

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, and 15, 2014</p> <p>Facility number: 000450 Provider number: 155801 AIM number: 100273890</p> <p>Survey team: Anna Villain, RN TC Barbara Fowler, RN Denise Schwandner, RN Diana Perry, RN Diane Hancock, RN (9/8, 9/9, 9/11, 9/15)</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 6 Medicaid: 31 Other: 8 Total: 45</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>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 10/10/2014 to the state findings of the recertification survey conducted on September 8th, 9th, 10th, 11th and 15th, 2014.</p>	

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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F000160 SS=A	<p>Quality review completed on September 19, 2014 by Jodi Meyer, RN</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>Based on record review and interview, the facility failed to ensure personal funds were conveyed within 30 days of 1 of 1 resident's death, in that the funds remained in the account 2 months after the resident's death. (Resident #41)</p> <p>Finding includes:</p> <p>The Business Office Manager (BOM) provided a list of residents with funds managed by the facility on 9/11/14 at 2:20 p.m. The list included, but was not limited to, Resident #41. The resident had a balance of \$26.65 in the resident trust account.</p> <p>The BOM was interviewed on 9/11/14 at 2:30 p.m. She indicated Resident #41 had died on 7/6/14. She indicated the resident's family wanted to leave the money in the account in case a haircut or</p>	F000160	<p>1</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that the responsible party for the resident identified as resident # 41 has received the monies which were in their resident trust fund.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that an audit of all resident trust funds was conducted to ensure that all discharged residents had received their monies from the resident trust fund in a timely manner. (within 30 days of discharge)</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 a one on one in-service was conducted for the office manager on the facility policy and procedure of returning all monies in a resident trust fund to the</p>	10/10/2014

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	<p>something else came up that needed paid for.</p> <p>The BOM indicated she was planning to write a check to the family. When queried about the time frame for conveying funds after a resident has died, she indicated she was unaware of the 30 day requirement.</p> <p>The policy and procedure for Resident Funds was provided by the Administrator on 9/15/14 at 2:41 p.m. The policy included, but was not limited to, the following: "After discharge of a resident, the facility shall refund to the appropriate party/parties, the remaining balance in the resident trust account, within 30 days per regulation."</p> <p>3.1-6(h)</p>		<p>resident and/or responsible party within 30 days of discharge.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that any resident that is discharged from the facility and has monies in the residents' trust fund will receive those monies within 30 days of discharge. This tool will be completed by the Executive Director and/or his designee 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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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure social services were provided for 1 of 1 resident whose behaviors were not being managed. (Resident #19)</p> <p>Findings include:</p> <p>During an observation on 9/9/14 at 8:58 a.m., Resident #19 was observed to be lying in her bed with her eyes closed.</p> <p>The clinical record of Resident #19 was reviewed on 9/9/14 at 2:15 p.m. Resident #19 had a diagnoses including, but not limited to, hypertension, diabetes mellitus type 2, depression, anxiety, chronic obstructive pulmonary disease, osteoarthritis, and morbid obesity. The MDS (Minimum Data Set) assessment indicated Resident #19 had a BIMS (Brief Interview for Mental Status) score of 13, indicating slight cognitive impairment.</p>	F000250	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as # 19 has been reviewed by the Social Service Director. An up-dated social service progress note has been added to the clinical record which reflects the additional social service interventions that have been provided for this resident. The resident's behaviors are now being tracked and interventions continue to be put in place in an effort to manage the resident's behavior. The documentation also includes documentation of any resident refusal of care and services.</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 reviewed and revised its behavior tracking policy and procedure. A housewide audit has been completed by the Social Services Director as it relates to residents with behaviors. The housewide audit has identified all residents who are experiencing behaviors. There currently is documentation in the clinical record</i></p>	10/10/2014

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	<p>A physician's order, dated 8/15/14 and signed by the physician on 8/18/14, indicated Resident #19 was to receive Cymbalta ( a medication used to treat depression) 60 mg (milligram) 1 (one) daily and Serax (a medication used to treat anxiety) 10 mg orally bid (twice a day) and prn (as needed).</p> <p>A physician's order, dated 8/19/14, indicated Resident #19 was to have the Cymbalta discontinued due to the resident's refusal.</p> <p>A physician's order, dated 8/20/14, indicated Resident #19 was to be evaluated by (name of an inpatient psychiatric unit) for possible admission and to begin Lexapro 10 mg (milligram) orally daily.</p> <p>A "Daily Skilled Nurses Note," dated 8/17/14 at 10:00 p.m., indicated Resident #19 had her call light on numerous times. The note indicated the resident had asked to have the privacy curtain adjusted "at least 8 times." The note indicated the resident would call for staff and have the staff wait for her to finish urinating in the bed. The note indicated the resident had requested her head of the bed to be raised and lowered several times. The note further indicated the resident refused to use the bedpan or be turned or</p>		<p>to support that social services are being provided foreach resident with behaviors and there are interventions in place to manage theresident's behaviors.</p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that the facility has revised its behavior tracking policyand procedure. The procedure includes the required documentation of the social services that were provided in anattempt to manage the residents' identified behaviors. A mandatory in-service was conducted forsocial services and nursing on the revised behavior tracking policy andprocedure.</p> <p><i>The corrective actiontaken to monitor to assure performance to assure compliance through qualityassurance is a Quality Assurance tool has been developed andimplemented to monitor the documentation as it relates to trackingbehaviors. The tool also includesmonitoring to ensure that social services is documenting the services beingprovided to treat the residents' behaviors. This tool will be completed by the Director of Nursing and/or herdesignee weekly for three weeks, then monthly for three months and thenquarterly for three quarters. Theoutcome of this tool will be reviewed at the facility Quality</i></p>	

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	<p>repositioned.</p> <p>A "Daily Skilled Nurses Note," dated 8/18/14 at 10:00 a.m., indicated Resident #19 had been very demanding.</p> <p>A "Daily Skilled Nurses Note," dated 8/19/14 at 6:00 a.m., indicated Resident #19 continued to be very demanding and uncooperative with staff.</p> <p>A "Daily Skilled Nurses Note," dated 8/20/14 at 6:00 a.m., indicated staff offered to use the Hoyer lift to get Resident #19 out of bed for a shower. Resident #19 refused to take a shower or have a partial bath given to her.</p> <p>A "Daily Skilled Nurses Note," dated 8/20/14 at 2:00 p.m., indicated Resident #19 was agitated and slightly combative with physical therapy. The note indicated refused therapy and began yelling and flinging her arms.</p> <p>A "Daily Skilled Nurses Note," dated 8/21/14 at 6:00 a.m., indicated Resident #19 refused to assist with turning or repositioning and use the bedpan. The note further indicated Resident #19 was resistive to any suggestion staff had regarding self-care.</p> <p>A "Daily Skilled Nurses Note," dated</p>		Assurance meeting to determine if additional action is warranted.		

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	<p>8/22/14 at 2:00 a.m., indicated Resident #19 would use her call light but would not attempt to do anything else for herself. The note indicated Resident #19 continued to refuse ADL's (activities of daily living.)</p> <p>A "Daily Skilled Nurses Note," dated 8/22/14 at 9:00 p.m., indicated Resident #19 refused to eat her supper as her husband was not at the facility to feed her. The note indicated Resident #19 refused to allow the staff to feed her and had been rude to the staff.</p> <p>A "Daily Skilled Nurses Note," dated 8/23/14 at 2:00 a.m., indicated Resident #19 constantly used her call light and refused to assist with any care. The note indicated Resident #19 was very rude to the nursing staff.</p> <p>A "Daily Skilled Nurses Note," dated 8/27/14 at 8:00 p.m., indicated Resident #19's husband fed her supper. The note indicated the resident had various complaints throughout the night.</p> <p>A "Daily Skilled Nurses Note," dated 8/21/14 at 5:00 p.m., indicated the (name of psychiatric unit) staff visited Resident #19 to evaluate the resident.</p> <p>A "Social Service Progress Note," dated</p>						

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	<p>8/22/14 indicated Resident #19 kept her eyes closed during the interview for the BIMS interview. The note further indicated the resident felt "down sometimes and had little energy."</p> <p>No further documentation was located on the chart regarding the (name of psychiatric unit) evaluation or from the SS department.</p> <p>During an interview on 9/10/14 at 9:30 a.m., the SSD (Social Service Designee) provided an "Inquiry Summary Sheet," dated 8/21/14, which indicated Resident #19 had refused to be admitted to (name of psychiatric unit). The SSD indicated she had not had the opportunity to place the summary sheet on the chart. The SSD indicated Resident #19 continued to have behaviors but she really didn't know what to do at that time. The SSD indicated she had not spoken to Resident #19's physician since the resident refused to be admitted to (name of psychiatric unit).</p> <p>The SSD indicated the facility is supposed to fill out an "All Staff Behavior Tracking" form and place it in a folder for her. The SSD indicated she had not received any tracking forms since she started employment in February, 2014.</p>				

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	<p>During an interview on 9/10/14 at 10:50 a.m., the DON (Director of Nursing) indicated Resident #19 had hit a PTA (physical therapy assistant) while the PTA attempted to assist her with care. The DON indicated the resident continued to have behaviors at times.</p> <p>During an interview on 9/10/14 at 11:25 a.m., the DON indicated the facility had tracked behaviors in the past years but had only been tracking new or worsening behavior recently. The DON indicated the resident was admitted to the facility in August, 2014.</p> <p>During an interview on 9/15/14 on 2:17 p.m., the DON indicated behaviors had not been tracked as per the facility's policy.</p> <p>The "Behavior Tracking Policy," obtained from the SSD on 9/10/14 at 2:55 p.m., indicated the "All Staff Behavior Tracking" form which provides information related to the behavior that occurred, and the interventions that were initiated was to be completed. The policy indicated the nurse must review and sign the form and the completed form was to be placed in the SS (Social Service) folder. The policy further indicated the DON, Administrator, and SS would</p>			

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F000323 SS=E	<p>review the behaviors and interventions each morning for placing them on the "behavior monitoring and interventions" form and making a note on the "behavior note." The form indicated after interventions become effective, the IDT (interdisciplinary team) would decide if the behavior needed to be tracked.</p> <p>3.1-34(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure an environment free of accidents and/or hazards, in that, side rails were observed to be loose, for 2 of 30 stage 1 sampled residents reviewed. (Resident #15, Resident #32)Chemicals</p>	F000323	The corrective action taken for those residents found to be affected by the deficient practice is that the bed rails that were found to be loose on the beds of residents #15 and #32 were immediately tightened by the maintenance director. The chemicals	10/10/2014

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	<p>were accessible to residents in 1 of 1 resident rooms (Resident #11) and the hydrocollator was observed to be unattended, this had the potential to affect 45 of 45 residents.</p> <p>Finding includes:</p> <p>1. During the initial tour on 9/8/14 at 9:10 a.m., the clean utility room on the East end of the facility was observed to be open and unattended. There was a can of Lysol disinfectant spray on a shelf in the room. The warning label indicated the spray could cause moderate eye irritation.</p> <p>At 9:11 a.m., the door to the therapy gym was open on the east end of the building. No staff members were present in or around the room. A hydrocollator was observed in the corner of the room. The hydrocollator was on and functioning with hot packs submerged in very hot water. The Occupational Therapy Assistant returned to the room at 9:12 a.m.</p> <p>On 9/8/14 at 4:00 p.m., the evening shift nurse indicated they had one resident who wandered, but his family was transferring him to a facility with an Alzheimer's Unit that evening. She indicated they had used sitters to ensure his safety over the weekend.</p>		<p>(Lysol) that were found in the room of the resident identified as resident # 11 were immediately removed. The hydrocollator was immediately relocated to a secured area away from resident access. The can of Lysol disinfectant which was observed in the clean utility room on the East end of the facility has been removed.</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 assessment of all bed rails was conducted and no other bed rails were found to be loose. A housewide audit of all residents' rooms was completed and any chemicals such as air fresheners were removed. The hydrocollator was relocated to a secured area away from resident access.</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 bed rails have been added to the preventative maintenance program and will be checked monthly in accordance with the preventative maintenance schedule. The checking for unsecured chemicals has been added to the housekeepers daily cleaning schedule so as the rooms are cleaned daily the housekeepers will</p>	

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	<p>2. On 9/8/14 at 11:39 a.m., Resident #15's left one half side rail was observed to be loose.</p> <p>On 9/10/14 at 10:24 a.m., Resident #15's left one half side rail was observed to be loose.</p> <p>3. On 9/8/14 at 11:53 a.m., Resident #11 was observed to have a can of "Lysol" lying on the bedside table.</p> <p>On 9/11/14 at 9:45 a.m., Resident #11 was observed to have a can of "Lysol" lying on the bedside table.</p> <p>On 9/15/14 at 9:23 a.m., the DON (Director of Nursing) indicated chemicals should be locked up.</p> <p>4. On 9/8/14 at 1:56 p.m., Resident #32's left one half side rail was observed to be loose.</p> <p>On 9/11/14 at 9:45 a.m., Resident #32's left one half side rail was observed to be loose.</p> <p>On 9/11/14 at 10:50 a.m., the Administrator was notified of the loose side rails. The Administrator indicated the loose side rails would be fixed immediately.</p>		<p>check for and remove any chemicals. The hydrocollator will continue to be stored in a secured area away from resident access. A mandatory in-service has been provided for all staff on their responsibility to report any loose bed rails or any unsecured chemicals to maintenance or housekeeping. The therapists have all been instructed on the safe storage of the hydrocollator.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the facility to maintain a safe environment for the residents. This tool will include the routine inspection of bed rails in accordance with the preventative maintenance program, checking for unsecured chemicals and the safe secured storage of the hydrocollator. This tool will be completed by the Executive Director and/or his designee 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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F000329 SS=D	<p>3.1-45(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
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	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate indications for the use of an antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications. (Resident #8, Resident #30)</p> <p>Findings include:</p> <p>1. On 9/9/14 at 1:36 p.m., Resident #8 was observed to be transferred from the wheelchair to the bed. There were no behaviors observed during that time.</p> <p>On 9/10/14 at 10:21 a.m., Resident #8 was observed sleeping in bed.</p> <p>On 9/10/14 at 8:34 a.m., Resident #8's clinical record was reviewed.</p> <p>Resident #8's diagnoses included, but were not limited, to psychotic mood disorder.</p> <p>The most recent signed physician's recapitulation orders, signed 7/16/14, indicated the Resident had an order for: Seroquel (an antipsychotic medication) 50 mg (milligrams) po (by mouth) bid (two times daily), ordered 1/16/13.</p>	F000329	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 8 and resident # 30 has been reviewed and now has supportive diagnosis to justify the use of psychotropic medications. The social service director has also developed behavior management plans to address the identified behaviors of resident # 8 and resident # 30 and the nursing staff is documenting the monitoring of the residents' behaviors.</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 on all residents on psychotropic medications and/or residents with behaviors to ensure appropriate diagnosis are in place. In addition the social service director has implemented behavior management plan to address the residents behaviors. Each resident on a psychotropic medication is being monitored each shift by the nurse and this information is being documented on the behavior /intervention monthly flow record.</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</p>	10/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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	<p>The gradual dose reduction recommendation, dated 4/10/14, was declined by the physician, the recommendation indicated "previous attempts unsuccessful and stable on current dose".</p> <p>The record lacked documentation for the monitoring of behaviors.</p> <p>There were no behavior sheets in the behavior log book.</p> <p>The Cognitive Deficit/Altered Mood State care plan, dated 8/18/14, indicated the resident often refers to herself in the third person. The interventions included, but were not limited to, "listen for her calling out repeatedly and assess for any physical cause of calling out". The care plan goals, included, but were not limited to, "...she will have no adverse effects r/t (related to) rx (prescription) needed for mood/anxiety/behaviors daily".</p> <p>The most recent Annual MDS (Minimum Data Set) assessment, dated 8/15/14, indicated Resident #8 had no behaviors and received an antipsychotic medication 7 out of 7 days.</p> <p>On 9/10/14 at 10:17 a.m., the SSD (Social Service Designee) provided the "Behavior Assessment" sheet, dated</p>		<p>reviewed and revised the behaviortracking program. A mandatory in-servicehas been provided for all staff on the revised behavior tracking program. Any new behaviors and/or significant changein a resident's behavior will be reported to the social service director byutilizing the all staff behavior tracking record. The social service director will then beresponsible developing the behavior monitoring and intervention form anddocument on the behavior note form... All new behaviors and/or significantchanges in behaviors will be reviewed daily Monday through Friday by theinterdisciplinary team for any additional action that may be warranted and a socialservice note will reflect the outcome of that review.</p> <p>The corrective action taken to monitor to assureperformance to assure compliance through quality assurance is thata Quality Assurance tool has been developed and implemented to ensure thatthere is supportive documentation for those residents on psychotropicmedications, including tracking of those identified behaviors. This tool will be completed by the Directorof Nursing and/or her designee weekly for three weeks, then monthly for threemonths, and then quarterly for three quarters. The outcome of this tool</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601		
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	<p>3/24/14. The assessment indicated Resident #8 did not have any behaviors.</p> <p>On 9/10/14 at 9:19 a.m., RN #1 indicated Resident #8 had behaviors of yelling out.</p> <p>On 9/10/14 at 9:42 a.m., the SSD indicated behavior tracking is completed in a master book and if a behavior is observed it is documented on another sheet with a date and time. The SSD further indicated Resident #8 did not have any behaviors.</p> <p>On 9/10/14 at 10:00 a.m., the DON indicated Resident #8 had behaviors of anxiety and crying out.</p> <p>2. On 9/10/14 at 10:22 a.m., Resident #30 was observed in her chair. Resident #30 indicated she was better that morning from an anxiety attack the previous evening.</p> <p>On 9/9/14 at 1:53 p.m., Resident #30's clinical record was reviewed.</p> <p>Resident #30's diagnoses included, but were not limited to, refractory major depression.</p> <p>The most recent physician's recapitulation orders, signed 8/26/14, indicated orders for, Risperdal (an</p>		will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601		
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	<p>antipsychotic medication) 2 mg (milligrams) po (by mouth) every morning, ordered on 7/29/13 and Risperdal 4 mg po every evening, ordered 7/29/13.</p> <p>The record recorded one dose reduction as follows: A gradual dose reduction recommendation, dated 7/21/13, was accepted. The telephone order dated 7/24/13 indicated, "d/c (discontinue)...Risperdal 4 mg....give Risperdal 2 mg every evening". The nurses notes indicated on 7/28/13 at 2100 (9:00 p.m.), "resident c/o (complaints) of nervousness about to have a nervous breakdown due to med change. Fax sent to physician at residents request." The nurses notes indicated on 7/29/13 at 9:30 a.m., "Res (resident) requested physician notified she wants meds (medications) back the way they were...I feel different...I had a nervous breakdown one time... faxed physician to inform". The nurses notes, dated 7/29/13 at 1630 (4:30 p.m.), indicated "....New orders received ....Risperdal 4 mg every evening and continue Risperdal 2 mg every 8:00 a.m.."  A gradual dose reduction recommendation, dated 1/29/14, was</p>				

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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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	<p>declined, and indicated, "doesn't need adjusted".</p> <p>A gradual dose reduction recommendation, dated 7/3/14, was declined, and indicated, "increased c/o (complaints) anxiety on visit 7/22/14." The form lacked a signature or recognition as to who made the note on 7/22/14.</p> <p>The Behavior Interventions Monthly Flow Record lacked any documented behaviors for May, July, and August 2014.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 8/4/14, indicated the resident exhibited no behaviors but received antipsychotic medication 7 out of 7 days.</p> <p>There were no behaviors documented in the behavior log.</p> <p>On 9/10/14 at 9:29 a.m., the SSD provided the "Behavior Assessment" sheet, dated 3/24/14. The sheet indicated Resident #30 did not have any behaviors.</p> <p>On 9/10/14 at 9:19 a.m., RN #1 indicated Resident #30 did not have any behaviors.</p> <p>On 9/10/14 at 10:14 a.m., the DON</p>			

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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
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F000371 SS=F	<p>indicated Resident #30's diagnoses for the antipsychotic medication were depression and anxiety. The DoN referred to the the dose reduction conducted July 2013 as a failure.</p> <p>On 9/10/14 at 9:42 a.m., the SSD indicated Resident #30 did not have any behaviors.</p> <p>On 9/10/14 at 2:55 p.m., the SSD provided the "Behavior Tracking Policy". The policy indicated, "Complete the 'All Staff Behavior Tracking' form which provides information related to the behavior that occurred, and the interventions that were initiated."</p> <p>3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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	<p>under sanitary conditions</p> <p>Based on observation, record review, and interview the facility failed to ensure that food was being properly stored and prepared in 1 of 1 kitchen, in that foods placed in freezer were not enclosed after opening and dated, peanut butter was opened and not dated, faucets were spraying water when turned on, and the handwashing sink was not draining. This deficiency had the potential to affect all 45 residents in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 9/8/14 at 8:42 a.m. the following was observed:</p> <ol style="list-style-type: none"> <li>1. A scoop was observed in a can of thickener.</li> <li>2. Meatballs in freezer #1 had freezer burn, were opened with ice in the bag, and not dated.</li> <li>3. In freezer #2 a bag of chicken breasts observed to have freezer burn, were opened, and not dated.</li> <li>4. In another freezer there was an open bag of shortcake loaves.</li> <li>5. A jar of peanut butter on the shelf was</li> </ol>	F000371	<p>The corrective action taken for those residents found to be affected by the deficient practice is that</p> <ol style="list-style-type: none"> <li>1. The scoop that was in the can of thickener was a clean scoop. The scoop was removed and the can of thickener properly sealed.</li> <li>2. The meatballs in freezer #1 that were identified as having freezer burn were discarded.</li> <li>3. The frozen chicken breasts in freezer #2 that were identified as having freezer burn were discarded.</li> <li>4. The open bag of shortcake loaves identified in another freezer was discarded.</li> <li>5. The jar of peanut butter that was identified as having been opened with no date was discarded.</li> <li>#6 The faucets that were identified as leaking were immediately repaired.</li> <li>#7 The handwashing sink which was identified as not properly draining was immediately repaired.</li> <li>#8 The caulking on the handwashing sink that was identified as pulling away from the wall has been replaced.</li> </ol> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a complete audit of all food products has been completed to ensure that all food items are properly sealed and dated. In addition the maintenance department has completed an audit of all dietary equipment to ensure proper functioning.</i></p>	10/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observed to be opened, with no open date.</p> <p>6. The handles to the faucet on one of three washing sinks, were covered with baggies to prevent water from spraying on employees. Dietary aide # 1 indicated it had been like that awhile.</p> <p>7. The handwashing sink was half full of water that was not draining.</p> <p>8. The handwashing sink had caulking around it which was pulling away from wall.</p> <p>On 9/9/14 at 8:55 a.m. the following were observed in the kitchen:</p> <p>9. In the freezers a bag of chicken breasts, meatballs and shortcakes were opened and undated..</p> <p>10. The peanut butter was on the shelf, opened and undated</p> <p>11. The handwashing sink caulking was pulling away from wall.</p> <p>On 9/10/14 at 8:50 a.m., the Dietary Manager was queried about the meatballs, chicken breasts, shortcake in freezer and peanut butter that was opened, with no open date on them. The</p>		<p>The measures or systematic changes 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 proper storage and dating of all food items. The staff has also been directed to immediately report any maintenance issues to the maintenance department so that timely repairs can be completed. In addition the maintenance department will conduct monthly audits of all dietary equipment for proper condition and functioning. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the proper storage and dating of food items. This tool will also include the monitoring of the condition and functioning of all dietary equipment. This tool will be completed by the Director of Dietary Services and/or her designee 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
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	<p>Dietary Manager indicated the items should be in closed bags and be dated, and they were thrown away by the Dietary Manager.</p> <p>On 9/11/14 at 11:00 a.m., the Dietary Manager was queried about the policy for opening and dating of foods placed in the freezer, and foods opened on shelves and dating. The Dietary Manager provided a document on the length of time foods could be in the freezer. The Dietary Manager indicated there was no actual policy for storage of foods after opening and dating of food after opening, except for a sign that was placed on the refrigerator door which stated to open and date all items that were opened and placed back in refrigerator or freezer.</p> <p>3.1- 21(I)(2) 3.1- 21(I)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601			
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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary environment was maintained for 8 of 21 rooms, in that, drywall was chipped, cove base was detached, resident care equipment was uncovered and unlabeled, and door thresholds were loose. (Room #9, 23, 1, 20, 2, 22, 5, 13)</p> <p>Findings include:</p> <p>1. On 9/8/14 at 8:21 a.m., Room #9 was observed. The cove base was observed to be detaching from the bathroom wall and the drywall was observed to be chipped. A urine collection container was observed to be sitting on the back of the toilet uncovered and unlabeled. On 9/11/14 at 9:37 a.m., the cove base was observed to be detaching from the bathroom wall and the drywall was observed to be chipped.</p> <p>2. On 9/8/14 at 10:33 a.m., Room #23 was observed. The plastic door threshold between the resident room and hall way was observed to be loose. The paint</p>	F000465	<p>The corrective action taken for those residents found to be affected by the deficient practice is that</p> <ol style="list-style-type: none"> <li>1. The room identified as room #9 has had the cove base re-secured to the bathroom wall and the chipped drywall has been repaired. The urine collection container which was sitting on the back of the toilet has been discarded.</li> <li>2. The room identified as room #23 has had the plastic door threshold between the resident room and the hallway has been re-secured tightly to the floor. The wall surface underneath the window has been repainted. The cove base has been re-secured to the wall.</li> <li>3. The room identified as room #1 which was identified as having peeling paint in the bathroom has been repainted.</li> <li>4. The room identified as room #20 which was identified as having a marred wall next to the chest of drawers has had the wall next to the chest of drawers repaired. The wall by Bed A which was identified as having chipped paint has been repainted and the cove base which was reported to be detached from the wall has had the cove base re-secured to the wall.</li> <li>5. The room identified as room #2</li> </ol>	10/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 305 E NORTH ST BOONVILLE, IN 47601
----------------------------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>underneath the window was observed to be chipped. On 9/11/14 at 9:54 a.m., the door threshold was observed to be loose, the paint underneath the window was loose, and the cove base was becoming detached from the wall.</p> <p>3. On 9/8/14 at 10:36 a.m., Room #1 was observed. The paint in the bathroom was observed to be peeling. On 9/11/14 at 10:15 a.m., the same was observed.</p> <p>4. On 9/8/14 at 10:54 a.m., Room #20 was observed. The wall next to the chest of drawers was observed to be marred. On 9/11/14 at 9:57 a.m., the wall next to the chest of drawers was observed to be marred, the paint was observed to be chipped beside Bed A, and the cove base was becoming detached from the wall.</p> <p>5. On 9/8/14 at 11:01 a.m., Room #2 was observed. The grout around the commode was observed to be stained brown. On 9/11/14 at 9:32 a.m., the grout around the commode was observed to be stained brown, the drywall was chipped, and cove base was detaching from the wall. A can of shaving cream, deodorant, and a comb were observed to be lying on the back of the sink unlabeled.</p> <p>6. On 9/8/14 at 11:18 a.m., Room #22</p>		<p>which was identified as having stained grout around the commode has had the grout replaced. The drywall which was identified as being chipped has been repaired and the cove base which was identified as detaching from the wall has been re-secured to the wall. The unlabeled can of shaving cream, deodorant and comb that were identified on the back of the sink were discarded. New personal care items were obtained for the resident and properly stored.</p> <p>6. The room identified as room # 22 has had the plastic door threshold between the resident room and the hallway has been re-secured tightly to the floor.</p> <p>7. The room identified as room #5 which was identified as having a build-up of dirt and debris in the corners and along the edges has been thoroughly clean and has no build-up of dirt and debris. The cove base that was identified as detaching from the wall has been re-secured to the wall. The drywall which was identified as being chipped has been repaired. The black bug was removed from the floor. The unlabeled and uncovered tooth brush which was identified on the back of the toilet was discarded and a new tooth brush which was properly stored and placed in the resident's bedside cabinet, has been provided for the resident.</p> <p>8. The room identified as room #13 which was identified as having cove base that was cracked and detaching</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014
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	<p>was observed. The plastic door threshold between the resident room and the hallway was observed to be loose. On 9/11/14 at 10:15 a.m., the same was observed.</p> <p>7. On 9/8/14 at 11:41 a.m., Room #5 was observed. Dirt and debris was observed to be built up in the corners and along the edges. The cove base was observed to be detaching from the wall and the drywall was observed to be chipped. A black bug was observed lying upside down on the bedroom floor. A toothbrush was observed to be unlabeled and uncovered on the back of the toilet. On 9/11/14 at 9:28 a.m., the dirt and debris was observed to be built up in the corners and along the edges, the cove base was detaching from the wall, and the drywall was cracked.</p> <p>8. On 9/8/14 at 3:51 p.m., Room #13 was observed. The cove base was observed to cracked and detaching from the walls. On 9/11/14 at 9:39 a.m., a toothbrush was observed unlabeled and uncovered on the back of the toilet.</p> <p>On 9/11/14 at 2:09 p.m., the Maintenance Director was interviewed. He indicated the nursing staff notify him if a resident</p>		<p>from the wall hashad the cove base replaced. The unlabeled and uncovered tooth brush which was identified on the back of the toilet was discarded and a new tooth brush which was properly stored and placed in the resident's bedside cabinet, has been provided for the resident.</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 check of all wall surfaces, cove bases, commodes and door threshold has been completed. All needed repairs have been completed. All resident rooms and bathroom have been checked for resident equipment and personal items. All resident equipment and personal items are properly stored and placed in the resident's bedside cabinet. A housewide check of dirt and debris in the corners of the floors has been completed and all floors are free of a build-up of dirt and debris. No additional bugs/insects were noted.</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 preventative maintenance schedule has been revised to include the checking of wall surfaces, cove bases, door thresholds, caulking of commodes</p>		

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	<p>room required maintenance.</p> <p>On 9/11/14 at 2:11 p.m., the HTL (Housekeeping Team Leader) indicated she checks the housekeeping work two times per week.</p> <p>On 9/11/14 at 2:11 p.m., the HTL provided the "Housekeeping Daily Cleaning Schedule". The schedule included, but was not limited to, "scrub toilet inside and out, including base...if base of toilet needs to be recaulked, make a note at bottom of page....if anything in bathroom is broke or loose, make note at bottom of page..."</p> <p>On 9/15/14 at 2:41 p.m., the Administrator provided the "Maintenance/Housekeeping Policy". The policy indicated, "The housekeeping cleaning schedule is to be followed which includes daily cleaning of resident rooms".</p> <p>3.1-19(f)</p>		<p>and sink areas. The housekeepers cleaning scheduled have been revised to include a thorough cleaning of the residents' rooms and bathrooms with a focus on clean corners. A mandatory in-service has been provided for the maintenance and the housekeeping department to instruct them on the additional tasks of checking wall surfaces, cove bases, door threshold, commodes/sinks and the thorough cleaning of resident's bathrooms and rooms with a focus on clean corners. A mandatory in-service has been conducted for all nursing staff on the proper storage of resident equipment and personal items.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure the resident's rooms are free of chipped dry wall, unsecured cove base, peeling paint, stained caulking, bugs/insects and un-secured door threshold and that all resident equipment and personal supplies are properly labeled and stored. The tool also monitors the cleanliness of the residents' floors with a specific focus on accumulated dirt/debris in corners. This tool will be completed by the Executive Director and/or his designee 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</i></p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

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			Assurance meeting to determine if any additional action is warranted.		