

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 09/06/2016
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00208286 and Complaint IN00208596.</p> <p>Complaint IN00208286 - Substantiated. Federal/State deficiencies related to the allegations are cited at F271 and F329.</p> <p>Complaint IN00208596 - Substantiated. Federal/State deficiencies related to the allegations are cited at F328.</p> <p>Survey dates: September 2 and 6, 2016</p> <p>Facility number: 000450 Provider number: 155801 AIM number: 100273890</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 5 Medicaid: 35 Other: 6 Total: 46</p> <p>Sample: 11</p>	F 0000		

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 0271 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on September 9, 2016.</p> <p>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>Based on interview and record review, the facility failed to obtain orders for Coumadin and orders for lab work to monitor the Coumadin, for 1 resident admitted to the facility who had been on Coumadin prior to admission, for 1 of 6 residents reviewed for physician admission orders, in a sample of 11.</p> <p>Resident F</p> <p>Findings include:</p>	F 0271	<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 September 16, 2016 to the state findings of the Complaint Survey conducted on September 2nd and 6th, 2016</p>	09/24/2016			

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	<p>The clinical record of Resident F was reviewed on 9/6/16 at 11:10 A.M. Diagnoses included, but were not limited to, Parkinson's disease and history of pulmonary embolism (blood clots in lungs).</p> <p>The resident was admitted to the facility from home on 7/28/16. A hospital history and physical, dated 7/11/16, indicated, "...He has chronic anemia, has a history of PE [pulmonary embolism] and is treated with Coumadin...."</p> <p>A document labeled "[Resident F] Home Meds," undated, included "Warfarin Sodium" (Coumadin).</p> <p>Admission orders did not include an order for Coumadin, nor lab work to monitor Coumadin levels.</p> <p>Progress Notes included the following notations:</p> <p>8/15/16 at 3:26 P.M.: "PT 12.3/INR 1.0 [lab work to monitor Coumadin] MD notified. Awaiting return call with order."</p> <p>8/17/16 at 10:16 A.M.: "New orders received this day to start resident back on Coumadin that resident was prescribed prior to admission to [name of facility]. New orders noted and faxed to pharmacy."</p>		<p>F – 271</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident F is now receiving Coumadin and is also receiving lab work to monitor the Coumadin in accordance with the physician's orders.</i></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 who require anticoagulants to ensure that the residents are receiving their medications along with appropriate lab work to monitor the use of the anticoagulant. In addition all residents that have been admitted in August 2016 and after have been reviewed to ensure that all hospital discharge orders have been accurately transcribed to the facility's admission orders.</i></p> <p><i>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 the policy on Admission to Facility. The policy now includes that two licensed nurses will review new admission orders to ensure the accuracy of the transcription of all admission orders. A mandatory in-service has been provided for all licensed nurses on the revised Admission to Facility policy to ensure their knowledge of the revised policy.</i></p>	

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	<p>Family notified."</p> <p>A Physician's order, dated 8/17/16, indicated, "Coumadin Tablet 1 mg. Give 1 tablet by mouth in the evening every Sun., Tue, Thu, Sat [sic] for pulmonary embolism."</p> <p>A Physician's order, dated 8/17/16, indicated, "Coumadin Tablet 2 mg. Give 1 tablet by mouth in the evening every Mon, Wed, Fri [sic] for pulmonary embolism."</p> <p>A Physician's order, dated 8/24/16, indicated, "May follow [name of physician] Coumadin protocol: If INR 2.0-3.0 continue same Coumadin dosage and recheck INR in 2 weeks. If INR <2.0 increase Coumadin dosage by 1 mg per week and recheck INR in 1 week....If INR >4.0 Hold Coumadin and notify MD for orders."</p> <p>On 9/6/16 at 12:00 P.M., during an interview with the Administrator, she indicated Resident F came from home and had a home medication list. She indicated the previous Director of Nursing (DON) neglected to obtain an order for the Coumadin or a PT/INR. She indicated the resident's mother approached the current DON and asked if the resident was receiving the Coumadin.</p>		<p><i>The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by a Quality Assurance Tool has been developed and implemented to monitor the accuracy of the transcription of admission 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 Quality Assurance meeting to determine if any additional action is warranted</i></p>		

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	<p>The Administrator indicated at that time the DON contacted the physician and obtained orders.</p> <p>On 9/6/16 at 4:00 P.M., the Administrator provided the current facility policy on "Admissions to the Facility," dated 3/15/16. The policy included, "Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident including orders covering at least:...Medication orders, including (as necessary) a medical condition or problem associated with each medication...."</p> <p>This Federal tag relates to Complaint IN00208286.</p> <p>3.1-30(a)</p>			

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F 0328 SS=D Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident receiving oxygen had her portable tank turned on, failed to ensure there were physician orders for oxygen, and that oxygen tubing and equipment was changed weekly, for 3 of 3 residents reviewed who required oxygen therapy, in a sample of 11. Residents D, E, and B</p>	F 0328	<p>F - 328</p> <p>1). <i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident D is receiving her oxygen therapy in accordance with the physician's orders. Resident D's oxygen equipment is changed out weekly and all equipment is dated when put into service.</i></p> <p>2). <i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident E now has an</i></p>	09/24/2016

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	<p>Findings include:</p> <p>1. On 9/2/16 at 8:40 A.M., during the initial tour, the Social Services Director (SSD) indicated Resident D required oxygen. Resident D was sitting in her wheelchair in her room. Her portable oxygen tank was not turned on. The SSD indicated, "It's supposed to be set on 2 liters." The SSD indicated the resident would not be able to turn off the oxygen on her own.</p> <p>The clinical record of Resident D was reviewed on 9/2/16 at 11:35 A.M. Diagnoses included, but were not limited to, ischemic cardiomyopathy and COPD.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 6/6/16, indicated Resident D scored a 3 out of 15 for cognition, required extensive assist of one staff for transfer, and did not ambulate.</p> <p>A Physician's order, dated 7/26/16 and on the current September orders, indicated, "O2 [oxygen] @ 2L/M [liters per minute] as need [sic] for SOB [shortness of breath]...."</p> <p>A Physician's order, dated 7/26/16 and on the current September orders, indicated, "Change O2 tubing nebulizer and</p>		<p>order for oxygen therapy as well as an order to change out oxygen equipment weekly. The resident is receiving his oxygen therapy in accordance with the physician's orders and the oxygen equipment is being changed out weekly with all equipment being dated when put into service.</p> <p>3). <i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident B currently has orders for oxygen therapy and to change oxygen equipment weekly. The resident is receiving oxygen therapy in accordance with the physician's orders and the oxygen equipment is being changed out weekly and dated when placed into service.</i></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 conducted on all residents to identify which residents have orders or are in need of orders for oxygen therapy. All residents in need of oxygen therapy have current physician's orders including orders to change out oxygen equipment weekly. Each resident with oxygen therapy orders is receiving their oxygen therapy in accordance with the physician's orders and their oxygen therapy equipment is being changed out weekly and the equipment is dated when placed into service.</i></p> <p><i>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</i></p>				

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	<p>hydration bottle (if needed). Change out bag for equipment weekly on Sunday every night every Sun for O2 and neb use related to Chronic Obstructive Pulmonary Disease...Date and Sign Equipment."</p> <p>On 9/2/16 at 1:30 P.M., Resident D was observed lying in bed. Her oxygen was being supplied by an oxygen concentrator. The humidifier bottle was not dated. An oxygen equipment bag was dated "6-12."</p> <p>On 9/2/16 at 1:40 P.M., the Director of Nursing indicated that nursing should change the oxygen equipment every week and date it. The Administrator indicated that they would obtain new bags and change the equipment immediately.</p> <p>2. On 9/2/16 at 8:40 A.M., during the initial tour, the Social Services Director (SSD) indicated Resident E required oxygen. Resident E was lying in bed. His oxygen was being supplied by an oxygen concentrator, and was set on 2 liters.</p> <p>On 9/2/16 at 1:35 P.M., Resident E was observed lying in bed. His oxygen humidifier bottle was not dated. His oxygen equipment bag was dated "7-17."</p> <p>The clinical record of Resident E was reviewed on 9/2/16 at 1:50 P.M. The</p>		<p>provided for all nursing staff on the facility policy and procedure related to oxygen therapy. The staff has been instructed on the facility policy related to following physician's orders related to oxygen administration as well as the facility policy of changing out oxygen therapy equipment weekly and dating the equipment when placed in service.</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 administration of oxygen therapy and to monitor the oxygen equipment to ensure that the equipment is changed weekly and dated when placed in service. 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 Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>resident was admitted to the facility on 8/26/16. Diagnoses included, but were not limited to, essential hypertension and anemia.</p> <p>Current physician orders did not indicate an order for the oxygen, nor an order to change the equipment weekly.</p> <p>On 9/2/16 at 2:10 P.M., during an interview with QMA # 1, she indicated she placed the new humidifier bottle on the resident's oxygen concentrator when he was admitted. The Administrator indicated at that time that she did not know why the resident's equipment bag was dated 7/17, when he wasn't admitted until 8-26.</p> <p>On 9/2/16 at 2:15 P.M., the SSD indicated the oxygen concentrators were kept in a clean supply room, and the oxygen tubing and humidified water were charged out separately, then placed in an equipment bag. The SSD reviewed the kiosk which listed charges, and could not find where the oxygen tubing or humidified water had been charged out or on what date.</p> <p>The resident's clinical record was again reviewed on 9/6/16 at 9:15 A.M.</p> <p>A Physician's order, dated 9/2/16,</p>			

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	<p>indicated, "Titrate Oxygen to keep Sats >90%. Check O2 Sats every shift."</p> <p>An additional Physician's order, dated 9/2/16, indicated, "Change oxygen tubing, water, and bag. Be sure to label all items and date. Every night shift every Sun [sic]."</p> <p>3. On 9/2/16 at 8:40 A.M., during the initial tour, the SSD indicated Resident B required oxygen. Resident B was observed sitting in a wheelchair. Her portable oxygen tank was full and was set on 2 liters.</p> <p>On 9/2/16 at 1:35 P.M., Resident B was observed sitting in a wheelchair in her room. Her humidified water on her oxygen concentrator was not dated. There was no oxygen equipment bag seen.</p> <p>The clinical record of Resident B was reviewed on 9/2/16 at 2:30 P.M. Diagnoses included, but were not limited to, Alzheimer's disease and COPD.</p> <p>A quarterly MDS assessment, dated 7/20/16, indicated the resident had a short term and long term memory loss, required extensive assistance of two + staff for transfer, and did not ambulate.</p> <p>Current physician orders did not include</p>			

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	<p>an order for the oxygen therapy, nor an order to change the tubing, water, and bag weekly.</p> <p>The resident's clinical record was again reviewed on 9/6/16 at 9:15 A.M.</p> <p>A Physician's order, dated 9/2/16, indicated, "Titrate oxygen to keep Sats >90 %. Check O2 every shift."</p> <p>An additional Physician's order, dated 9/2/16, indicated, "Change oxygen tubing, water, and bag. Be sure to label all items and include date. Every night shift every Sun [sic]."</p> <p>On 9/6/16 at 9:15 A.M., the Administrator provided the current facility policy on "Oxygen Administration," dated 3/6/15. The policy included: "The purpose of this procedure is to provide guidelines for safe oxygen administration...Verify that there is a physician's order for this procedure...Adjust the oxygen delivery device so that is comfortable for the resident and the proper flow of oxygen is being administered...All oxygen equipment will be replaced weekly to prevent the spread of infection...Filters on the oxygen concentrators will be washed with warm water weekly and as needed. Oxygen equipment such as cannulas and</p>			

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F 0329 SS=G Bldg. 00	<p>mask will be stored in a respiratory therapy plastic bag when not in use."</p> <p>This Federal tag relates to Complaint IN00208596.</p> <p>3.1-47(a)(6)</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</p>			

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	<p>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 receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free of unnecessary drugs, failed to ensure physician orders for the discontinuation of blood pressure medications was followed, which resulted in a hospitalization for unresponsiveness, and low blood pressure, for 1 of 6 residents reviewed for receiving the correct medications, in a sample of 11. Resident A</p> <p>Findings include:</p> <p>On 9/2/16 at 9:25 A.M., the Administrator provided a list of residents, indicating those residents who were considered interviewable. Resident A</p>	F 0329	<p>F - 329</p> <p>Please note that the resident identified as resident A had had the same type of unresponsive episodes prior to the event that was identified during the survey which occurred on 08-07-16. These prior events were not a result of any medication administered. The resident has also had unresponsive episodes since the 08-07-16 episode. There is documentation in the clinical record validating that the resident has had</p>	09/24/2016

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	<p>was marked as interviewable.</p> <p>The clinical record of Resident A was reviewed on 9/2/16 at 10:55 A.M. Diagnoses included, but were not limited to, legal blindness and hypertension.</p> <p>A Physician's order, dated 5/6/16 and on the July 2016 orders, indicated, "Clonidine [for high blood pressure] 0.2 mg Take 1 tablet by mouth twice daily if SBP [systolic blood pressure] >170."</p> <p>A Physician's order, dated 5/6/16 and on the July 2016 orders, indicated, "Verapamil ER [for high blood pressure] 120 mg tablet Take (1) tablet by mouth once daily."</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/11/16, indicated the resident scored a 14 out of 15 for cognition, with 15 indicating no memory impairment.</p> <p>Physician orders, dated 7/3/16, indicated, "Discontinue Clonidine."</p> <p>A Physician's order, dated 7/31/16, indicated, "Discontinue Verapamil."</p> <p>The resident's Medication Administration Record (MAR), dated August 2016, indicated the resident received Verapamil</p>		<p>these unresponsive episodes dating as far back as 04-04-14 which again were not related to any medications administered.</p> <p><i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A has had her hospital discharge orders reviewed and compared to the facility admission orders. All orders are accurate and the resident is receiving her medications in accordance with the physician's orders.</i></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 conducted to compare physician's orders to the resident's MARs to ensure accuracy. No other discrepancies were identified. Each resident is receiving their medications in accordance with their physician's orders.</i></p> <p><i>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 licensed nurses and QMAs on the facility's standard of practice in the accurate transcription of physician's orders to the clinical record including the medication record to ensure that each resident is receiving their medications in accordance with the physician's orders. The in-service also addressed the importance of ensuring that any order to discontinue a</i></p>	

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	<p>on August 1, 3, 4, 5, 6, and 7, 2016.</p> <p>The August MAR also indicated Resident A received Clonidine twice on August 1, once on August 2, once on August 4, and twice on August 7, 2016. The resident's blood pressure ranged from 128/70 to 141/70 on those dates.</p> <p>Nurses Notes included the following notations:</p> <p>8/7/16 at 10:33 A.M.: "Resident non-responsive. Unable to obtain Blood Pressure. Other vitals WNL [within normal limits]...On Call doctor paged, awaiting response."</p> <p>The resident was transferred to the hospital on 8/7/16 at 11:03 A.M., and was admitted to the hospital.</p> <p>A hospital history and physical, dated 8/7/16 at 6:03 P.M., indicated, "The patient is a 87 y.o. female...who resides at the NH [nursing home]. Was found this morning...minimally responsive with low blood pressure...Pt [patient] began to respond when legs were raised and initial BP [blood pressure] was documented 88/50...Family thought patient was off all BP medications at the NH...Current Outpatient Prescriptions...Clonidine 0.2 mg...Verapamil 120</p>		<p>medication is properly processed to ensure that the resident does not receive any medication that is currently not ordered.</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 administration of medications to ensure that the resident is only receiving medications in which there is a current physician's order for. 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 Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>mg...Assessment/Plan: Syncope [fainting] - likely related to hypotension [low blood pressure]/mild dehydration. Had similar episode few months ago. Will hold antihypertensives and hydrate...."</p> <p>On 9/2/16 at 11:45 A.M., during an interview with the Administrator, she indicated from what she understood, Resident A's daughter informed the previous DON that her mother was allergic to Verapamil, and it was discontinued. She indicated she was unaware of a problem with the Clonidine. The Administrator indicated the previous DON or ADON incorrectly imported the discontinued medications into the August 2016 orders.</p> <p>On 9/6/16 at 10:40 A.M., Resident A was interviewed. Resident A indicated she "was feeling okay now." She indicated she had been in the hospital approximately 1 month previous, because she "got too much medicine. It knocked me out."</p> <p>On 9/6/16 at 1:45 P.M., the Administrator provided the current facility policy on "Medication Administration," dated 1/27/16. The policy included, "The facility will provide appropriate care and services to</p>			

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	<p>manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcomes. 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 IN00208286.</p> <p>3.1-48(a)(1)</p>			