

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  02/02/2016
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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 IN00191412.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00191412- Substantiated Federal/State deficiencies related to the allegations are cited at F 353.</p> <p>Survey dates: January 26, 27, 28, 29, and February 1 and 2, 2016</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 1000266240</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payer type: Medicare: 16 Medicaid: 54 Other: 6 Total: 76</p> <p>These deficiencies also reflect State findings cited in accordance with 410</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 March 3, 2016 to the state findings of the Complaint survey conducted on January 26, 27, 28, 29 and February 1 and 2, 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 0353 SS=E Bldg. 00	<p>IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on February 10, 2016.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse</p>			

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	<p>on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available to provide services on 1 of 3 nursing units. (West Unit, Confidential Family Interview, Resident G, Resident L, Resident J, Resident H, Resident Z, Resident K)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During a confidential family interview on 1/26/16 at 3:52 P.M., the interviewee indicated the facility did not have enough staff.</li> <li>2. During an interview on 1/27/16 at 8:30 A.M. Resident #G indicated he/she had requested to get out of bed at 6:00 A.M. that morning and was still waiting. Resident G further indicated the facility was short on help.</li> <li>3. During a random observation on 1/27/16 at 9:00 A.M., Resident L was observed propelling through the West unit dining room towards the hallway in a wheelchair and stated, "Oh, help me, it hurts!" At that time, LPN #15 and the WCN (Wound Care Nurse) were observed standing at medication carts in the West Unit dining room, the DON</li> </ol>	F 0353	F – 353 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the facility hasreviewed the needs of all residents on the West Unit, as the identity of thoseresidents mentioned in the survey is confidential. The facility has reviewed its staffingpatterns to ensure that the staffing patterns meets or exceeds the needs of theresidents. Each resident on the WestUnit is now receiving the necessary care and services to meet theirindividualized needs in a timely manner. The corrective action takenfor the other residents having the potential to be affected by the samedeficient practice is thatsince all residents on the West Unit have the potential to be affected by thisdeficient practice, the facility has reviewed the needs of all residents on theWest Unit. The facility has reviewed itsstaffing patterns to ensure that the staffing patterns meets or exceeds theneeds of the residents. Each resident onthe West Unit is now receiving the necessary care and services to meet theirindividualized needs in a timely manner. The measures that have beenput into place to ensure that the deficient practice does not recur is that a mandatory in-service has beenprovided for all staff on their responsibility to ensure that each	03/03/2016

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	<p>(Director of Nursing) and UM (Unit Manager) #1 were observed standing at the nursing station. Housekeeper #5 was observed to approach Resident L and state, "...what do you need..." During an interview, at that time, Resident L stated, "I need to go to the bathroom" and Housekeeper #5 then stated, "I will get someone". Housekeeper #5 was then observed to walk past the nursing station, LPN #15, the WCN, the DON, the UM #1 and enter a resident room. Resident L was then observed to enter a resident room and was observed to moan and stated, "Oh hurry up!". The AD (Activity Director) was then observed, at that time, to approach Resident L and stated, "what do you need?" Resident L stated, "My bladder is full, it hurts so bad!" The AD was observed to exit the resident room and stated, "I am going to get some help" CNA #2 was observed to enter the room at 9:20 A.M. and transport Resident L to the bathroom.</p> <p>4. During an interview on 1/27/16 at 10:45 A.M., Resident J indicated sometimes he/she rings the call light and no staff come to assist him/her.</p> <p>5. During an interview on 1/27/16 at 11:00 A.M. Resident H indicated the facility was frequently short of staff during the night.</p>		<p>residentreceives the necessary care and services to meet their individualized needs in a timely manner. <i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that each resident is receiving the necessary care and services by facility staff in a timely manner. This tool will include observation of staff providing care in addition to resident interviews. 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 Quality Assurance meeting to determine if any additional action is warranted.</i></p>				

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	<p>6. The CNA assignment sheets provided by the DON on 1/27/16 at 2:00 P.M., indicated the following:</p> <p>West Hall: (Total of 36 residents): Required assist of staff for transfers: 36 residents Require assist of 2 staff for transfer: 18 residents At risk to experience a fall: 15 residents Required mechanical lift for transfer: 4 residents Required staff assistance for ADL (Activity of Daily Living) care: 36 residents Incontinent of bladder and/or scheduled toileting plan: 15 residents</p> <p>7. During an interview 1/28/16 at 10:30 A.M. the MDS (Minimum Data Set) Coordinator indicated the West Unit census was 36. The MDS Coordinator further indicated the following: Required assist of staff for transfers: 28 residents At risk to experience a fall: 24 residents Experienced cognitive impairment: 21 residents Experienced pressure related skin impairment: 4 residents At risk to experience pressure related skin impairment: 36 residents</p>			

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	<p>8. During an interview on 1/28/16 at 10:50 A.M., the DON indicated the nursing staff on the West unit nursing staff typically worked 12 hour shifts. The DON further indicated the West unit was usually staffed with 2 nurses with 3 CNA's on the first shift and 1 nurse with 3 CNA's on the second shift. The DON then indicated the unit managers don't have set hours, but are usually on the unit by 8:00 A.M. The DON then provided the daily staffing schedules as worked from 1/1/16 through 1/27/16. The schedules indicated the following:</p> <p>West Unit:</p> <p>1/10/16: 6:00 A.M. to 9:00 A.M.-1 RN/LPN and 1:00 P.M. to 6:00 P.M.-1 RN/LPN</p> <p>1/11/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 2:00 P.M. to 6:00 P.M.-1 CNA, and 12:00 A.M. to 6:00 A.M.-2 CNA's</p> <p>1/12/16: 2:00 P.M. to 8:00 P.M.- 2 CNA's, 8:00 P.M. to 2:00 A.M.-1 CNA, and 2:00 A.M. to 6:00 A.M.-2 CNA's</p>			

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	1/13/16: 6:00 P.M. to 6:00 A. M.-2 CNA's			
	1/15/16: 10:00 P.M. to 6:00 A.M.-2 CNA			
	1/16/16: 2:00 P.M. to 6:00 P.M.-1 LPN and 9:00 P.M. to 6:00 A.M.-2 CNA's			
	1/18/16: 6:00 P.M. to 6:00 A.M.-2 CNA's			
	1/20/16: 10:00 P.M. to 6:00 A.M.-2 CNA's			
	1/21/16: 6:00 A.M. to 8:00 A.M.-2 CNA's and 6:00 P.M. to 6:00 A. M.- 2 CNA's			
	1/22/16: 12:00 A.M. to 6:00 A.M.-1 CNA			
	1/23/16: 6:00 A.M. to 8:00 A.M.-1 CNA and 8:00 P.M. to 6:00 A.M.-2 CNA's			
	1/24/16: 6:00 A.M. to 8:00 A.M.-1 CNA			

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	<p>1/25/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 2:00 P.M. to 4:00 P.M.-2 CNA's, 4:00 P.M. to 6:00 P.M.-1 CNA, and 6:00 P.M. to 6:00 A. M.-2 CNA's</p> <p>1/26/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 6:00 A.M. to 8:30 A.M.-1 CNA 6:00 P.M. to 10:00 P.M.- The staffing sheet lacked any documentation to indicate a nurse was assigned, 6:00 P.M. to 6:00 A. M.- 2 CNA's</p> <p>1/27/16: 2:00 P.M. to 6:00 P.M.-1 LPN and 2 CNA's 6:00 P.M. to 8:00 P.M.-1 LPN. 8:00 P.M. to 10:00 P.M.-The staffing sheet lacked any documentation to indicate a nurse was assigned. 6:00 P.M. to 6:00 A.M.-1 CNA</p> <p>9. During a random observation on 2/1/16 at 2:35 P.M. Resident Z was observed sitting in a wheelchair, at a table in the main dining room, moaning. During an interview, at that time, Resident Z indicated he/she needed</p>			

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	<p>assistance to go to the bathroom. QMA #10 was then alerted to the request of Resident Z. QMA #10 was observed to transfer Resident Z from the main dining room to the West dining room and speak to CNA #16. QMA #10 was then observed to exit the West Unit dining room. CNA #16 was then observed to place Resident Z at a dining room table, near the nursing station, and exit the West Unit dining room. CNA #16 was observed to not speak to any other staff member before exiting the West Unit dining room. Resident Z was observed from 2/1/16 at 2:37 P.M. through 2:55 P.M. waving at passing staff, moaning, and stating, "please, please". During that time, the UM #1 was observed sitting at the nursing station and the DON was observed standing at the nursing station. On 2/1/16 at 2:55 P.M., the WCN was observed to alert CNA #6 to Resident Z's request and CNA #6 was observed to transfer Resident Z to the bathroom.</p> <p>10. During an interview on 2/1/16 at 2:44 P.M., UM #1 indicated the West Unit current census was 34. UM #1 further indicated the following: Required assist of staff for transfers: 17 residents Required mechanical lift for transfer: 2 residents Required assist of two staff for bed</p>			

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	<p>mobility: 4-5 residents At risk to experience a fall: 14 residents Experienced cognitive impairment: 28 residents Required staff assistance for ADL care: 34 residents Incontinent of bladder and/or scheduled toileting plan: 34 residents At risk to experience pressure related skin impairment: 34 residents</p> <p>11. The Resident Council minutes from November 2015 through January 2016 were reviewed on 2/2/16 at 10:00 A.M. and indicated the following, "...November 2015...they get to [Resident K] too late to roll...bed down...December 2015...they are a little shorthanded sometimes..."</p> <p>12. On 2/2/16 at 2:30 P.M., the HFA (Health Facilities Administrator) indicated all staff should be assisting residents and it should be the usual practice of the facility to ensure staffing was sufficient to meet the needs of the residents.</p> <p>The Policy and Procedure for Staffing provided by the HFA on 2/2/16 at 2:50 P.M. indicated, "...Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and</p>			

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	<p>licensed nursing staff are available to provide...resident care services...Our facility publicly posts the daily staffing patterns each day to reflect the specific numbers of licensed and unlicensed staff that are available to provide direct patient care on each shift..."</p> <p>This Federal tag relates to Complaint IN00191412.</p> <p>3.1-17(a) 3.1-17(b)</p>			