

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2016
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189680, Complaint IN00190660, and Complaint IN00190863.</p> <p>Complaint IN00189680 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00190660 - Substantiated. Federal/State deficiencies related to the allegations are cited at F202 and F203 .</p> <p>Complaint IN00190863 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F425, and F514.</p> <p>Survey dates: January 14, 15, and 19, 2016</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 13 Medicaid: 56</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective February 18th 2016 to the state findings of the complaint survey conducted on January 14th, 15th and 19th, 2016.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0202 SS=D Bldg. 00	<p>Other: 5 Total: 74</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on January 20, 2016.</p> <p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under</p>			

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	<p>paragraph (a)(2)(iv) of this section.</p> <p>Based on interview and record review, the facility failed to ensure a resident who received an involuntary discharge notice had revised care plans and interventions to address the resident's needs, and failed to provide documentation from a physician regarding why the resident's needs could not be met, for 1 of 4 residents reviewed for discharge notices, in a sample of 15. Resident C</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 1/14/16 at 2:50 P.M.</p> <p>A Social Services Note, dated 9/15/15 at 3:07 P.M., indicated, "[Resident C] is alert and oriented x 3 able to make her needs and preferences known. Since her admission we have struggled getting her to understand the standards that are in place at the facility. She has had her son take her to the emergency room for a cold. She request [sic] him to bring in over the counter medications that try's [sic] to keep in her room. She is a hoarder and refuses staff to clean her room. We have explained on several occasions the regulations at the facility as well as our concern related to falls in regard to the clutter in her room...She has</p>	F 0202	<p>F - 202</p> <p>It should be noted that in the legal document from the administrative law judge that presided over the notice of transfer/discharge hearing which was conducted on 01-25-16 did determine that the facility had in fact personally provided resident C with the notice of transfer/discharge document on November 30, 2015 which is in compliance with the required 30 day notice. The administrative law judge's ruling was that resident C's appeal was denied and that a hearing on the merits of the reason for the transfer or discharge are moot. It should also be noted that the facility Executive Director did notify the facility ombudsman and provided her with copies of the notice of transfer/discharge form.</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident C no longer resides at the facility. The facility has developed and implemented a policy on involuntary transfer/discharge notice which does include revision of the care plan and physician documentation upon the determination by the interdisciplinary team that an involuntary transfer/discharge notice is warranted based upon review of the resident's financial/clinical records. It should also be noted that a transfer/discharge</p>	02/18/2016

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	<p>been care planned accordingly."</p> <p>Nursing Progress Notes, dated 11/17/15 at 3:40 P.M., indicated, "Resident turned on call light. When CNA [name] entered room resident stated she did not want that particular cna's assistance."</p> <p>Physician's Progress Notes, dated 11/25/15, indicated, "Pt [patient] is doing fairly well. No new symptoms. Continue to [illegible] have static hand tremors. Lungs clear. Heart sounds ok. P [plan] orders reviewed."</p> <p>Social Services Notes included the following notations:</p> <p>11/30/15 at 10:02 A.M.: "Pt [sic] son reported to Executive Director that he was having issues with his mother being very disrespectful and unappreciative. He expressed concern with her ongoing behaviors and her being mean to everyone. Son stated he didn't know what to do to help, but would do what he could. Pt has a history of being extremely disrespectful and rude to staff."</p> <p>11/30/15 at 10:34 A.M.: "Executive Director spoke with pt about her hoarding tendencies in her room. It was explained to pt that the uncleanliness of her room is causing safety hazards which could lead</p>		<p>appeal hearing was conducted at the request of resident C on 01-25-16. The Administration Law Judgedetermined that the facility was completely within their right to discharge the resident due to the inability of the facility to meet the resident's needs based on the resident's continuous non-compliance which placed the safety of the resident at risk.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has conducted an audit of discharged resident's clinical records from the past 30 days. No other residents had been given a 30 day discharge notice.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has conducted a mandatory in-service for all members of the interdisciplinary team on the newly developed involuntary transfer/discharge notice policy. Each member of the interdisciplinary team was instructed on their responsibilities to ensure that the involuntary transfer/discharge policy is followed as outlined by the facility. In addition each attending</p>	

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	<p>to accidents. Pt was asked to clean her room to prevent such accidents."</p> <p>11/30/15 at 10:37 A.M.: "Since conversation with ED [Executive Director] about the cleanliness of her room, it was reported that he patient is now throwing her dirty laundry in the hallway...Pt was educated on why this was inappropriate and dangerous."</p> <p>12/2/15 at 1:58 P.M.: "Addendum to note on 11/30/15 at 10:02...The reason patient was asked to clean her room was because she will not allow staff to clean her room. Patient will only allow certain staff to attend to her needs and promptly directs all other staff to leave her room."</p> <p>A Nursing Note, dated 12/11/15 at 4:33 P.M., indicated, "Res [resident] asked staff to open bottle of medication for her. Staff told her they couldn't do that and she shouldn't have medication in rm [room]. Res states she is perfectly capable of taking care of her medications on her own. Nurse noted no orders for meds in room and res states that is because she sees her Dr and not a Dr from here...Says she gets her meds in the mail and would continue to do so and she will cont to see [name of physician] as she sees fit."</p>		<p>physician has been notified of their responsibility to document in the resident's clinical record upon notification by the facility of the concerns/issues which have prompted the need for a 30 day discharge notice for their resident.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor the compliance of the facility's policy on involuntary transfer/discharge notification. The Quality Assurance tool will audit to ensure that there is documentation to support that the resident's care plan has been revised to include interventions to address the resident's needs. The Quality Assurance tool will also monitor to ensure that there is physician documentation on the clinical record to reflect the reason/issues which have prompted the need for a 30 day transfer/discharge notice to be given to the resident. This tool will be completed by the Social Service Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's regularly scheduled Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>A "Plan of Care Note," dated 12/15/15 at 10:54 A.M., indicated, "Care plan conference...[Administrator] explaining that her shower time is important... [Administrator] now going over medications, explaining that we have guideleines [sic] that we have to follow. We are unsure of the medications she is on d/t [due to] her having them in her room...[Administrator] has brought up her refusing care with certain CNAs...now brought up accdients [sic] and supervision r/t [related to] her room being cluttered...Financial conversation has now come up...[Resident C] has refused to pay the full amount for September and October. [Resident C] has voiced that she does not have to pay her co pay...[Resident C] still owes copays for February and March...In order to make her account current, [Resident C] owes the facility \$19.037.00...."</p> <p>Physician Progress Notes, dated 12/31/15, indicated, "Pt is doing well. No aches or pains. Lungs clear. Heart sounds ok...orders reviewed."</p> <p>A Social Services Note, dated 1/6/16 at 4:02 P.M., indicated, "Care Conference held today with President, Executive Director, Social Services Director, Director of Business Office Services, the Resident and her son. A conference was</p>			

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	<p>called due to the resident continuing to be non-compliant to the extent that discharge is the only option. On 11/30/15, the resident was given a 30-day discharge notice, along with a rate increase letter, due to her having an outstanding bill and increased non-compliance with care and safety. A care conference was held on 12/15/15 to address concerns and non-compliance. Since the care conference on 12/15/15, the resident has continued to have an outstanding bill in excess of \$20,000, the resident has continued to be non-compliant with her care plan and has not the addressed the safety concerns and uncleanliness of her room, related to her hoarding tendencies. It was explained to the resident and her son that it is evident that our facility cannot meet the unrealistic needs of the resident and she would better be served elsewhere."</p> <p>A "Notice of Transfer or Discharge," dated 1/7/16, included: "Resident is being transferred to: home...Reason for Transfer or Discharge: The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility."</p> <p>A Care Plan, dated 7/15/15, indicated, "[Resident C] is non-compliant r/t medications and ordering medications</p>			

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	<p>from the pharmacy. Interventions: Explain the importance of ordering and receiving [sic] medications in a timely manner. If she chooses not to allow staff to order medications from our pharmacy, encourage her to order the medications from her pharmacy of choice in a timely manner." The Care Plan Goal indicated it was revised on 12/10/15, but there were no interventions dated after 7/15/15.</p> <p>A Care Plan, dated 8/21/15, indicated, "[Resident C] leaves to go to the emergency department and brings back medications and keeps them in her room without staff knowing. Interventions: 1:1 attention regarding her health. Date Initiated: 12/10/2015."</p> <p>A Care Plan, dated 9/15/15, indicated, "The resident exhibits hoarding behavior, non-adherent behavior r/t care, housekeeping, medications, maintenance (extension cords). Interventions included: Anticipate and meet the resident's needs. Caregivers to provided [sic] opportunity for positive interaction, attention. Educate the resident/family/caregivers on successful coping and interaction." The Care Plan indicated it was revised on 12/10/15, but there were no interventions documented after 9/15/15.</p> <p>On 1/15/16 at 9:25 A.M., during an</p>			

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	<p>interview with the Administrator, he indicated he had given Resident C an involuntary discharge notice on 11/30/15, effective 12/30/15. He indicated the resident would not let staff clean her room, was hiding medications, and owed the facility \$21,000. The Administrator indicated the resident would not let the physician see her. He indicated the resident left the facility on 1/7/16. He indicated the facility notified the ombudsman of the transfer on 1/7/16, but not during the 11/30/15 transfer notice. The Administrator provided a "soft file" of documents related to the transfer.</p> <p>The soft file contained a "Notice of Transfer of Discharge," dated 11/30/15, and indicated, "Reason for Transfer or Discharge, The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility." The notice was not signed by the resident. A handwritten notation indicated, "Copy given to [Resident C] 11-30-15 [with] rate letter increase."</p> <p>The soft file also contained a statement, dated 11/30/15, and written by the Administrator. The statement indicated: "RE: [Resident C's anticipated non compliance]. We distributed our private rate letter increase notifications on November 30th 2015 effective January</p>			

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	<p>1st 2016. [Resident C] has a history of not paying her bill while at [the facility]...With [Resident C's] letter, I have attached a 30 day discharge notice. I anticipate [Resident C] will either refuse to pay the increase or she will continue to be non-compliant with her plan of care. [Resident C's] noncompliance with her plan of care includes but is not limited to, refusing to let us clean her room, hording [sic] medications in room, refusing to see our doctor, has son transfer to emergency room and doesn't tell any of our staff, refuses to allow us to remove extension cords in room, etc."</p> <p>The soft file also contained a Social Service Note, dated 12/1/15. The note indicated, "SSD [Social Services Director] went to Resident's room as requested. Resident needed help with something on her computer. SSD helped her with her needs. SSD noticed that the resident had opened the rate increase letter and discharge notice she was given on 11/30/15, but had pushed it to the side in a pile of papers. SSD informed resident that she did not need to ignore the importance of the letters she was given and handed the papers to her. She pushed it aside and said she will address it when she has the time. SSD received another copy of the rate increase letter and discharge notice and took another</p>			

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	<p>copy down to the resident. Resident acknowledged the importance and urgency of the letter, but said she would deal with it later, as she was too involved in her book right now. Before leaving the room, SSD reminded the resident if she has questions about anything to let her know and that answers would be given, even if we needed to have a care conference."</p> <p>On 1/15/16 at 1:55 P.M., during an interview with the SSD, she indicated there was not a specific care plan conference prior to 11/30/15 in which facility staff addressed the resident's issues and informed the resident that she would be given an involuntary discharge notice. The SSD indicated she did not specifically inform the resident about the discharge notice on 12/1/15.</p> <p>On 1/19/16 at 10:00 A.M., during an interview with the Administrator, he indicated the facility did not have a specific policy regarding involuntary discharges.</p> <p>This Federal tag relates to Complaint IN00190660.</p> <p>3.1-12(a)(5)</p>			

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F 0203 SS=D Bldg. 00	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under</p>			

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	<p>paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on interview and record review, the facility failed to ensure the resident</p>	F 0203	F - 203	02/18/2016	

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	<p>and family member were notified of a resident's discharge notice 30 days prior to discharge, for 1 of 4 residents reviewed for discharge notices, in a sample of 15. Resident C</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 1/14/16 at 2:50 P.M.</p> <p>Social Services Notes included the following notations:</p> <p>11/30/15 at 10:34 A.M.: "Executive Director spoke with pt [patient] about her hoarding tendencies in her room. It was explained to pt that the uncleanliness of her room is causing safety hazards which could lead to accidents. Pt was asked to clean her room to prevent such accidents."</p> <p>A "Plan of Care Note," dated 12/15/15 at 10:54 A.M., indicated, "Care plan conference...[Administrator] explaining that her shower time is important... [Administrator] now going over medications, explaining that we have guideleines [sic] that we have to follow. We are unsure of the medications she is on d/t [due to] her having them in her room...[Administrator] has brought up her refusing care with certain</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident C no longer resides at the facility. The facility has developed and implemented a policy on involuntary transfer/discharge notice which does include the direction that the facility will schedule a care conference with the resident and/or responsible party at the time that an involuntary discharge notice is given to the resident. Copies of the discharge notice will be provided to the resident and/or responsible party at the time of the care conference. It should also be noted that a transfer/discharge appeal hearing was conducted at the request of resident C on 01-25-16. The Administration Law Judge indicated in his ruling that resident C was her own personal representative in that she did not have a power of attorney or a guardian and that she had received the Notice of Transfer/Discharge in a timely manner (30 days).</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has conducted an audit of discharged resident's clinical records from the past 30 days. No other residents had been given a 30 day discharge notice.</i></p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice</p>	

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	<p>CNAs...now brought up accidents [sic] and supervision r/t [related to] her room being cluttered...Financial conversation has now come up...[Resident C] has refused to pay the full amount for September and October. [Resident C] has voiced that she does not have to pay her co pay...[Resident C] still owes copays for February and March...In order to make her account current, [Resident C] owes the facility \$19,037.00...."</p> <p>A Social Services Note, dated 1/6/16 at 4:02 P.M., indicated, "Care Conference held today with President, Executive Director, Social Services Director, Director of Business Office Services, the Resident and her son. A conference was called due to the resident continuing to be non-compliant to the extent that discharge is the only option. On 11/30/15, the resident was given a 30-day discharge notice, along with a rate increase letter, due to her having an outstanding bill and increased non-compliance with care and safety. A care conference was held on 12/15/15 to address concerns and non-compliance. Since the care conference on 12/15/15, the resident has continued to have an outstanding bill in excess of \$20,000, the resident has continued to be non-compliant with her care plan and has not the addressed the safety concerns and</p>		<p>does not recur is that that the facility has conducted a mandatory in-service for all members of the interdisciplinary team on the newly developed involuntary transfer/discharge notice policy. Each member of the interdisciplinary team was instructed on their responsibilities to ensure that the involuntary transfer/discharge policy is followed as outlined by the facility. The in-service included the instructions per facility policy that a care plan meeting will be conducted by the interdisciplinary team and the written involuntary notice of transfer/discharge will be given to the resident and/or responsible party at that time. The interdisciplinary team was also instructed on their responsibility to answer any questions that the resident and/or responsible party may have and will assist the resident in the necessary arrangements for their transfer if they so desire.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is by the development and implementation of a Quality Assurance tool to monitor the compliance of the facility's policy on involuntary transfer/discharge notification. The Quality Assurance tool will audit to ensure that there is documentation to support that any resident receiving an involuntary</i></p>	

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	<p>uncleanliness of her room, related to her hoarding tendencies. It was explained to the resident and her son that it is evident that our facility cannot meet the unrealistic needs of the resident and she would better be served elsewhere."</p> <p>A "Notice of Transfer or Discharge," dated 1/7/16, included: "Resident is being transferred to: home...Reason for Transfer or Discharge: The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility."</p> <p>On 1/15/16 at 9:25 A.M., during an interview with the Administrator, he indicated he had given Resident C an involuntary discharge notice on 11/30/15, effective 12/30/15. He indicated the resident would not let staff clean her room, was hiding medications, and owed the facility \$21,000. The Administrator indicated the resident would not let the physician see her. He indicated the resident left the facility on 1/7/16. He indicated the facility notified the ombudsman of the transfer on 1/7/16, but not during the 11/30/15 transfer notice. The Administrator provided a "soft file" of documents related to the transfer.</p> <p>The soft file contained a "Notice of Transfer of Discharge," dated 11/30/15,</p>		<p>discharge is notified of this involuntary discharge in writing thirty days prior to the discharge. The tool will also monitor to ensure that the resident and/or responsible party has had the opportunity to attend a care conference to discuss the involuntary discharge thirty days prior to the date of discharge. This tool will be completed by the Social Service Director and/or other 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 regularly scheduled Quality Assurance meeting to determine if any additional action is warranted.</p>		

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	<p>and indicated, "Reason for Transfer or Discharge, The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility." The notice was not signed by the resident. A handwritten notation indicated, "Copy given to [Resident C] 11-30-15 [with] rate letter increase."</p> <p>The soft file also contained a statement, dated 11/30/15, and written by the Administrator. The statement indicated: "RE: [Resident C's anticipated non compliance]. We distributed our private rate letter increase notifications on November 30th 2015 effective January 1st 2016. [Resident C] has a history of not paying her bill while at [the facility]...With [Resident C's] letter, I have attached a 30 day discharge notice. I anticipate [Resident C] will either refuse to pay the increase or she will continue to be non-compliant with her plan of care. [Resident C's] noncompliance with her plan of care includes but is not limited to, refusing to let us clean her room, hording [sic] medications in room, refusing to see our doctor, has son transfer to emergency room and doesn't tell any of our staff, refuses to allow us to remove extension cords in room, etc."</p> <p>The soft file also contained a Social Service Note, dated 12/1/15. The note</p>			

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	<p>indicated, "SSD [Social Services Director] went to Resident's room as requested. Resident needed help with something on her computer. SSD helped her with her needs. SSD noticed that the resident had opened the rate increase letter and discharge notice she was given on 11/30/15, but had pushed it to the side in a pile of papers. SSD informed resident that she did not need to ignore the importance of the letters she was given and handed the papers to her. She pushed it aside and said she will address it when she has the time. SSD received another copy of the rate increase letter and discharge notice and took another copy down to the resident. Resident acknowledged the importance and urgency of the letter, but said she would deal with it later, as she was too involved in her book right now. Before leaving the room, SSD reminded the resident if she has questions about anything to let her know and that answers would be given, even if we needed to have a care conference."</p> <p>On 1/15/16 at 1:55 P.M., during an interview with the SSD, she indicated there was not a specific care plan conference prior to 11/30/15 in which facility staff addressed the resident's issues and informed the resident that she would be given an involuntary discharge</p>			

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	<p>notice. The SSD indicated she did not specifically inform the resident about the discharge notice on 12/1/15.</p> <p>On 1/19/16 at 10:00 A.M., the Administrator provided a copy of the facility's current policy on "Notice of a Transfer and/or Discharge," dated 4/15/15. The policy included: "Our facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30) day written notice of an impending transfer or discharge...."</p> <p>This Federal tag relates to Complaint IN00190660.</p> <p>3.1-12 (a)(6)(A) 3.1-12(a)(7)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was administered as ordered by the physician, for 1 of 8 residents reviewed for medications given, in a sample of 15. Resident J</p> <p>Findings include:</p> <p>On 1/15/16 at 8:50 A.M., during observation of a medication pass, QMA # 1 was observed to administer Resident J medications including Lasix 20 mg [a</p>	F 0282	<p>F - 282</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that upon review of resident J.'s medication record the resident is receiving all medications in accordance with their current physician's orders.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all medication records has been completed and each resident is receiving their medications in accordance with their physician's orders. If the medication has not been administered there is supportive</i></p>	02/18/2016

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	<p>medication used to treat high blood pressure].</p> <p>On 1/15/16 at 9:00 A.M., the clinical record of Resident J was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, history of stroke, and hypertension.</p> <p>Physician's orders, initial date unknown but on the current January 2016 recertification orders, indicated: "Lasix 40 mg [one] po [by mouth] Q [every] day," and "Lasix 20 mg [one] po daily as needed."</p> <p>At that time, during an interview with QMA # 1, he indicated he mistakenly gave the Lasix 20 mg to Resident J. He indicated he picked up the wrong medication card.</p> <p>On 1/19/16 at 10:00 A.M., the Administrator provided the current facility policy on "Medication Administration," revised 7/22/15. The policy included: "The licensed nurse and/or QMA shall administer each resident's medications in accordance with the physician's orders and the resident's plan of care."</p> <p>This Federal tag relates to Complaint IN00190863.</p>		<p>documentation to reflect that the physician has been notified and additional instructions have been given by the physician.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised its policy on medication administration. A mandatory in-service has been provided for all licensed nurses and QMAs on the facility's revised medication administration policy. The in-service advised the nurses and QMAs of their responsibility to ensure that each resident received their medications in accordance with the physician's orders and if the resident did not receive a medication for whatever reason that the nurse must notify the physician and obtain further direction if warranted. The nurses were also instructed that it is their responsibility to document in the clinical record the notification of the physician.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is by the development and implementation of a Quality Assurance medication administration audit tool. This tool will be a visual observation of the licensed nurses and QMAs during medication administration.</i></p>	

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	3.1-35(g)(2)		This tool will also monitor the resident's medication records to ensure that the resident is receiving their medications in accordance with the physician's orders. The tool will also monitor to ensure that if the resident does not receive their medication for any reason that there is documentation to support that the physician has been notified and additional instruction provided if warranted. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's regularly scheduled Quality Assurance meeting to determine if any additional action is warranted.		
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.				

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	<p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on interview and record review, the facility failed to obtain and reorder a prescription for Xanax [an anti-anxiety] medication, and failed to administer the Xanax as ordered for 20 days, for 1 of 3 residents reviewed who received psychotropic medications, in a sample of 15. Resident G</p> <p>Finding include:</p> <p>The clinical record of Resident G was reviewed on 1/14/16 at 1:25 P.M. A Physician's order, initially dated 6/29/15 and on the November 2015 recertification orders, indicated, "Xanax [an anti-anxiety] medication 0.25 mg Take 1 tablet by mouth twice daily. Dx [diagnosis]: nerves."</p> <p>An additional Physician's order, dated 11/25/16, indicated, "DC [discontinue] Xanax."</p>	F 0425	<p>F - 425 The corrective action taken for those residents found to be affected by the deficient practice is that resident G's physician was notified related to the need of a new prescription for the resident's Xanax. The physician decided to discontinue the medication. Upon review of the resident's medication record the resident is receiving all of their medications in accordance with the current physician's orders. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of the medication records has been completed. All resident are receiving their medications in accordance with their current physician's orders in that prescriptions have been obtained in a timely manner to ensure all medications are readily available for administration to each resident. The measures or systematic changes that have been put into place to ensure that the deficient practice does not</i></p>	02/18/2016

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	<p>The resident's Medication Administration Record [MAR], dated November 2015, indicated the resident was to receive Xanax at 8:00 A.M. and 8:00 P.M.</p> <p>Circled initials were observed from 11/5/15 through 11/24/15 at 8:00 A.M. The reverse page of the MAR indicated, "11/6 0800 [8:00 A.M.] Xanax 0.25 mg po, Reason Med unavailable." Documentation of the reasons for the other circled initials was not found in the clinical record.</p> <p>Nurse's Notes from 11/6/15 through 11/24/15 did not indicate a reason the resident was not receiving the Xanax, nor if the physician was notified.</p> <p>On 1/19/16 at 10:50 A.M., during an interview with Unit Manager # 1, she was aware that the resident had not received the Xanax. She indicated that when a resident requires a "hard script" from the physician, as was required for Xanax, the pharmacy was to notify the facility, and the nurse was to notify the physician. She indicated in the past, the pharmacy and the facility would notify the physician. She indicated she had implemented a new policy, and had instructed staff to "pull the drug label when there was a week's worth of pills remaining." She indicated that she had also started reviewing every</p>		<p>recur is that the facility has reviewed its practices related to obtaining prescriptions in a timely manner to ensure all medications are readily available for each resident. A mandatory in-service has been provided for all licensed nurses and QMAs on the facility's new practice on ensuring that prescriptions are obtained in a timely manner to ensure availability of the medications for each resident. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is by the development and implementation of a Quality Assurance tool which monitors to ensure that prescriptions are obtained for those medications requiring a prescription in a timely manner. The tool will also monitor to ensure that medications are reordered in a timely manner to ensure that all medications are readily available for administration in accordance with the physician's orders. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's regularly scheduled Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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F 0514 SS=D Bldg. 00	<p>resident who required "hard scripts" on Wednesdays, so that a resident would not run out of drugs during the weekend. Unit Manager # 1 indicated the staff had informed her that the resident had actually been less lethargic while off of the Xanax, and the physician was notified and the medication was discontinued.</p> <p>This Federal tag relates to Complaint IN00190863.</p> <p>3.1-25(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;</p>			

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	<p>readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was complete on a resident's Medication Administration Record (MAR), for 1 of 3 residents reviewed for complete documentation of MARs, in a sample of 15. Resident G</p> <p>Findings include:</p> <p>The clinical record of Resident G was reviewed on 1/14/16 at 1:25 P.M.</p> <p>The resident's MAR, dated November 2015, indicated the resident was to receive "Xanax [an anti-anxiety medication] 0.25 B.I.D. [twice daily] Dx [diagnosis]: Nervous Disorder" at 8:00 A.M. and 8:00 P.M.</p> <p>Circled initials were observed from 11/5/15 through 11/24/15 at 8:00 A.M. The reverse page of the MAR indicated,</p>	F 0514	<p>F - 514</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that upon review of the medication record of resident G there is documentation to support that the resident is receiving their medication in accordance with the physician's orders. If for any reason the medication would be circled indicating that the medication was not administered, there is documentation to explain why the medication was not administered and there is physician notification documented in the clinical record.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed of all medication records. There is documentation to support that the residents are receiving their medications in accordance with the physician's orders. If for any reason the medication is circled indicating that the medication was not administered there is documentation to support that the physician has been notified of</i></p>	02/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2016
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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	<p>"11/6 0800 [8:00 A.M.] Xanax 0.25 mg po, Reason Med unavailable." Documentation of the reasons for the other circled initials was not found in the clinical record.</p> <p>Nurse's Notes from 11/6/15 through 11/24/15 did not indicate a reason the resident was not receiving the Xanax.</p> <p>On 1/19/16 at 10:50 A.M., during an interview with Unit Manager # 1, she indicated staff had been educated to document the reason a medication was not given.</p> <p>On 1/19/16 at 10:00 A.M., the Administrator provided the current facility policy, "Medication Administration," revised 7/22/15. The policy included: "Any medications which are not administered as ordered will be circled with an explanation documented in the clinical record. The physician will be notified of any missed doses as medically warranted."</p> <p>This Federal tag relates to Complaint IN00190863.</p> <p>3.1-50(a)(1)</p>		<p>the omission in administering the medication and the reason for the omission, e.g. resident refusal, etc.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised its policy on medication administration. The policy now reflects the required documentation needed if a medication is not administered as ordered. The policy also includes the required documentation of physician notification when a medication is not administered for any reason. A mandatory in-service has been conducted for all licensed nurses and QMAs on the facility's revised medication administration policy. The QMAs were instructed on their responsibility of reporting missed doses to the licensed nurse. The licensed nurses were instructed on their responsibility of physician notification of missed doses and the documentation of this notification.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is by the development and implementation of a Quality Assurance tool. This tool will monitor the resident's medication records to ensure that the resident is</i></p>	

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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601		
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			receiving their medications in accordance with the physician's orders. The tool will also monitor to ensure that if the resident does not receive their medication for any reason that there is documentation to support that the physician has been notified and additional instruction provided if warranted. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's regularly scheduled Quality Assurance meeting to determine if any additional action is warranted.		