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	05/08/2025

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. Survey dates: May 4, 5, 6, 7, and 8, 2025 Facility number: 000328 Provider number: 155502 AIM number: 100287960 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 41 Other: 8 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 20, 2025.	F 0000	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 (06/06/2025) to the state findings of the Recertification and State Licensure Survey conducted on May 8, 2025.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation and record review, the facility failed to ensure staff promoted dignity by allowing a resident to use the bathroom when requested for 1 of 1 dining observations. (Resident 18) Finding includes:	F 0550	F - 550 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #18 is now being toileted promptly upon request of the resident.	06/06/2025

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

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	On 5/4/25 at 12:16 P.M., Resident 18 was observed in the dining room. Resident 18 told Certified Nurse Aide (CNA) 9 she needed to go pee. CNA 9 told Resident 18 she could not go to the bathroom because she had to eat. On 5/6/25 at 8:44 A.M., Resident 18's clinical record was reviewed. Resident 18 was admitted on 1/5/22. Diagnoses included, but were not limited to, type 2 diabetes. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 4/8/25, indicated Resident 18 was severely cognitively impaired, required supervision from staff while eating, and substantial assistance (staff does more than half of the work) for toileting, bathing, and transfers. Physician orders included, but were not limited to: Lasix oral tablet (a diuretic medication) - Give 20 mg (milligrams) by mouth one time a day for edema; start date 7/29/23. Medication administration record for May recorded the administration of Lasix was scheduled for every morning. Current care plans included, but were not limited to: I have a history of bladder incontinence related to activity intolerance, impaired mobility, nocturia, urgency of urination; start date 1/5/21. On 5/8/25 at 10:12 A.M., the Regional Consultant provided an undated policy titled Dignity, that indicated: "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at		*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. The dignity of all residents is now being promoted by staff by promptly attending to all of their needs and/or concerns. *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 policies related to residents' rights, dignity and respect. All staff members were re-educated on their responsibilities to ensure that each resident's rights are promptly honored and respected. *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 resident's rights are being honored and that each resident's needs are being provided with dignity and respect. This tool will be completed by the Social Service 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	

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	all times. Residents may exercise their rights without interference, coercion, discrimination, or reprisal from any person or entity associated with this facility. When assisting with care, residents are supported in exercising their rights, for example, residents are: allowed to choose when to sleep, eat, and conduct activities of daily living. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example: promptly responding to a resident's request for toileting assistance." 3.1-3(t)		warranted.	
F 0553 SS=D Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 1 of 5 residents reviewed for unnecessary medications (Resident 27) and 1 of 3 residents reviewed for wound care (Resident 14). Findings include: 1. On 5/6/25 at 9:14 A.M., Resident 27's clinical record was reviewed. Resident 27 was admitted on 1/9/25. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/21/25, indicated Resident 27 was moderately cognitively impaired and required substantial assistance (staff does more than half of the work) for toileting, bathing, and transfers. On 5/6/25 at 9:14 A.M., the clinical record lacked a	F 0553	F - 553 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #27 as well as the resident's responsible party have now been invited to participate in a care plan conference for the resident. There is documentation in the clinical record of the notifications of these invitations to the resident and their responsible party. The facility will continue to make these notifications of scheduled care plan conferences at least quarterly and more often if warranted. These notifications will be recorded in the clinical record. *2.) The corrective action taken for those residents found to have*	06/06/2025

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	care plan conference held since 1/15/25. On 5/6/25 at 9:35 A.M., care plan conferences held in 2025 were requested. On 5/7/25 at 10:55 A.M., the Regional Consultant provided a Care Plan Conference Summary, with a completion date 5/6/25 at 12:20 P.M., that indicated a care plan conference was held on 4/15/25 and included Resident 27's POA (power of attorney). During an interview on 5/7/25 at 10:56 A.M., Resident 27's POA indicated she had not been invited to or included in a care plan conference since January 2025. 2. On 5/5/25 at 2:21 P.M., Resident 14's clinical record was reviewed. Resident 14 was admitted on 11/20/24. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/27/25, indicated Resident 14 was moderately cognitively impaired and required supervision from staff for eating, toileting, bathing, and transfers. On 5/5/25 at 2:21 P.M., the clinical record lacked a care plan conference held since 11/27/24. On 5/6/25 at 9:35 A.M., care plan conferences held in 2025 were requested. On 5/7/25 at 10:55 A.M., the Regional Consultant provided a Care Plan Conference Summary, with a completion date 5/6/25 at 12:25 P.M., that indicated a care plan conference was held on 2/27/25.		*been affected by the deficient practice is that* the resident identified as resident # 14 as well as the resident's responsible party have now been invited to participate in a care plan conference for the resident. There is documentation in the clinical record of the notifications of these invitations to the resident and their responsible party. The facility will continue to make these notifications of scheduled care plan conferences at least quarterly and more often if warranted. These notifications will be recorded in the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all care plan conference notifications has now been conducted. The Social Service Director will now be responsible for ensuring that each resident and/or their responsible party is invited to participate in a care plan conference at least quarterly and more often if warranted. The Social Service Director will also be responsible for documenting these invitations to participate in the care plan conferences in the resident's clinical record. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	

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	During an interview on 5/7/25 at 11:14 A.M., the Social Services Director indicated care plan conferences should be held every three months, care plan conferences should be documented in the clinical record when completed, and that Resident 27 and Resident 14's care plan conferences had been backdated or documented late. On 5/8/25 at 10:12 A.M., the Regional Consultant provided an undated policy titled Care Plans Comprehensive Person-Centered, that indicated: "The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: participate in the planning process; participate in establishing the expected goals and outcomes of care; see the care plan and sign it after significant changes are made. The resident is informed of his or her right to participate in his or her treatment, and provide advance notice of care planning conferences. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment." 3.1-3(n)(3) 3.1-35(d)(2)(B)		been provided for the Social Service Director on their responsibility of inviting each resident and/or their responsible party to participate in the resident's care plan conferences. The Social Service Director was also re-educated on their responsibility to ensure that each invitation to participate in a care plan conference is recorded in the resident's clinical record. *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 for compliance. This tool will monitor to ensure that there is documentation in the clinical record to support that the resident and/or their responsible party has been invited to attend and participate in the resident's care plan conferences at least quarterly and more often if warranted. This tool will be completed by the Director of Nursing 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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp			

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	Based on observation, interview, and record review, the facility failed to ensure residents that were self-administering medications were assessed for capability to self-administer medications for 1 of 1 residents observed with medications in their room. (Resident 203) Finding includes: On 5/4/25 at 10:51 A.M., Resident 203 was observed in his recliner with a bottle of Tums on his bedside table. On 5/5/25 at 10:14 A.M., Resident 203 was observed in his recliner with a bottle of Tums on his bedside table. On 5/6/25 at 10:18 A.M., Resident 203's clinical record was reviewed. Diagnoses included, but were not limited to, cellulitis, diabetes mellitus, and obesity. Resident 6 was admitted to the facility on 4/28/25. The Admission Minimum Data Set (MDS) Assessment was still in progress and indicated the resident was cognitively intact. Sections regarding medication and functional abilities had not been completed. Physician orders lacked an order for Tums and a self-administration of medication order. The comprehensive care plan lacked a care plan for self-administration of medications. A Self-Administration of Medication Assessment, dated 4/28/25, indicated that the resident did not wish to self-administer his own medications. On 5/7/25 at 11:12 A.M., the Director of Nursing	F 0554	F - 554 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #203 no longer has any medications at their bedside as they have chosen not to self-administer medications. *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 conducted to ensure that there are no medications at bedside without the proper assessment to support the resident's ability to self-administer. Self-administration of medication assessments will continue to be completed quarterly for those residents who chose to self-administer to ensure their on-going ability to safely self-administer medications. *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 licensed nurses and QMAs on the facility's policy related to the self-administration of medications. The staff was re-educated on their responsibility to ensure that self-administration	06/06/2025

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	(DON) indicated that no one in facility self-administered their own medications. On 5/8/25 at 10:12 A.M., Registered Nurse (RN) 5 provided a current undated Self-Administration of Medication policy that indicated "If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan ... If the team determines that a resident cannot safety self-administer medications, the nursing staff administer the resident's medications ... Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party". 3.1-11(a)		of medication assessments are completed quarterly to ensure the on-going safety of the resident. In addition, the staff was reminded of their responsibility to continue to monitor the resident's environment to ensure only those medications that have been approved for self-administration are safely stored in the resident's room. *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 storage and administration of those medications that have been approved for self-administration. This tool will be completed by the Director of Nursing 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 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for wound treatment, labs were obtained prior to antibiotic use, and antibiotics were administered for the duration ordered for 1 of 3 Residents reviewed for wound treatments. (Resident 14)	F 0658	F - 658 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #14 is now receiving all care and services,	06/06/2025

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	Finding includes: On 5/4/25 at 11:02 A.M., Resident was observed with bilateral feet wrapped with brown bandages over white gauze, no shoes or socks on, and feet directly on the ground. On 5/5/25 at 2:21 P.M., Resident 14's clinical record was reviewed. Resident 14 was admitted on 11/20/24. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/27/25, indicated Resident 14 was moderately cognitively impaired and required supervision from staff for eating, toileting, bathing, and transfers. Physician orders included, but were not limited to: Cleanse bilateral lower extremities (BLE) with wound cleanser, pat dry, apply oil emulsion to top of foot, wrap with Kerlix (an absorbent gauze) from toes to below knees, secure with paper tape, initial and date, every day shift for wound care and as needed for soiled or dislodged dressing, start date 5/1/25. Cefdinir (an antibiotic medication) capsule 300 mg (milligrams) - Give one capsule by mouth two times a day for infection for seven days; start date 5/1/25 through 5/8/25 Enhanced barrier precautions related to wounds on bilateral lower extremities; start date 4/16/25 Current care plans included, but were not limited to: I have non-pressure wounds to my left foot and right foot. Treatment as ordered, medications as		including medications and treatments as ordered by their physician. *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 of all MARs/TARs has been conducted. There is documentation to support that all medications and treatments are now being provided for each resident as ordered by their respective physicians and in accordance with their plan of care. *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 their responsibility to document in the clinical record, the care and services that are being provided for each resident as ordered by their physician and in accordance with the individualized plan of care. Additional education was provided for the licensed nurses and QMAs on their responsibility to document each medication and treatment provided for the resident as ordered by their physician. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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	ordered, keep clean and dry; date initiated: 4/16/25 I am on an antibiotic related to bilateral lower extremities. Administer medication as ordered, monitor for adverse reactions, Notify physician of any concerns; date initiated: 5/1/25 A physician progress note signed by the physician on 5/8/25, indicated the physician assessed Resident 14 on 4/30/25 and ordered Omnicef (cefdinir) 300 mg twice a day for ten days. No additional documentation was in the record as to the changes in duration of the antibiotic with the above order from 10 days to seven days. A treatment order administration record indicated the following order was not administered on 4/30/25: Cleanse bilateral lower extremities with wound cleanser, pat dry, apply oil emulsion to top of foot, wrap with unna boot (a zinc oxide gauze wrap) from toes to below knees, secure with Coban (a compression bandage wrap), initial and date every day shift every Wednesday and Saturday for wound care, started on 4/19/25 and discontinued on 5/1/25. A progress note, dated 5/2/25 at 12:28 A.M., indicated the resident continued with unna boots bilateral legs and feet. A progress note, dated 5/2/25 at 3:13 P.M., indicated the resident continued with unna boots to bilateral legs and feet. A progress note, dated 5/3/25 at 12:51 A.M., indicated the resident continued unna boots to bilateral lower extremities. A progress note, dated 5/3/25 at 2:09 P.M.,		developed and implemented to monitor the documentation in the clinical record to ensure that all physician ordered medications, treatments and other supportive services are being provided in accordance with the plan of care. This tool will be completed by the Director of Nursing 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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	indicated the resident continued with unna boots to bilateral feet. During an interview on 5/8/25 at 8:57 A.M., the Infection Preventionist indicated the facility policy was typically to wait for cultures to come back prior to starting an antibiotic, but Resident 14 did not have a skin culture obtained prior to starting Cefdinir. On 5/8/25 at 10:12 A.M., the Regional Consultant provided a policy titled Medication Orders, dated 6/2008, that indicated: "Medication orders will be accurate, timely, appropriate, and legible." 3.1-18(b) 3.1-48(a)(6)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure residents received consistent implementation of interventions to prevent falls for 4 of 4 residents reviewed for accidents related to falls. Fall interventions were observed out of place. (Resident 6, Resident 28, Resident 46, and Resident 45) Findings include: 1. On 5/5/25 at 1:26 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of the lower end of left radius. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/13/25, indicated Resident 6 was cognitively intact, required partial	F 0689	F - 689 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 6 now has non-skid strips on the floor at bedside. Upon observation of the resident and their room, all safety interventions are now in place in accordance with the plan of care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident #28 now has a motion detector night light in their room. Upon observation of the resident, all safety	06/06/2025

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	to moderate assistance of staff (staff does less than half of the effort) for transferring and toileting, and had one fall with major injury since the prior assessment. A current risk for falls care plan, last revised on 3/5/25, included the following interventions: Anticipate and meet the resident's needs, dated 9/9/19 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, dated 9/9/19 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, dated 9/9/19 Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair, dated 9/9/19 Follow facility fall protocol, dated 9/9/19 Physical therapy (PT) evaluate and treat as ordered or as needed (PRN), dated 9/9/19 The resident needs a safe environment (even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach), dated 9/9/19 Assure resident is centered in bed. Bed enablers to assist with bed mobility, dated 8/24/21 Encourage to rise slowly and wear shoes or gripper socks when ambulating in room, dated 1/18/22 Discussed eye sight and vision with glasses as relates to falls. Will see eye Dr for new glasses, dated 3/2/22 Use of nonskid shoes, encourage to not wear "crocs", dated 1/19/24 Room rearranged, dated 12/6/24 Nonskid strips at bedside, dated 3/5/25		interventions are now in place in accordance with the resident's current plan of care. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 46 now has all fall risk intervention in place and are being consistently followed by facility staff, including not leaving the resident in the room in wheel chair unattended. All fall risk safety interventions are now being consistently followed by the facility staff in an attempt to prevent future falls. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 45 has been reviewed by the interdisciplinary team related to fall risks. All current fall risk interventions are now in place in accordance with the current plan of care. *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 of all residents fall risks has now been conducted. The fall risk care plans have now been reviewed to ensure all appropriate fall risk interventions have been identified	

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	A fall risk assessment was completed on 1/8/25 and the resident was determined to be at risk for falls. On 3/5/25 at 3:30 A.M., Resident 6 had an unwitnessed fall while attempting to self-toilet. An abrasion to the left elbow was noted along with pain with flexing and edema below the elbow. An x-ray of the left humerus (upper arm bone) was ordered. Results were negative for fracture. On 3/5/25 at 3:19 P.M., the physician ordered an x-ray of the left wrist. On 3/6/25 at 2:45 P.M., Resident 6 returned from a visit to an orthopedic urgent care with a cast on her left wrist and a diagnosis of a wrist fracture. A fall risk assessment was completed on 3/5/25 and the resident was determined to be at risk for falls. The IDT met on 3/5/25 and determined the new intervention to be "Nonskid strips at bedside". A social service progress note, dated 4/28/25 at 4:15 P.M., indicated that a care conference was held with the Interdisciplinary Team (IDT), resident, and responsible party, and resident care plans were adequate to resident care with no changes made. On 5/7/25 at 11:10 A.M., Resident 6's room was observed. There were no nonskid strips next to her bed. On 5/7/25 at 2:17 P.M., the Regional Consultant confirmed that there were no nonskid strips next to Resident 6's bed and there should have been.2. On 5/6/25 at 8:27 A.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and repeated falls.		and are in place for each resident to ensure the resident's safety. *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 fall risk policies and procedures and their responsibility to ensure that each resident's fall risk interventions are consistently in place in accordance with their individualized plan of care. *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 resident's fall risk care plans with a focus on ensuring that each identified intervention is consistently in place. This tool will be completed by the Director of Nursing 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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	The current Quarterly Minimum Data Set (MDS) Assessment, dated 2/8/25, indicated Resident 28 was mildly cognitively impaired. The resident needed supervision for eating, dressing, and toileting. Physicians ordered included, but were not limited to: Up with one assist and wheelchair, dated 5/15/20. May participate in activities as tolerated, dated 5/15/20 A care plan conference was conducted on 4/28/25 with revisions to the care plan. The current fall risk care plan, dated 4/28/25, indicated the resident was at risk for falls due to unsteady gait, previous falls, and unaware of safety needs. Interventions included but were not limited to: Place motion sensor night light in room, dated 4/28/25 Encourage resident to ask for assistance for transfers before rising when dizzy, dated 9/6/23 When out with family encouraged to rest and sit when tired, dated 7/10/23 The nursing alert notes, dated 4/26/25 at 2:57 A.M., indicated the resident had an unwitnessed fall when she missed her bed and fell on the floor. The fall risk assessment done at the same time indicated the resident was at a high fall risk. An Interdisciplinary Team (IDT) note, dated 4/28/25 at 9:27 A.M., indicated the intervention that would be in place was the facility would provide a motion sensor night light in the resident's room to provide adequate lighting during nighttime so the resident could see her surroundings.			

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	On 5/6/25 at 8:55 A.M., there was no motion sensor night light observed in Resident 28's room. During an interview on 5/6/25 at 8:58 A.M., Qualified Medicine Aide (QMA) 7 indicated there was no motion detector night light located in the room. 3. On 5/6/25 at 10:31 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and idiopathic aseptic necrosis of the right toes. The current Quarterly Minimum Data Set (MDS) Assessment, dated 4/17/25, indicated Resident 46 was moderately cognitively impaired. Resident 46 needed supervision to eat, was dependent on staff for transferring, and needed partial assistance of staff (staff does less than half of the effort) for hygiene and toileting. Physician orders included but were not limited to: May use a mechanical lift as needed, dated 1/8/25. A care plan conference was conducted on 4/10/25 with revisions to the care plan. The current fall risk care plan, dated 4/10/25, indicated the resident was a fall risk related to decreased mobility, weakness, and history of falls. Interventions included, but were not limited to: Resident is not to be left in wheelchair unattended in room, dated 2/14/25 Re-educate resident on the use of call light, dated 9/17/24 An nursing alert note, dated 2/12/25 at 12:12 P.M., indicated Resident 46 had an unwitnessed fall.			

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	The resident was found sitting on his buttocks on the floor in his room while attempting to transfer himself and fell. The fall risk assessment indicated that the resident was a high fall risk. On 2/14/25 at 3:53 P.M., an Interdisciplinary Team (IDT) note indicated that an appropriate intervention for the resident was to not leave the resident in his wheelchair while in his room unattended and to remove his wheelchair from the room after assisting the resident to bed. On 5/6/25 at 12:08 P.M., Resident 46 was observed alone in his room sitting in his wheelchair waiting for a meal. On 5/7/25 at 9:00 A.M., Resident 46 was observed alone in his room sitting in his wheelchair after breakfast. During an interview on 5/7/25 at 9:46 A.M., Registered Nurse (RN) 5 indicated the resident should be in the dining room if up in the wheelchair and was not to be left in his room unattended. 4. On 5/5/25 at 1:50 P.M., Resident 45's clinical record was reviewed. Resident 45 was admitted on 2/2/24. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/12/25, indicated Resident 45 was severely cognitively impaired, required partial assistance (staff does half of the effort) for toileting, bathing, and transfers, and two or more falls with injury occurred since the previous MDS assessment. Current care plans included, but were not limited to: I am at risk for falls related to impaired gait,			

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	balance, and weakness, dated 2/2/24. Interventions included, but were not limited to: Bed in lowest position while in bed, dated 2/12/24 Place "call, don't fall sign" in bathroom, dated 2/3/25 On 5/6/25 at 11:33 A.M., Resident 45 was resting in bed. The bed was not in the lowest position. The bathroom did not have a "call don't fall" sign. A progress note, dated 5/6/2025 at 1:05 P.M., indicated staff went into the resident's room and a call don't fall sign was not in place. On 5/7/25 at 11:21 A.M., Resident 45 was sitting on the side of the bed. The bed was not in the lowest position. At that time, Resident 45's wife indicated staff did not leave the bed in the lowest position because Resident 45 could not get out of bed when the bed was down that low. On 5/7/25 at 2:08 P.M., the Regional Consultant indicated that once IDT determined a new intervention, it went into place immediately. On 5/8/25 at 10:12 A.M., Registered Nurse (RN) 5 provided a current undated Falls - Clinical Protocol policy that indicated "The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling ... The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling". On 5/8/25 at 10:12 A.M., RN 5 provided a current undated Care Plans, Comprehensive Person-Centered policy that indicated "Each resident's comprehensive person-centered care			

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	plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to...receive the services and/or items included in the plan of care ... The comprehensive, person-centered care plan...describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being". 3.1-45(a)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff Based on record review and interview, the facility failed to ensure the kitchen manager met required qualifications for 1 of 1 dietary manager qualifications reviewed. (Food Services Director) Finding includes: During an interview on 5/5/25 at 9:30 A.M., the Food Services Director (FSD) provided a document that indicated she had been enrolled in a food service manager class from [Program Title] since September 2024 and had not completed it. On 5/7/26 at 10:27 A.M., the employee record for the FSD was reviewed. It indicated she started her role as the FSD on 6/30/24. During an interview on 5/8/25 at 9:11 A.M., the FSD indicated she did not start the management course until September because she did not know which course to be enrolled in. On 5/8/25 at 10:49 A.M., the Regional Consultant Nurse provided a current, non-dated job description for the Director of Food Services that	F 0801	F - 801 *The corrective action taken for those residents found to have 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 facility does have a qualified food service manager as outlined in the State regulation who has met the certification requirements. *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 facility does have a qualified food service manager as outlined in the State regulation who has met the certification requirements.	06/06/2025

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	indicated "the director was to provide leadership training that includes the administrative and supervisory principles essential of the Food Services Department...".		*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 the Executive Director on the Federal and State requirements related to the qualifications of the food service manager to ensure they understand the criteria that must be met to fulfil this position. *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 employee files to ensure there is on-going documentation to support that the current food service manager meets all Federal and State requirements. This tool will be completed by the Regional Consultant Nurse 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. The individual must be a certified dietary manager, certified food service manager or has a similar national certification from a national certifying body for food service management and safety Associate's degree or higher in	

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			food service management or in hospitality, if the course study from an accredited institution includes food service or restaurant management Meets State requirements for food service managers or dietary managers in States that have such established requirements INFORMAL DISPUTE RESOLUTION DESK REVIEW REQUEST May 18, 2025 Suzanne Williams Director Division of Long-Term Care Indiana State Department of Health 2 N. Meridian Street Indianapolis, Indiana 46204 Dear Ms. Williams, On May 8, 2025, an Annual Recertification and State Licensure Survey was conducted at Transcendent Healthcare of Owensville. At the time of the survey the facility was cited under F - 801 "failed to ensure the kitchen manager met required qualifications for 1 of 1 dietary manager qualifications reviewed." The facility respectfully requests an Informal Dispute resolution in the form of a desk review. The facility presents the following information to support the facts that the facility met the guidelines as outlined by the State regulation which we believe supersedes the Federal requirement. The State	

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			regulation reads as follows; The food service director must be one (1) of the following: (1) A qualified dietitian. (2) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year experience in some aspect of institutional food service management. The Federal regulation reads as follows; If the qualified person listed above is not a full-time staff member (35+ hours/week), the facility must designate someone to serve as the Director of Food and Nutrition Services. To be qualified for this role, the individual must: Meet the requirements mentioned above within 5 years after November 28, 2016, or no later than 1 year after November 28, 2016, for staff members designated after November 28, 2016. Receives "frequently scheduled consultations" from a qualified dietitian/nutritional professional The facility's current food service manager was hired on 01-12-21 as a dietary aide. She had previous work experience in the long-term care setting in New Harmony, Indiana in the dietary department as head cook for three years. Prior to that she had worked for several years in the restaurant industry.	

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			While living in California she was Safe Serve certified while working in a bakery. While working at Transcendent she was promoted to dietary team leader on 02-17-21. She was then promoted again on 06-30-24 to food service director and completed the Safe Serv certification on 08-01-23. She then enrolled in the University of North Dakota's food service director's course in September 2024 and will have that course completed within the required year ending in September 2025. She is anticipated to successfully complete this course no later than September 2025. She continues to receive on-going guidance and education from the facility's dietician who visits every week to oversee the overall operations of the dietary department. The dietician is also available by phone should any questions arise in between their weekly visits. Based on the above information, the facility believes that we are in compliance with the regulation F - 801 and respectfully request that this citation be removed. Thank you for your prompt attention to this matter. Respectfully submitted, Mr. Tom O'Niones HFA Executive Director President and Owner of Transcendent Healthcare of Owensville	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, and dated properly in accordance with professional standards for food service for 1 of 2 kitchen observations. (Kitchen) Finding includes: On 5/4/25 at 9:23 A.M., an initial tour of the kitchen was conducted. The following items were observed: In the reach-in freezer: 1 container of butter oil with no open date 4 premade lunches with no preparation date or open date Spice Cabinet: 1 container of oil with no open date 1 container of pumpkin spice with no open date 1 container of ground mustard with no open date 1 container of white pepper with no open date 1 container of spray cooking oil with no open date 1 container of basil with no open date 1 container of garlic powder with no open date 2 containers of parsley flakes with no open date 1 container of thyme with no open date 1 container of mild chili powder with no open date 1 container of onion powder with no open date 1 container of dill weed with no open date 1 container of Margerum with no open date 1 container of rosemary with no open dated Dry Storage: 1 bin of flour with no open date 1 bin of sugar with no open date	F 0812	F - 812 *The corrective action taken for those residents found to have 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. All of the items identified during the survey in the reach in freezer, spice cabinet, dry storage area and the walk-in freezer have been discarded. All food items are now properly labeled, dated and stored in the appropriate areas of the kitchen. The staff will continue to label, date and store all food items received and utilized in the dietary department. *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. All food items are now being labeled, dated and stored in accordance with food safety protocols. *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 policy and procedures related to food	06/06/2025

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	1 bag of panko breadcrumbs with no open date Walk-in Freezer: 1 bag of waffles open to air, not dated During an interview on 5/4/25 at 9:40 A.M., the Cook indicated that spices should be dated when opened. On 5/8/25 at 10:12 A.M., Registered Nurse (RN) 5 provided a current policy "Food Receiving and Storage" that was revised December 2008. The policy indicated "...food shall be stored in a manner that complies with safe food handling practices...dry foods that are stored in bins will be removed from original packages, labeled and dated...all foods stored in the refrigerator or freezer will be covered, labeled, and dated...". 3.1-21(i)(2) 3.1-21(i)(3)		storage. All dietary staff was reminded of their responsibility to ensure that all food items are properly labeled, dated when opened and stored in accordance with the food safety guidelines. *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 storage of food items. The tool will monitor to ensure that all food items are labeled, dated when opened and stored in accordance with food safety guidelines. 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.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed during wound treatment for 1 of 3 Residents reviewed for wound treatments. (Resident 14) Finding includes:	F 0880	F - 880 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 14 is now receiving their wound dressing changes by licensed nurses in	06/06/2025

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	155502	A. BUILDING 00 B. WING	05/08/2025

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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	On 5/4/25 at 11:02 A.M., Resident was observed with bilateral feet wrapped with brown bandages over white gauze, no shoes or socks on, and feet directly on the ground. On 5/5/25 at 2:21 P.M., Resident 14's clinical record was reviewed. Resident 14 was admitted on 11/20/24. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/27/25, indicated Resident 14 was moderately cognitively impaired and required supervision from staff for eating, toileting, bathing, and transfers. Physician orders included, but were not limited to: Cleanse bilateral lower extremities (BLE) with wound cleanser, pat dry, apply oil emulsion to top of foot, wrap with Kerlix (an absorbent gauze) from toes to below knees, secure with paper tape, initial and date, every day shift for wound care and as needed for soiled or dislodged dressing, start date 5/1/25. Enhanced barrier precautions related to wounds on bilateral lower extremities; start date 4/16/25 Current care plans included, but were not limited to: I have non-pressure wounds to my left foot and right foot. Treatment as ordered, medications as ordered, keep clean and dry; date initiated: 4/16/25 During a wound care observation on 5/7/25 at 11:39 A.M., the wound nurse removed Resident 14's dressings from the left and right feet that consisted of gauze wrapped in Coban. The wound nurse performed wound care on the right foot, removed the dressings from the left foot, and		accordance with acceptable standards of infection control practices. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents with wound treatments have the potential to be affected by this deficient practice. All residents with current wounds are now receiving wound dressing changes by licensed nurses in accordance with acceptable standards of infection control practices. *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 nurses on the facility policy related to infection control practice in wound care and dressing changes. All nurses were re-educated on their responsibility in utilizing proper infection control practices during wound dressing changes. *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 infection control practices during wound dressing changes. This tool will monitor to ensure that the nurses are utilizing proper infection control techniques during the changes of wound dressings. This tool will be completed by the	

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	cleansed the left foot. While the wound nurse was performing hand hygiene, Resident 14 rested his left foot with no dressings directly on the floor. The wound nurse applied the dressings to Resident 14's left foot without cleansing the foot after it had made contact with the floor. During an interview on 5/8/25 at 8:57 A.M., the Infection Preventionist indicated that Resident 14's feet, only covered with absorbent dressings, directly on the floor was an infection control concern. On 5/8/25 at 10:12 A.M., the Regional Consultant provided an undated policy titled Wound Care that indicated: "Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier ... Wear sterile gloves when physically touching the wound ...". 3.1-18(b)		Infection Control Preventionist 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 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on interview and record review, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident occupancy rooms in 1 of 34 rooms reviewed. (Room 31) Finding includes: During the entrance conference interview on 5/4/25 at 9:50 A.M., the Administrator in Training (AIT) indicated that room 31 required a room variance waiver to have three residents in the room. A waiver had been applied for and not granted. On 5/5/25 at 2:10 P.M., Registered Nurse (RN) 5	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 specific residents identified to be affected by this deficient practice as there are only two residents in this room and not three. The corrective action taken for the other residents that have 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	06/06/2025

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	provided a document that indicated "Rooms that require a variance: Room 31 measures 70.29 square feet per resident". On 5/8/25 at 9:47 A.M., the Regional Consultant indicated that the facility did not have a room variance policy and followed the federal regulations. 3.1-19(l)(2)(A)		the license for that bed but is not placing three residents in that room. The measures 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. The corrective action taken to monitor to ensure the deficient practice will not recur is that the Executive Director will maintain a file of the submitted room waiver annually.	