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	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00435912. Complaint IN00435912: Federal/State deficiencies related to the allegations are cited at F 609. Survey date: June 25, 2024 Facility number: 000328 Provider number: 155502 AIM number: 100287960 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 2 Medicaid: 45 Other: 5 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 27, 2024.	F 0000	On June 25, 2024 a Complaint Survey was conducted at our facility. 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 that the plan of correction be considered our allegation of compliance effective July 5, 2024 to the State findings of the Complaint Survey conducted on June 25, 2024. We respectfully request a desk review to validate the facility's compliance to the findings of the Complaint Survey of June 25, 2024. Please feel free to contact the facility is any additional information is needed.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Haley Rhew	Executive Director	07/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

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	misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the state agency for 1 of 1 allegations of abuse reviewed. After being made aware of an allegation of abuse the facility failed to report the incident and findings to the state agency. (Resident D) Finding includes: During record review on 6/25/24 at 9:15 A.M., Resident D's diagnoses included, but was not limited to, anxiety, bipolar disorder, dementia with agitation, and senile degeneration of brain. Resident D's most recent Quarterly MDS (Minimum Data Set) assessment, dated 5/8/24,	F 0609	*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D has had no additional allegations of abuse reported to the facility at this time. Any future allegations of abuse will be promptly reported to the State agency. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit has now been	07/05/2024

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	indicated the resident had severe cognitive impairment. Resident D's nurses' progress notes included the following: 6/3/24 at 5:08 A.M. - Resident took self to bathroom, CNA tried to help the resident and resident yelled and punched the CNA several times with fists. Resident has skin tears to bilateral hands, bandaged left hand to help stop bleeding. 6/3/24 at 4:09 P.M. - Residents family notified regarding incident during night shift. Residents alarm began to sound around 5:00 A.M., CNA entered room and found that Resident D was in the bathroom. CNA made her presents known to resident and when resident laid eyes on CNA he began yelling because he thought she was a man. Resident stated, "I was going to fight that man, he was in my house." Resident D began thrashing and attempted to hit CNA. CNA told resident she was a woman and called for help. Another CNA and nurse on duty entered Resident D's room and noted resident thrashing and observed skin tears to bilateral hands. Resident stated to the nurse on duty that he was agitated due to thinking the CNA was a man but that he knows she is a woman because she showed her breast. During a review on 6/25/24 at 10:10 A.M. of the facility's investigation of the incident that occurred on 6/3/24, an Employee Warning Notice, dated 6/3/24 and signed as received by CNA 7 included that CNA 7 received a 3-day suspension due to an "abuse complaint" that included, "Complaint of alleged abuse from a family member." During an interview on 6/25/24 at 10:30 A.M., the DON (Director of Nursing) indicated that Resident D's family thought that CNA 7 may have exposed		completed and there are no other allegations of abuse that have been reported to administration. All future allegations of abuse will be reported promptly to the state agency *The measures 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's abuse program. All staff members have been educated on all components of the facility's abuse policy and administration has been instructed on their responsibility to report all allegations of abuse promptly to the state agency per the regulation. *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 ensure that each allegation of abuse has been reported promptly to the state agency as required by the regulation. 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 outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	her breasts to Resident D during the incident that occurred on 6/3/24 and that the allegation was found to be unfounded and was not reported to the state agency. On 6/25/24 at 11:00 P.M., the facility administrator supplied an undated facility policy, titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. The policy included, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management..." This Federal tag relates to complaint allegation IN00435912. 3.1-28(c)			