level on documenting all social service related resident events/information in the clinical record.<br><br>*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 social services documentation of resident's psychosocial needs/events in the clinical record. This tool will be completed by the Director of Nursing Services and/or her designee weekly for four weeks, then 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 any additional action is warranted.<br><br>The date the systemic changes will be completed is December 8, 2017. | |

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| | physician's order for pain and antianxiety medications. The note further indicated the resident's physician was notified and requested the resident transported to [Name of Hospital] for evaluation.<br><br>A nursing progress note, dated 9/9/17 at 6:08 a.m., indicated Resident C wanted to leave the facility. The note further indicated the resident signed out of the facility against medical advice.<br><br>On 11/14/17 at 2:27 p.m., the Social Services (SS) person indicated she had been involved throughout all the incidents and had documented on the resident but was unable to locate the documentation in the resident's clinical record.<br><br>A policy, dated 2010 and obtained from the Administrator on 11/14/17 at 5:11 p.m., indicated the SS Coordinator or designee would document significant events in the resident's life. The policy indicated changes in the resident's emotional needs would be documented.<br><br>This Federal tag relates to Complaint IN00240842.<br><br>3.1-50(a)(1) | | | |