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	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	7336 W STATE ROAD 165 OWENSVILLE, IN 47665

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00381809. This visit was in conjunction with Investigation of Complaint IN00388717. Complaint IN00381809 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00388717 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: August 22, 23, 24, 25, 2022 Facility number: 000328 Provider number: 155502 AIM number: 100287960 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 21 Medicaid: 26 Private: 2 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 2, 2022.	F 0000		
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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

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	§483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored and handled in accordance with food safety standards to maintain a sanitary environment and prevent foodborne illness during 2 of 2 kitchen observations. Food was stored in containers resting on the floor of the walk-in refrigerator and freezer, an air vent had built up dust, and a kitchen staff member handled food while wearing acrylic nails. Finding includes: During a kitchen observation on 8/22/22 at 9:21 A.M., an air vent above the dishwasher had built up, dark colored, dust. The walk-in freezer contained 3 boxes of frozen vegetables stored on the floor. During a kitchen observation on 8/24/22 at 10:45	F 0812	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 08-19-2022 to the state findings of the Recertification and State Licensure survey and complaint survey conducted on August 25, 2022. F - 812 *The corrective action taken for those residents found to have*	09/19/2022

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	A.M., an air vent above the dishwasher had built up, dark colored, dust. The walk in refrigerator contained three crates of milk, chocolate milk, and orange juice, all resting on the floor. The Dietary Manager (DM) was wrapping individual slices of shortbread in plastic wrap while wearing acrylic nails and no gloves. During an interview on 8/25/22 at 9:13 A.M., the DM indicated they vent above the dishwasher should be cleaned regularly by maintenance. The DM indicated containers of food should not be stored directly on the refrigerator or freezer floor but that sometimes there isn't enough room in the refrigerator to store the beverage cartons off the floor, and that acrylic nails should not be worn if handling food directly. During an interview on 8/25/22 at 9:33 A.M., Maintenance Staff 2 indicated they were supposed to clean the vent in the kitchen a month ago, but they had gotten busy and weren't able to get to it. Maintenance Staff 2 indicated they were about to clean the vent at that time. On 8/25/22 at 12:00 P.M. the MDS (Minimal Data Set) Nurse supplied a facility policy titled, Food Receiving and Storage, and dated 6/16/22. The policy included, "...1. Food Services, or other designated staff, will maintain clean food storage areas at all times... 9. Refrigerated food will be stored in such a way that promotes adequate air circulation around food storage containers. Refrigerators/walk-ins will not be overcrowded." 3.1-21(i)(2) 3.1-21(i)(3)		*been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The air vent located above the dishwasher has been cleaned and is now free of dust and debris. The air vent has been placed on the facility's routine cleaning schedule to ensure this issue does not reoccur. The three crates of milk, chocolate milk and orange juice that were located on the floor were immediately removed. All food items are now stored properly on the shelves in the walk-in refrigerator. During the preparation and handling of any food items, the dietary staff that are wearing acrylic nails are wearing gloves. All dietary staff that is handling any food items are wearing gloves during the handling of any food items. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The air vent located above the dishwasher has been cleaned and is now free of dust and debris. The air vent has been placed on the facility's routine cleaning schedule to ensure this issue does not reoccur. The three crates of milk,	

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			chocolate milk and orange juice that were located on the floor were immediately removed. All food items are now stored properly on the shelves in the walk-in refrigerator. During the preparation and handling of any food items, the dietary staff that are wearing acrylic nails are wearing gloves. All dietary staff that is handling any food items are wearing gloves during the handling of any food items. *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 dietary staff on the facility's policies related to the storage and handling of food items. The dietary staff has also been re-in-serviced on hand hygiene and glove usage in the preparation/handling of all food items. The in-service included a reminder that staff wearing acrylic nails must wear gloves during the handling and preparation of all food items. A mandatory in-service was also provided for the maintenance department on their responsibility related to the regular cleaning of all air vents, including the air vent located above the dishwasher. Pg. 2 F – 812 continued	

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			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 safe/sanitary handling and storage of all food items. The tool includes the monitoring of the cleanliness of the air vent above the dishwasher, the storage of food items in the walk-in refrigerators/freezers to ensure all food items are properly stored on the shelves and the proper wearing of gloves when food items are handled, including the wearing of gloves when acrylic nails are worn. This tool will be completed by the Director of Food Services 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.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(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: §483.80(a)(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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must 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			

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	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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 ensure infection control practices were followed for 5 of 7 observations of resident care and 1 of 4 residents observed for medication administration. Gloves were not changed between dirty and clean tasks during incontinence care, handwashing was completed for less than 20 seconds, a nurse failed to wipe the rubber stopper with an alcohol wipe prior to screwing on the needle, and PPE was not put on before entering an isolation room.(Resident 19, Resident 29, Resident 22, Resident 43, Resident 9) Findings include: 1. On 8/24/22 at 9:20 A.M., Certified Nurse Aide	F 0880	Pg. 3 F – 880 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 19 is now receiving incontinent care by staff members who are donning and doffing gloves in accordance with proper infection control practices for incontinent care and they are demonstrating proper hand hygiene in accordance with acceptable standards of practice. The CNAs identified as CNA 11 and CNA 13 have been	09/19/2022

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	(CNA) 11 and CNA 13 was observed performing incontinence care for Resident 19. CNA 11 obtained gloves and resident was rolled to the left, CNA 11 removed the incontinence brief, wiped residents buttocks, disposed of dirty brief, wiped residents buttocks again. Resident 19 was rolled to the right side and CNA 11 grabbed resident's left shoulder and left thigh with the same gloves used to clean. After providing care, CNA 11 washed hands with a 2 (two) second lather with soap. 2. On 8/24/22 at 9:12 A.M., Qualified Medication Aide (QMA) 3 was observed applying a cream to Resident 29's arms and legs. QMA 3 entered Resident 29's room, and washed her hands with a 3 (three) second lather with soap. Gloves were put on, the cream applied, then gloves removed. QMA 3 then washed her hands with an 8 (eight) second lather with soap. At that time, QMA 3 indicated hands should be lathered with soap for 30 (thirty) seconds when washing hands. 3. On 8/23/22 at 1:29 P.M., CNA 5 was observed to open room 31's door, and stick her head in to speak with a resident in the room. CNA 5 then stepped from the doorway to the hall, obtained a gown and faceshield from a cart sitting by the door, then entered the room with the PPE (personal protective equipment) in her hand. CNA 5 then put on the gown and faceshield just inside the doorway of the room, then shut the door. At that time, a sign was observed on room 31's door that indicated droplet/contact precautions. During an interview on 8/25/22 at 2:17 P.M., the ADON (Assistant Director of Nursing) indicated Resident 22 was in room 31 on Transmission Based Precautions due to testing positive for		re-educated on the facility policies related to incontinence care, glove usage and hand hygiene. CNA 11 and 13 have successfully completed return demonstration on incontinence care with proper glove usage and hand hygiene. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 29 is now having their cream applied by staff members who are demonstrating proper hand hygiene in accordance with facility policy. The QMA identified as QMA 3 has been re-educated on the facility policy related to hand hygiene and has successfully completed return demonstration on hand hygiene. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 22 no longer requires transmission-based precautions. However, should the resident require transmission-based precautions in the future, all staff who enter the resident's room will be donned with all appropriate personal protective equipment prior to entering the isolation room. The CNA identified as CNA 5 has been re-educated on the proper donning and doffing of personal protective equipment and has successfully completed a	

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	COVID-19 on 8/12/22. 4. On 8/24/22 at 9:30 A.M., QMA 7 and CNA 9 were observed to perform incontinence care for Resident 43. CNA 9 washed her hands with a 7 (seven) second lather with soap prior to putting on gloves. With gloved hands, CNA 9 was observed to put the head of the bed down, lower the bed, obtain a clean incontinence brief and trash bag (both placed on the bed), then hold the resident's hand. QMA 7 and CNA 9 both used wipes to clean the resident, then wearing the same gloves, put on clean incontinence brief, pull the resident's pants up, then placed a sheet and blanket over the resident. Gloves were not changed during care. QMA 7 then washed her hands with a 13 (thirteen) second lather with soap, and CNA 9 washed her hands with a 12 (twelve) second lather with soap. 5. On 08/24/22 at 9:54 AM, CNA 11 was observed assisting with a dressing change for Resident 9. Upon entering the room, CNA 11 washed their hands with a 4 (four) second lather with soap, then put on gloves. CNA 11 assisted with the dressing change, then assisted resident into wheelchair. The same gloves were worn for the duration of the dressing change and transfer. CNA 11 then washed hands with a 2 (two) second lather with soap and exited the room. After performing the dressing change, CNA 13 washed her hands with a 7 (seven) second lather with soap and exited the room. 6. During an observation on 8/24/22 at 10:58 A.M., Registered Nurse (RN) 2 prepared and administered 6 units of insulin from a Humalog Kwikpen 100 Unit/ML (milliliter) for Resident 1. While preparing the insulin pen, RN 2 failed to wipe the rubber stopper with an alcohol wipe prior to screwing on the needle.		return demonstration of these tasks in accordance with facility policies and infection control practices. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 43 is now receiving incontinent care by staff members who are donning and doffing gloves in accordance with proper infection control practices during incontinent care and they are demonstrating proper hand hygiene in accordance with acceptable standards of infection control practices. The staff members identified as QMA 7 and CNA 9 have been re-educated on the facility policies related to incontinent care, glove usage and hand hygiene. QMA 7 and CNA 9 have successfully completed a return demonstration on providing incontinent care, proper glove usage and proper hand hygiene in accordance with facility policy and acceptable standards of infection control practices. Pg. 4 F – 880 continued *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 9 is now	

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	During an interview on 8/24/22 at 11:13 A.M., RN 2 indicate the did not wipe the rubber stopping with an alcohol pad, and did not realize they were supposed to. During an interview on 8/25/22 at 2:25 P.M., the Infection Preventionist (IP) indicated nursing staff should wipe the rubber stopper at the end of an insulin pen just the same as they should an insulin vial prior to inserting a needle. Manufacturers instructions for use from uspl.lilly.com/humalog, revised 4/2020, include, "...Step 1: Pull the Pen Cap straight off... Wipe the Rubber Seal with an alcohol swab..." During an interview on 8/25/22 at 2:25 P.M., the Infection Preventionist (IP) indicated gloves should always be changed and hands washed when moving from a dirty area of the body to a clean area of the body. She further indicated staff should put on all PPE before entering an isolation room. On 8/25/22 at 2:08 P.M., a current Hand Hygiene policy, revised June 2010, was provided and indicated "employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...before and after assisting a resident with personal care...before and after changing a dressing" the policy further indicated hands should be lathered for at least 15 seconds. On 8/25/22 at 2:08 P.M., a current Gloves policy, revised August 2009, was provided but did not include instructions when to change gloves. On 8/25/22 at 2:08 P.M., the Administrator provided an example form for donning PPE, but		receiving dressing changes by staff members that are utilizing appropriate infection control practices related to hand hygiene and glove usage during a dressing change. The CNAs identified as CNA 11 and 13 have been re-educated on proper glove usage and hand hygiene during a dressing change. CNAs 11 and 13 have successfully completed return demonstrations on the proper use of gloves during a dressing change and proper hand hygiene in accordance with facility policies and acceptable standards of infection control practices. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #1 is now receiving their insulin by a licensed nurse that is demonstrating proper infection control technique in the preparation and administration of insulin via a Kwikpen. The nurse identified as RN 2 has been re-educated on the proper preparation and administration of insulin via a Kwikpen. RN 2 has successfully completed a return demonstration of the preparation and administration of insulin via a Kwikpen. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all	

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	the form failed to include information related to where PPE should be donned. 3.1-18(b)(2) 3.1-18(l)		residents have the potential to be affected by these deficient practices. All residents are now receiving personal care and services, including incontinent care, transmission-based precautions, dressing changes, medication administration, donning/doffing of PPE, glove usage and hand hygiene etc. by all staff members who are demonstrating the acceptable standards of infection control practices and facility policies. *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 nursing staff on the facility's infection control practices. All nursing staff has been re-educated on the acceptable standards of infection control practices related to hand hygiene, glove usage, donning and doffing of personal protective equipment related to transmission-based precautions, incontinent care, and dressing changes. Each nursing staff member has successfully completed a return demonstration in each of the above listed areas to ensure acceptable standards of infection control practices are in place. In addition, all licensed nurses and insulin certified QMAs have been re-educated on the facility policy related to the use of Kwikpen insulin. All licensed	

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			nurses and insulin certified QMAs have successful completed a return demonstration of the preparation and administration of insulin via a Kwikpen. Pg. 5 F – 880 continued *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 staff infection control practices related to; glove usage and hand hygiene during incontinence care and dressing changes, hand hygiene practices in accordance with facility policy, proper donning/doffing of personal protective equipment prior to and upon leaving a resident on transmission-based precautions, and medication administration related to the use of Kwikpen insulin. This tool will be completed by the facility Infection Control Preventionist and/or their designee daily for two weeks, 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 meetings to determine if additional action is warranted.	

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F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(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, interview, and record review, the facility failed to ensure that 1 of 33 resident rooms reviewed met the requirement of 80 square feet per resident. (Room 31) Finding includes: On 8/25/22 at 1:15 P.M., Room 31 (certified for Title 18/19 SNF/NF) was observed. The measurements of Room 31 were observed to measure 15 feet 10 inches long by 13 feet 6 inches wide. This would result in 71.25 square feet per resident, for 3 residents in the room. On 8/25/22 at 1:10 P.M., a form on [facility] letter head indicated room number 31 measured 70.29 square feet per resident. On 8/25/22 at 1:34 P.M., the Administrator indicated the facility would like to maintain the ability to have 3 (three) residents in the room. 3.1-19(l)(2)(A)	F 0912	F - 912 The corrective action taken for those residents found to have been affected by the deficient practice is that there were no residents identified to be affected by this deficient practice as there are no residents in this room at this time. There was only one resident in room 31 at the time of survey who was on transmission-based precautions. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility is submitting a room waiver as the facility wants to maintain the license for that bed but is not placing three residents in that room. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility will continue to submit a room waiver annually to maintain the license for that bed.	09/19/2022

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	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	7336 W STATE ROAD 165 OWENSVILLE, IN 47665

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			The corrective action taken to monitor to assure performance to assure compliance through quality assurance is the Executive Director will maintain a file of the submitted room waiver annually.	