

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 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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
F000000	<p>This visit was for the Investigation of Complaint Numbers IN00137443, IN00137271 and IN00137920.</p> <p>Complaint Numbers: IN00137443, Substantiated, no deficiencies related to the allegations are cited. IN00137271, Substantiated with Federal/State deficiencies related to the allegations are cited at F282 and F465. IN00137920, Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey Dates: 10/16/13, 10/17/13</p> <p>Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240</p> <p>Survey Team: Diane Hancock, RN TC Barb Fowler, RN Denise Schwandner, RN Diana Perry, RN Anna Villain, RN</p> <p>Census Bed Type: SNF: 5 SNF/NF: 61</p>	F000000	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 that the plan of correction be considered our allegation of compliance effective November 6, 2013 to the complaint survey conducted on October 16 and 17, 2013. The facility also request that our plan of correction be considered for paper review compliance. The facility will be respectfully submitting to you any paper work you may need for review.	

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.

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 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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>Total: 66</p> <p>Census Payor Type:</p> <p>Medicare: 16</p> <p>Medicaid: 41</p> <p>Other: 9</p> <p>Total: 66</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 21, 2013, by Jodi Meyer, RN</p>			

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 10/17/2013	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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			
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 provide care for 2 of 3 residents in a total sample of 7 reviewed for behaviors, in that 2 residents did not have behavioral monitoring as per their care plans. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. Resident B was observed on 10/16/13 at 7:00 a.m., to be propelling in a wheelchair on the front northeast hall. Another resident was sitting in a wheelchair in the hall and Resident B backed the wheels into the wheelchair of the resident who was sitting in the hall.</p> <p>Resident B was observed on 10/16/13 at 7:08 a.m., propelling in a wheelchair on the front northeast hall. Resident B was observed to be propelling into a resident's room. Resident B was removed from the resident's room after being informed by LPN #1 that Resident B was in the wrong room.</p>	F000282	<p>It is the practice of this facility to assure that that behavior monitoring occurs if it is identified on the plan of care as an intervention. The correction action taken for those residents found to be affected by the deficient practice include: Resident B now has behavior monitoring in place for wandering both into other residents' room and exit seeking. Resident C was identified as a closed record and no longer resides in the facility. However, it should be noted that the facility was unaware of resident not swallowing medications until after the resident was transferred from facility. This information was shared with facility by another resident whom Resident C had told and was shared with facility staff following resident's transfer. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to determine if behaviors are present. If behaviors are present that need behavior monitoring per assessment and the plan of care, it is now in place. The measures or systematic changes that have been put into place to ensure that the deficient practice does not</p>	11/06/2013			

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 10/17/2013
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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>Resident B was observed on 10/16/13 at 2:15 p.m., attempting to stand and place herself on the sofa in the lobby on the front east unit. Resident B's alarm sounded and was assisted to a sitting position on the sofa with the assist of 4 staff members.</p> <p>Resident B was observed on 10/17/13 at 1:30 p.m., to be opening an outside door at the facility. The door alarm sounded and Resident B was removed from the door.</p> <p>The clinical record for Resident B was reviewed on 10/16/13 at 9:20 a.m. A care plan, dated 7/1/13, indicated Resident B had a history of wandering into other resident rooms and a history of exit seeking. The interventions included, but were not limited to, utilizing behavior tracking.</p> <p>The clinical record contained no documentation of behaviors for Resident B.</p> <p>During an interview on 10/16/13 at 9:55 a.m., CNA (certified nursing assistant) #1 indicated Resident B will "doodle" into other resident rooms frequently.</p>		<p>recur include: All staff will be in-serviced related to behavior protocol and monitoring of behaviors. Social Services will be in-serviced related to behavior protocol, reviewing of behaviors, behavior monitoring, and updating of the plan of care as needed. Social Services will be part of the interdisciplinary team that reviews the 24-hr reports, behavior monitoring sheets, etc, each business morning to assist with updated knowledge related to the any resident behaviors. As behaviors are monitored, if a behavior occurs that interventions were ineffective, the plan of care will be reviewed and new interventions implemented as needed. The corrective action taken to monitor performance to assure compliance through quality assurance is: A PI tool has been established that randomly reviews 5 resident that have behaviors to assure that the plan of care is being followed and that behavior monitoring is in place as needed. Social Services, or designee, are responsible for completion of the tool. This tool will be completed weekly x3, monthly x3, and then quarterly x3. Any identified issues will be immediately corrected. The quality assurance committee will review the PI tools at the regularly scheduled meetings with additional recommendations if there is any negative outcome on the PI tools. The date the</p>		

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 10/17/2013	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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>During an interview on 10/16/13 at 10:02 a.m., RN (registered nurse) #1 indicated the facility does not a "tracking" form for behaviors. RN #1 indicated behaviors are tracked in the resident's nurses notes.</p> <p>During an interview with the DoN (Director of Nursing) on 10/16/13 at 2:43 p.m., the DoN indicated Resident B does not propel self into other resident's rooms. The DoN indicated Resident B has only has exit seeking behaviors.</p> <p>During the interview with the DoN on 10/16/13 at 2:43 p.m., the DoN indicated a behavior assessment form and a behavior monitoring and intervention log is used to track behaviors on residents. Resident B did not have documentation on the "Behavior Assessment" form or the "Behavior Monitoring and Intervention Log."</p> <p>2. The closed clinical record for Resident C was reviewed on 10/16/13 at 10:10 a.m. The closed clinical record indicated Resident C had behaviors on 9/28/13 at 9:15 a.m.</p> <p>A care plan, dated 9/24/13, indicated Resident C to have a "potential for</p>		systemic changes will be completed: November 6, 2013				

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 10/17/2013
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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>mood disorder" related to "resistive to care, delusions/hallucinations." The interventions included, but were not limited to, anticipate and meet needs and assure residents safety.</p> <p>During an interview on 10/16/13 at 2:43 p.m., the DoN indicated the resident had not been swallowing his medications. The DoN indicated Resident C had received his medications and pretended to swallow them, but would go into the bathroom and flush the medications down the commode after the nurse left the room. The DoN indicated the resident had behaviors.</p> <p>During the interview on 10/16/13 at 2:43 p.m., the DoN indicated a behavior assessment form and a behavior monitoring and intervention log was used for tracking behaviors on residents. Resident C had a "Behavior Assessment" and a "Behavior Monitoring and Intervention Log," but there was no documentation present.</p> <p>This Federal Tag relates to Complaint IN00137271.</p> <p>3.1-35(g)(2)</p>				

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 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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

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 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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
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 and interview, the facility failed to ensure the environment was free of odors, soil, and functional, for 3 of 3 resident units, in that urine odors were present, floor tile was soiled and/or broken, cove base was soiled/stained, and light fixtures were broken/leaking. (East Unit, West Unit, Seasons Unit)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 10/16/13 at 6:45 a.m., there was a strong urine odor noted on the East Unit, near rooms 20, 21, and 22. The area was observed again at 9:30 a.m. and continued to have a strong urine odor. Room 29, on the Seasons Unit, was observed to have a light fixture in the shower that consisted of a glass globe. The light bulb was broken and hanging down into the globe. There was amber colored liquid in the bottom third of the globe; the light bulb was setting in the liquid. On 10/17/13 at 8:15 a.m., the East Unit center hall had a strong urine odor. 	F000465	<p>It is the practice of Transcendent Healthcare of Boonville to assure that a safe, functional, sanitary, and comfortable environment for residents, staff, and the public is provided. The correction action taken for those residents found to be affected by the deficient practice include: No specific residents were identified. The area on the East unit near rooms 20, 21, and 22 has been addressed and no odors are currently present. Room 29 light fixture light bulb has been replaced and the cover cleaned. The East Unit Center hall has been addressed and no longer has a urine odor. The Northwest hall has been addressed and no longer has a urine odor and the cove base has been cleaned. The Men's Room on the west unit has been thoroughly cleaned and the caulking replaced. The Women's Room on the West unit has been addressed and no longer has a urine odor. The East unit Women's Room has been addressed and does not have an odor. The tile in front of the toilet has been replaced. The season's unit dining area cove bases has been cleaned. Other residents that have the potential to be affected have been identified by:</p>	11/06/2013

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 10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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>4. On 10/17/13 at 11:00 a.m., a tour of the environment was conducted. The following were noted:</p> <p>a. The North West hall had a strong urine odor. The cove base along both sides of the hall was soiled/marred/stained.</p> <p>b. The Mens Room on the West Unit had floor tile around the toilet that was soiled and stained. Caulking around the toilet was dull and missing.</p> <p>c. The Womens Room on the West Unit had a strong urine odor.</p> <p>d. The East Unit Womens Room had a strong urine odor. The tile in front of the toilet was cracked and the floor was depressed.</p> <p>e. The Seasons Unit dining area cove base was soiled/stained.</p> <p>5. The Administrator was interviewed on 10/17/13 at 1:00 p.m. She indicated they had been working on replacing some flooring to help with the odors and hadn't been able to complete everything.</p> <p>This Federal Tag relates to Complaint IN00137271.</p>		<p>All residents rooms/bathrooms and hallways have been reviewed to assure clean, odor free, proper caulking, and cove bases in good repair. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for nursing staff, housekeeping staff, and maintenance staff related to cleanliness and proper repair of resident rooms, bathrooms, common areas, and hallways. Administration will be making rounds through the facility daily to assure that rooms/bathrooms, common areas, and hallways are clean, odor free, and in good repair including caulking, tile, cove bases, and light fixtures. The corrective action taken to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly observes 5 residents rooms/bathrooms, common areas, and hallways related to cleanliness, odors, and good repair. The Administrator, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed</p>	

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 10/17/2013
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND 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	
	3.1-19(f)		based on the outcomes of the tools. The date the systemic changes will be completed: November 6, 2013		