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	01/10/2017

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		F 0000		

This visit was for a Recertification and State Licensure Survey.

Survey dates : January 3, 4, 5, 9, 10, 2017.

Facility number: 000328
Provider number: 155502
AIM number: 100287960

Census bed type:
SNF/NF: 51
Total: 51

Census payer type:
Medicare: 8
Medicaid: 38
Other: 5
Total: 51

These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on January 17, 2017 by #02748.

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

Any defiencystatement 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.

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	01/10/2017

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 0241 SS=E Bldg. 00	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Based on observation, record review, and interview, the facility failed to provide dignity to residents by failing to knock before entering their room for 6 of 22 residents on the West unit. (Resident #34, Resident #62, Resident #28, Resident #25, Resident #49, Resident #24) Findings include: 1. During an observation on 1/3/17 at 11:55 a.m., Helping Hand Aide (HH) #1 was observed passing a meal tray to Resident #34. No knock or acknowledgement was observed. 2. During an observation on 1/3/17 at 11:56 a.m., HH #1 was observed passing a meal tray to Resident #62. No knock or acknowledgement was observed. 3. During an observation on 1/3/17 at 11:58 a.m., the DON was observed to enter Resident #62's room to assist HH#1. No knock or	F 0241	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 February 3, 2017 to the state findings of the Recertification and State Licensure survey conducted on January 10, 2017. F - 241 *The corrective action taken for those residents found to be affected by the deficient practice is that* the residents identified as resident # 34, # 62, # 28, # 25, # 49 and # 24 are now being provided dignity by the facility staff by the staff knocking on the residents' doors prior to the staff entering the room to provide any services. *The corrective action taken for the other*	02/03/2017

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	01/10/2017

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
	acknowledgement was observed. 4. On 1/3/17 at 12:07 p.m., the Helping Hand aide #1 (HH) was observed to enter Resident #28's room with her lunch tray. HH#1 did not knock or announce herself prior to entering the resident's room. 5. On 1/3/17 at 12:10 p.m., HH #1 was observed to deliver the lunch tray to Resident #25. HH #1 did not knock or announce herself prior to entering the resident's room. 6. On 1/3/17 at 12:14 p.m., the DON (Director of Nursing) was observed to deliver the lunch tray to Resident #49. The DON did not knock or announce herself prior to entering the resident's room. 7. On 1/3/17 at 12:17 p.m., the DON was observed to deliver the lunch tray to Resident #24. The DON did not knock or announce herself prior to entering the room. During an interview on 1/9/17 at 9:51 a.m., the DON indicated staff was to knock on the door of the room and wait to be acknowledged before entering a resident room. During a review of the Resident Rights policy on 1/9/17 at 10:10 a.m.,		*residents having the potential to be affected by the same deficient practice is that* all residents are being treated with dignity and respect by the staff by the staff knocking on the residents' doors prior to entering the residents' rooms to provide care. *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 facility policy related to resident dignity. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality Assurance tool has been developed and implemented to monitor compliance with facility policy on dignity to ensure that all residents are treated in a dignified manner. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then 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 facility Quality Assurance meeting to determine if any additional action is warranted.	

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	01/10/2017

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
	the policy indicated all or in part, but not limited to "...Privacy in your room." 3.1-3(t)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest			

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	01/10/2017

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
	practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for activities for 1 of 6 residents in a total sample of 16 who met the criteria.	F 0279	F – 279 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident	02/03/2017

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	01/10/2017

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
	(Resident #34) Findings include: On 1/3/17 at 2:37 p.m., Resident #34 indicated he would like for activities to be provided more often. On 1/5/17 at 10:13 a.m., Resident #34's clinical record was reviewed. The Admission MDS (Minimum Data Set) assessment, dated 12/13/16, indicated Resident #34 had a slight cognitive impairment. The Activities section of the MDS assessment, indicated it was very important for Resident #34 to participate in his favorite activities, go outside for fresh air, have books, newspapers, and magazines to read, and to keep up with the news. The clinical record lacked an activities care plan. On 1/09/17 at 9:55 a.m., Resident #34 was observed reading a newspaper. On 1/9/17 at 3:38 p.m., the DON and Activity Director indicated Resident #34 had not had an activities care plan. On 1/10/17 at 11:32 a.m., the DON provided the "Care Planning-Interdisciplinary Team" policy,		identified as resident # 34 is no longer a resident at the facility. Prior to the resident's discharge an activity care plan was developed and implemented to meet the resident's activity needs. *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 resident's activity care plans has been completed to ensure that all activity care plans are current and meet the needs of each resident. *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 the Activity Director to ensure her working knowledge of how to develop an accurate and effective activity care plan for each resident to meet their needs. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality Assurance tool has been developed and implemented to ensure each resident has an activity care plan that meets their needs. This tool will be completed by the Social Service Director 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 facility Quality Assurance meeting to determine if any additional action is warranted.	

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	01/10/2017

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
	revised 3/14/15. The policy included, but was not limited t, "A comprehensive care plan for each resident is developed within seven days of the completion of the resident assessment (MDS)." 3.1-35(a)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	01/10/2017

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
	(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on interview, observation, and record review, the facility failed to ensure adequate handwashing and during food preparation for prevention of contamination during food preparation for 7 of 7 residents who received pureed diets. (Resident #1, #5, #7, #8, #48, #51, #67) Findings include: 1. On 1/3/17 at 9:07 a.m., during initial tour of kitchen, an open Coke can was observed on counter next to packaged sandwiches. Policy provided on 1/9/17 at 9:30 a.m., Dietary Department Guidelines indicated but was not limited to, "Employees are not to eat in the food preparation or serving areas, only in area designated for employee dining." 2. On 1/5/17 at 11:46 a.m., the cook was observed to lick her fingers to turn recipe page. She gathered measuring spoons and cups, and then stood holding spatula surface. She proceeded to scoop 8 portions ham loaf into puree machine for 7 pureed diets. She then reached in the "Thick It" container and removed a blue	F 0371	F – 371 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident # 1 no longer resides at the facility. The resident's identified as resident # 5, # 7, # 8, # 48, # 51 and # 67 are receiving their meals that have been prepared in accordance with acceptable standards of food preparation practices to prevent contamination. *1.) The corrective action taken for those residents found to be affected by the deficient practice is that* there are no employee drinks or food items in the kitchen area. *2.) The corrective action taken for those residents found to be affected by the deficient practice is that* the cook is now preparing the food in accordance with acceptable standards of food preparation and handwashing practices. *3.) The corrective action taken for those residents found to be affected by the deficient practice is that* the nourishment refrigerator in the middle hallway now contains only resident food items that are appropriately labeled and dated. Employees are storing their food items in the small refrigerator only. All employee food items stored in the small refrigerator are dated. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice*	02/03/2017

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	01/10/2017

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
	measuring device, lifted her glasses with her right hand, and dropped the blue measuring device back into the "Thick It" container. She was observed to touch her nose and face. She added chicken broth and "Thick It" to the pureed mixture and mixed substances. She was further observed to use a spatula to scrape out pureed ham loaf into a pan. The cook was further observed to wash hands for approx. 30 seconds. She touched the handle of faucet to turn off water, dried her hands with a paper towel, and then disposed of the paper towel into the trash receptacle utilizing foot pedal. The policy for handwashing provided on 1/9/17 at 9:30 a.m., by the Dietary Manager for Infection Control - Food handling. Section D. When to Wash Hands or Change Disposable Gloves, indicated but was not limited to, "Hands must be washed - After touching bare human body parts other than clean hands and arms." The policy for Food Safety indicated but was not limited to, dry hands with individual paper towel and turn off faucet with paper towel. During an interview with the Dietary Manager (DM) on 1/9/16 at 10:24 a.m., she indicated the cook should have washed her hands before the pureeing task.		*is that* this practice has the potential to affect all residents. All residents are receiving their meals which have been prepared in accordance with acceptable standards of food preparation practices to prevent contamination. Only resident food items are stored in the nourishment refrigerator in the hallway by the time clock. All employee food items are dated and stored in the small refrigerator in the middle hallway. *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 dietary staff on the facility policy related to food preparation practices to prevent contamination. This in-service included a review of the facility's handwashing policy. In addition a mandatory in-service was provided for all employees on the proper storage and labeling of employee food items. *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 dietary practices as it related to sanitary food preparation and proper handwashing. The QA tool also includes the monitoring of food storage in the nourishment refrigerator and employee refrigerator to ensure food items are stored in accordance with facility policy. This tool will be completed by the Food Service Director daily for one week, then 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 facility Quality Assurance meeting to	

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	01/10/2017

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
	3. On 1/9/17 at 9:06 a.m., the nourishment refrigerator located in hallway by the time clock, which contained covered and dated glasses of juice and cartons of nutritional supplements. The refrigerator was observed to have an unlabeled and undated red lid container with slices of pizza visible on the inside of the door. On 1/9/17 at 10:31 a.m., CNA #1 was observed eating slices of pizza in the back common area, from a red lid container. On 1/9/17 at 10:36 a.m., CNA #1 was interviewed. She indicated they were allowed to keep food items in the mini refrigerator next to the large refrigerator. On 01/9/17 1:06 p.m., DON interviewed and she indicated staff should not keep food in the resident nourishment refrigerator. She indicated the facility had a mini refrigerator for staff food. 3.1-21(i)(2) 3.1-21(i)(3)		determine if any additional action is warranted.	

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	01/10/2017

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 0431 SS=A Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	01/10/2017

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
	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976			

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	01/10/2017

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
	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. Based on observation, record review, and interview, the facility failed to ensure the medication refrigerator log was updated for 1 of 1 medication rooms. Findings include: During an observation on 1/9/17 at 2:00 p.m., the refrigerator in the medication storage room lacked a temperature log. During an interview with LPN #1 on 1/9/17 at 2:01 p.m., she indicated the temperature log should be updated and kept on the front of the refrigerator door. During an interview with the DON on 1/9/17 at 3:05 p.m., she indicated the temperature log was not available due to housekeeping removing it to replace the old refrigerator. No temperatures had been obtained fro the week of 1/1/17 through 1/8/17. During a review of the Storage of Medications policy on 1/9/17 at 4:05 p.m., provided by the DON, the policy indicated all or in part, but not limited to, "...The nursing staff shall be responsible for maintaining medication storage," "...Medications	F 0431	F – 431 *The corrective action taken for those residents found to be affected by the deficient practice is that* no residents were identified during the survey related to this citation however all residents have the potential to be affected by this deficient practice. The identified medication refrigerator now has a temperature log in place and temperatures are being recorded daily. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a temperature log is now in place on the refrigerator in which medications are being stored and temperatures are being recorded daily. *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 housekeeping staff and licensed nurses on the facility's practice of ensuring that temperatures are recorded daily on the refrigerator utilized to store medications to ensure the safe storage of those medications.	02/03/2017

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	01/10/2017

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
	requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location," and "...must be labeled accordingly." 3.1-25(m)		*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 documentation of temperatures on the refrigerator in which medications are being stored. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then 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 facility Quality Assurance meeting to determine if any additional action is warranted.	
F 0441 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must			

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	01/10/2017

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
	include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to			

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	01/10/2017

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
	prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 1 of 6 residents reviewed for care. Hands were not washed and gloves were not changed during personal care of a resident. (Resident #67) Findings include: During an observation on 1/9/17 at 9:23 a.m., CNA #2 and LPN #2 was observed to be assisting with the bathing of and dressing change for Resident #67. LPN #2 was observed to enter the shower room and apply gloves. No hand hygiene was performed. CNA #2 entered the room and washed her hands for 10 seconds prior to applying gloves. Resident #67 was incontinent of stool and urine while sitting on the shower chair. LPN #2 and CNA #2 were observed to pick up a brown formed substance from the floor and discard it prior to attempting to undress the resident. LPN #2 removed her gloves and washed her hands for 6 (six) seconds. CNA #2 was observed to remove her	F 0441	F – 441 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident # 67 is now receiving personal hygiene care and treatments in accordance with acceptable standards of handwashing and glove usage practices and facility policy. *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. All residents are now receiving personal care and treatments in accordance with acceptable standards of handwashing and glove usage practices and facility policy. *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 revised facility policy related to handwashing and glove usage. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is*	02/03/2017

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	01/10/2017

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
	gloves and wash her hands for 5 (five) seconds. LPN #2 and CNA #2 reapplied gloves. Resident #67 refused her shower, and CNA #2 was observed to obtain sanitary wipes and perform pericare to the resident. CNA #2 removed her gloves and washed her hands for 10 (ten) seconds. The resident was assisted into her wheelchair with 2 person assist by CNA #2 and LPN #2. CNA #2 was observed to apply a clean pair of briefs to the resident, cover the resident with a clean blanket, and wheel the resident into her room. CNA #2 left the room and returned with a cup of water for the resident. CNA #2 and LPN #2 assisted the resident into her bed. LPN #2 was observed to wash her hands for 10 seconds and applied clean gloves prior to completing a dressing change to the resident's bilateral lower extremities (BLE). LPN #2 was observed to cleanse the resident's BLE with soap and water and rinse the legs with water. LPN #2 was observed to apply lotion onto the resident's lower extremities and then applied Santyl ointment to the left outer lower leg and on top of the left foot below the great toe. LPN #2 changed her gloves and wrapped the resident's legs. LPN #2 was observed to removed the wet pads from under the		that a Quality Assurance tool has been developed and implemented to monitor the staff's performance related to following facility policy related to handwashing and glove usage during the care and treatment of the residents. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then 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 facility Quality Assurance meeting to determine if any additional action is warranted.	

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	01/10/2017

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
	resident's lower legs. LPN #2 removed her gloves and washed her hands for 10 seconds prior to leaving the resident's room. CNA #2 removed the trash bag and left the room to discard it. During an interview on 1/9/17 at 10:00 a.m., CNA #2 indicated hands should be washed for 30 seconds and gloves should be changed when going from a clean to a dirty area. CNA #2 indicated she did not know if she had washed her hands for the allotted length of time but that she had to wash them quickly as the resident was very impatient and noncompliant. CNA #2 indicated, "at least I washed them." A policy, revised 1/14/15 and obtained from the DON (Director of Nursing) on 1/9/17 at 10:10 a.m., indicated employees must wash their hands for at least twenty (20) seconds after contact with a resident's body fluids or excretions. 3.1-18(b)(1) 3.1-18(l)			

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	01/10/2017

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

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	01/10/2017

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 0458 SS=D Bldg. 00	483.90(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (d)(1)(ii) 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, record review, and interview, the facility failed to ensure 1 of 33 resident rooms measured 80 square feet per resident, Room #31 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 1/3/17 at 10:15 a.m., the Administrator indicated the facility would like to maintain the ability to have 3 (three) residents in the room. On 1/9/17 at 1:45 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 would result in 70.29 square feet per	F 0458	F – 458 Although the facility is not submitting a formal IDR, the facility respectfully disagrees with the level of severity of the citation being at a D level. It is the facility's position that the facility should be permitted to submit the room waiver prior to survey each year so that the citation could be avoided. 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;	02/03/2017

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	01/10/2017

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
	resident, for 3 residents in the room. On 1/9/17 at 3:15 p.m., the Adm provided the "Physical 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 resident. 3.1-19(l)(2)		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 Recertification and Licensure survey for F – 458 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 licensure for three beds. The room measures 70.29 square feet per resident. The health and safety of the residents that reside in that room has not been jeopardized and their needs are being met as evidenced by the following; The staff is easily able to facilitate the resident care needs in a safe and private environment. The resident's personal items are available and easily reached as needed by the residents. Based on the above information, Transcendent Healthcare of Owensville is requesting that a waiver be granted to continue to operate the facility at its current licensed bed capacity of 68 beds. Sincerely,	

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	01/10/2017

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
			Robert O'Niones, HFA Executive Director Transcendent Healthcare of Owensville	

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	01/10/2017

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

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	01/10/2017

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 0465 SS=E Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON (h) Other Environmental Conditions			

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	01/10/2017

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
	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 10 of 24 rooms reviewed during Stage 1 of the Survey. Paint was chipped, dirt and debris was built up in the corners and along the edges, and wires were exposed. (Rooms 7, 9, 26, 20, 23, 25, 29, 30, 31, 33) Findings include: 1. On 1/4/17 at 10:30 a.m., Room #7 was observed. In the bathroom, used tissues were on the floor, the caulking around the base of the commode was brown, and the paint was chipped off of the doors to the bathroom. On 1/9/17 at 11:14 a.m., Room #7 was observed. In the bathroom, the caulking around the base of the commode was brown and the paint was chipped off of the bathroom doors. The bathroom was shared by two residents. 2. On 1/3/17 at 11:28 a.m., Room #9 was observed. In the bathroom, screw sized holes were on the wall and paint was	F 0465	F – 465 *1.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 7no longer has tissues on the floor. The caulking around the base of the commode has been replaced. The bathroom door has been re-painted and is free of chipped paint. *2.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as # 9 has had the screw size holes in the bathroom wall have been repaired. The bathroom door has been re-painted and is free of chipped paint. *3.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 26 has had the telephone connecting box removed from the call light outlet. The privacy curtain has been repaired. The bathroom door has been re-painted and is free of chipped paint. The bathroom floor has been deep cleaned and is free of dirt and debris build-up.	02/03/2017

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	01/10/2017

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
	chipped off the bathroom door. On 1/9/17 at 10:31 a.m., the same was observed. The bathroom as shared by two residents. 3. On 1/4/17 at 9:19 a.m., Room #26 was observed. In the bedroom, a telephone like connecting box was hanging from the call light outlet. Wires were observed to be exposed. The privacy curtain was unhooked on the last hook. In the bathroom, paint was chipped off of the doors and dirt and debris was built up in the corners and along the edges. On 1/9/17 at 1:32 p.m., the same was observed. The bathroom was shared by four residents. 4. On 1/4/17 at 10:24 a.m., Room #20 was observed. A brown substance was observed splattered on the soap dispenser in the bathroom. On 1/9/17 at 2:11 p.m., the same was observed. The bathroom was shared by two residents. 5. On 1/3/17 at 11:45 a.m., Room #23 was observed. Paint was chipped off of the bathroom doors. On 1/9/17 at 10:55 a.m., Room #23 was observed. Paint was chipped off of the bathroom doors. In the bedroom, a telephone like connector box was hanging from the call light outlet. Wires were observed to be exposed. The bathroom was shared by four residents.		*4.) 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 soap dispense in the bathroom cleaned and it is free of any brown splattered substance. *5.) 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 telephone connector box removed from the call light outlet. The bathroom door has been re-painted and is free of chipped paint. *6.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 25 has had the bathroom door painted and the bathroom floor deep cleaned and it is now free of dirt and debris in the corners and along the edges of the bathroom floor. *7.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 29 has had the bathroom floor deep cleaned and it is free of any build-up of dirt and debris.	

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	01/10/2017

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
	6. On 1/3/17 at 12:01 p.m., Room #25 was observed. In the bathroom, the paint was chipped off of the doors and dirt and debris was built up in the corners and along the edges On 1/9/17 at 10:52 a.m., the same was observed. The bathroom was shared by four residents. 7. On 1/4/17 at 9:08 a.m., Room #29 was observed. In the bathroom, dirt and debris was built up in the corners and along the edges. On 1/9/17 at 10:45 a.m., the same was observed. The bathroom was shared by two residents. 8. On 1/4/17 at 10:23 a.m., Room #30 was observed. The wire glove box container was loose from the wall, dirt and debris was built up in the corners and along the edges, the entry door knob was loose, and paint was chipped off the bathroom door. On 1/9/17 at 10:47 a.m., the same was observed. 9. On 1/4/17 at 10:16 a.m.,. Room #31 was observed. A telephone like connecter box was observed to hanging from the call light outlet. Wires were observed to be exposed. On 1/9/16 at 10:42 a.m., the same was observed. 10. On 1/4/17 at 9:49 a.m., Room #33 was observed. In the bathroom, paint		*8.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 30 has had the wire glove box container re-secured to the wall and it is no longer loose. The bathroom door has been painted and is free of chipped paint. The floor has been deep cleaned and is free of any build-up of dirt and debris. The entry door knob has been repaired and is no longer loose. *9.) The corrective action taken for those residents found to be affected by the deficient practice is that* the room identified as room # 31 has had the telephone connector box removed from the call light outlet. *10.) 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 bathroom door painted and it is free of chipped paint. The toilet paper holder has been repaired and is no secure on the bathroom wall. The bathroom floor has been deep cleaned and is free of any build-up of dirt and debris. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been conducted of all resident rooms and bathrooms to identify any environmental concerns. All identified concerns have	

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	01/10/2017

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
	was chipped off of the doors, the toilet paper holder was falling out of the wall, and dirt and debris was built up in the corners and along the edges. The bathroom was shared by two residents in one room and 1 resident in the adjoining room. On 1/9/17 at 3:03 p.m., the Maintenance Supervisor indicated he walked the hallways daily to see if anything was in disrepair. He further indicated staff let him know if anything needed repaired. The Maintenance Supervisor indicated the telephone like box hanging from the call light outlet was a telephone connector. He further indicated there was low voltage running through the wires. On 1/9/17 at 3:30 p.m., the Administrator provided the "Physical Environment Policy", undated. The policy included, but was not limited to: Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior environment are provided. 3.1-19(f)		been repaired, replaced or cleaned to ensure a safe, sanitary environment. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* additional housekeeping tasks have been added to the daily cleaning schedule to ensure a clean environment for the residents. In addition, additional tasks have been added to the preventative maintenance program to ensure environmental issues are checked weekly and repairs made in a timely manner. A mandatory in-service has been provided for all housekeeping and environmental staff on the additional tasks that have been added to the daily cleaning schedules and the preventative maintenance program. *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 cleanliness and environmental safety of the resident's rooms and	

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	01/10/2017

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
			bathrooms. This tool will be completed by the Executive Director and/or his 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 facility Quality Assurance meeting to determine if any additional action is warranted.	