

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

PRINTED: 09/19/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 7336 W STATE ROAD 165 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>This visit was for the Investigation of Complaint IN00414291.</p> <p>Complaint IN00414291 - Federal/state deficiencies related to the allegations are cited at F659.</p> <p>Survey dates: August 15, 2023</p> <p>Facility number: 000328 Provider number: 155502 AIM number: 100287960</p> <p>Census Bed Type: SNF/NF: 57 Total: 57</p> <p>Census Payor Type: Medicaid: 52 Other: 5 Total: 57</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 22, 2023.</p>			F 0000	<p>By submitting the enclosed materials, 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 September 1, 2023 to the state findings of the Complaint Survey conducted on August 15, 2023.</p>		
F 0659 SS=D Bldg. 00	<p>483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure residents received care by</p>			F 0659	<p>F - 659 1.) The corrective action taken for</p>		09/01/2023

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

TITLE

(X6) DATE

Robin McCarty

Executive Director

09/05/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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.

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

PRINTED: 09/19/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>qualified staff for 3 of 4 diabetic residents reviewed. QMAs (Qualified Medication Aide) documented the administration of routine insulin injections without being certified to administer insulin. (Resident F, Resident G, Resident H)</p> <p>Findings include:</p> <p>1. During record review on 8/15/23 at 10:45 A.M., Resident F's diagnoses included, but were not limited to; type II diabetes.</p> <p>Resident F's physician orders included, but were not limited to; NovoLog FlexPen (insulin pen) 100 units/mL (milliliter) per sliding scale four times a day (initiated 10/19/21).</p> <p>During a review of Resident F's medication administration record (MAR) from 7/1/23 thru 8/15/23, the resident's routine insulin order (NovoLog FlexPen 100 units/mL per sliding scale four times a day) was documented as administered by QMA 2 on the following dates; 7/1/23, 7/2/23, 7/10/23, 7/11/23, 7/15/23, 7/16/23, 7/19/23, 7/20/23, 7/24/23, 7/25/23, 7/26/23, 7/29/23, 7/30/23, 8/2/23, 8/7/23, 8/8/23, 8/9/23, 8/11/23, 8/12/23, and 8/13/23. Resident F's insulin was documented as administered by QMA 7 on the following dates: 7/3/23, 7/5/23, 7/6/23, 7/8/23, 7/12/23, 7/13/23, and 7/17/23.</p> <p>2. During record review on 8/15/23 at 11:00 A.M., Resident G's diagnoses included, but were not limited to; type II diabetes.</p> <p>Resident G's physician orders included, but were not limited to; insulin lispro (insulin pen) 100 units/mL, sliding scale before meals, 18 units 1 time a day, and 4 units one time a day (initiated 10/13/22) and Lantus Solostar (insulin pen) 100</p>				<p><i>those residents found to have been affected by the deficient practice is that the resident identified as resident F is now receiving their insulin by a licensed nurse or a QMA who has successfully completed the insulin administration course and has successfully passed their final exam to administer insulin. The QMAs identified as QMA 2 and 7 had completed the insulin administration course and had been scheduled to take the final exam. The vocational school who was scheduled to give the final exam however had cancelled the exam at the time of the survey.</i></p> <p><i>2.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident G is now receiving their insulin by a licensed nurse or a QMA who has successfully completed the insulin administration course and has successfully passed their final exam to administer insulin. The QMAs identified as QMA 2 and 7 had completed the insulin administration course and had been scheduled to take the final exam. The vocational school who was scheduled to give the final exam however had cancelled the exam and had not re-scheduled the exam at the time of the</i></p>		

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

PRINTED: 09/19/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>units/mL, 40 units one time a day (initiated 8/5/22).</p> <p>During a review of Resident G's MAR from 7/1/23 thru 8/15/23, the resident's routine insulin orders (insulin lispro 100 units/mL, per sliding scale before meals, 18 units 1 time a day, and 4 units 1 time a day, and Lantus Solostar 100 units/mL, 40 units one time a day) were documented as administered by QMA 2 on the following dates; 7/1/23, 7/2/23, 7/10/23, 7/11/23, 7/15/23, 7/16/23, 7/19/23, 7/20/23, 7/24/23, 7/25/23, 7/26/23, 7/29/23, 7/30/23, 8/2/23, 8/7/23, 8/8/23, 8/9/23, 8/11/23, 8/12/23, and 8/13/23. Resident F's insulin was documented as administered by QMA 7 on the following dates: 7/3/23, 7/5/23, 7/6/23, 7/8/23, 7/12/23, 7/13/23, and 7/17/23.</p> <p>3. During record review on 3/9/23 at 11:15 A.M., Resident H's diagnoses included, but were not limited to; type II diabetes.</p> <p>Resident H's physician orders included, but were not limited to; Humalog KwikPen Solution (insulin pen) 100 units/mL, per sliding scale four times a day (initiated 2/19/21).</p> <p>A review of Resident H's MAR from 7/1/23 thru 8/15/23, the resident's routine insulin order (Humalog KwikPen Solution 100 units/mL, per sliding scale four times a day) was documented as administered by QMA 2 on the following dates; 7/1/23, 7/2/23, 7/10/23, 7/11/23, 7/15/23, 7/16/23, 7/19/23, 7/20/23, 7/24/23, 7/25/23, 7/26/23, 7/29/23, 7/30/23, 8/2/23, 8/7/23, 8/8/23, 8/9/23, 8/11/23, 8/12/23, and 8/13/23. Resident F's insulin was documented as administered by QMA 7 on the following dates: 7/3/23, 7/5/23, 7/6/23, 7/8/23, 7/12/23, 7/13/23, and 7/17/23.</p> <p>During a review of the facilities QMA</p>				<p>survey.</p> <p>3.) <i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident H is now receiving their insulin by a licensed nurse or a QMA who has successfully completed the insulin administration course and has successfully passed their final exam to administer insulin. The QMAs identified as QMA 2 and 7 had completed the insulin administration course and had been scheduled to take the final exam. The vocational school who was scheduled to give the final exam however had cancelled the exam and had not re-scheduled the exam at the time of the survey.</i></p> <p><i>The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that an audit was completed for all residents who receive insulin. All residents who receive insulin are now receiving their insulin by a licensed nurse or a QMA who has successfully completed the insulin administration course and has successfully passed their final exam to administer insulin.</i></p> <p><i>The measures that have been put into place to ensure that the</i></p>		

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

PRINTED: 09/19/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 7336 W STATE ROAD 165 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>certifications, QMA 2 and QMA 7 were found to be uncertified for the administration of insulin.</p> <p>During an interview on 8/15/23 at 12:10 P.M., LPN 4 indicated that a QMA who is not certified to administer insulin should not administer insulin, but rather get a nurse or a QMA who is certified to administer the insulin dose.</p> <p>On 8/15/23 at 12:40 P.M., the facility administrator supplied a facility policy titled, Insulin Administration, and dated 10/2010. The policy included, "1. Only appropriate licensed or certified personnel shall draw and administer insulin." The facility administrator also supplied an "Indiana State Department of Health Qualified Medication Aide (QMA) - Insulin Administration Education Module Instructor Manual." The manual included, "...The Insulin Administration Education Module must include: ...3. a written examination administered by the Indiana state approved testing entity which the QMA must pass; and 4. a practical examination, which the QMA must pass with 100% competency administered by an approved Program Director of an Indiana approved QMA Training Program."</p> <p>This Federal tag relates to Complaint IN00414291.</p> <p>3.1-14(j)</p>				<p><i>deficient practice does not recur is that a mandatory in-service has been provided for the Director of Nursing and all QMAs on the facility's policy related to QMAs administration of insulin. The Director of Nursing was instructed on their responsibility to ensure that the appropriate documentation was in place for each QMA to ensure that they had successfully completed a State approved insulin administration course along with verification that they had successfully completed their final exam prior to the QMA being permitted to administer insulin to any resident with physician's orders for insulin administration.</i></p> <p><i>The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor the administration of insulin. The tool will monitor to ensure that when insulin is administered by a QMA, that there is supportive documentation in the QMAs employee file that the QMA has successfully completed the insulin administration course including successful completion of the final exam. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The</i></p>		

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155502		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF OWENSVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 7336 W STATE ROAD 165 OWENSVILLE, IN 47665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
					outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.		