

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 03/18/2016
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F 0000 Bldg. 00	<p>This visit was for Investigation of Complaint IN00195866.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/2/16.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to Complaint IN00191412 completed on 2/2/16.</p> <p>Survey dates: March 16, 17, 18, 2016</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 1000266240</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 14 Medicaid: 46 Other: 5 Total: 65</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<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 March 25, 2016 to the state findings of the Complaint Survey conducted on March 17th and 18th, 2016.</p>	
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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 0323 SS=G Bldg. 00	<p>Quality review completed by #02748 on March 24, 2016.</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and effective interventions were provided to prevent falls for 2 of 3 residents who met the criteria for the review of accidents. One of one residents randomly observed located behind fire doors out of the sight of staff and without supervision. This deficient practice resulted in Resident G experiencing a fall which resulted in a pelvic fracture, a fall which resulted in a fractured wrist, and Resident C received 10 sutures to the forehead. (Resident G, Resident C, Resident R)</p> <p>Findings include:</p> <p>1. On 3/17/15 at 2:05 P.M., Resident G</p>	F 0323	<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 March 25, 2016 to the state findings of the Complaint Survey conducted on March 17th and 18th, 2016.</p> <p>F - 323</p> <p>1.) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident G has been reviewed related to their fall risks. A new fall risk assessment has been completed and interventions are now in place in an attempt to</p>	03/25/2016

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	<p>was observed receiving therapy with Physical Therapy Assistant #3. Resident G was sitting in a wheelchair and wore a cast on the right lower arm. Resident G was in no apparent distress.</p> <p>The clinical record of Resident G was reviewed on 3/17/16 at 3:31 P.M. The record indicated the diagnoses of Resident G included, but were not limited to, dementia with behavioral disturbances, unsteadiness on feet, and difficulty walking.</p> <p>The most recent Admission MDS (Minimum Data Set) assessment dated 2/3/16 indicated Resident G experienced severe cognitive impairment and needed the assistance of one person for transfers, ambulation, and toileting.</p> <p>The most recent Physician's Order Recap dated 3/21/16 included, but was not limited to, "...Up ad lib [at liberty]..."</p> <p>A Care Plan for Falls included, but was not limited to, "The resident is at risk for falls r/t Unaware of safety needs, confusion, Gait/balance problems..." Initial interventions dated 2/10/16 included, but were not limited to, "...follow facility protocol...Anticipate and meet the resident's needs...call light within reach...encourage the resident to</p>		<p>preventfuture falls.</p> <p>2.) The correctiveaction taken for those residents found to be affected by the deficient practiceis that the resident identified asresident C has been reviewed related to their fall risks. The fall risk care plan has been reviewed andup-dated to include appropriate safety interventions in an attempt to preventfuture falls.</p> <p>3.) The correctiveaction taken for those residents found to be affected by the deficient practiceis that the resident identified asresident R did not have a fall while the fire doors were temporarilyclosed. The nursing staff has also beendirected that whenever it is necessary for the fire doors to be closed that onestaff member must be posted behind each closed fire door set to providesupervision to those residents.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that a housewide audit has been completed on all fallrisk residents to ensure that appropriate safety interventions are in placebased on the individualized needs of the residents.</i></p> <p>The measures or systematic changes that have been put into place to</p>				

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	<p>use it...CNA for assistance as needed. The resident needs prompt response to all requests for assistance...Follow facility's fall protocol." Care Plan for Falls updated on 2/16/16 included, but was not limited to, interventions of "...refer to orth [orthopedic doctor] and therapy to eval [evaluation] and treat..." Care Plan for Falls updated on 3/8/16 included, but was not limited to, interventions of "...pressure pad to bed and chair. Move resident closer to nurses' station..."</p> <p>A Fall Risk Assessment dated 1/27/16 indicated Resident G experienced the following, "...1 - 2 falls in the past months...chair bound - requires assistance with elimination...Requires assistive device cane, walker, w/c [wheelchair] furniture..." The Fall Risk Assessment determined Resident G was at a high risk for falls.</p> <p>A "Progress Note" "Late Entry" dated 2/7/16 at 5:00 A.M., "...Resident found on the floor beside the bathroom door...states "I fell and don't know what happened...grasp left hip and c/o pain. She was 1:1 supervision...Addition intervention was to put slipper socks on when resident going to bed to sleep..."</p>		<p>ensure that the deficient practice does not recur is that the facility has reviewed and revised their fallmanagement policy to include the instructions that following any fall a newimmediate interventions must be added in an effort to prevent futurefalls. A mandatory in-service has beenprovided for all nursing staff on the revised fall management policy. In addition that staff was reminded of thefacility protocol related to when fire doors are closed that at least one staffmember must be posted behind the closed fire doors to provide supervision ofthose residents.</p> <p><i>The corrective action will be monitored to ensure the deficient practice will not recur through thequality assurance program by a Quality Assurance tool has been developedand implemented to ensure that any resident at risk for falls or any residentwho has had a fall has documentation to support that appropriate interventionsare in place in an attempt to prevent future falls. If the resident has had a fall then thedocumentation reflects that a new intervention was immediately put inplace. This tool shall be completed bythe Director of Nursing Services weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurancemeetings to determine if any additional action is</i></p>	

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	<p>Documentation was lacking that a fall risk assessment was completed after Resident G's fall on 2/9/16.</p> <p>A "Progress Note" dated 2/10/16 at 9:38 P.M., "...X-ray report stated fracture of pelvis."</p> <p>A "Progress Note" dated 3/7/16 at 7:00 A.M., "...Resident having increased confusion this morning, blowing...nose on...pants leg, and continually getting up from wheelchair..."</p> <p>A "Progress Note" dated 3/7/16 at 8:36 A.M., "Urine is no longer red is dark yellow. Confusion continues."</p> <p>A "Progress Note" dated 3/8/16 at 6:50 A.M., "...Resident was sitting in her wheelchair in the TV room. I heard..."Help, I fell." Found resident on her back on the floor in the middle of the room. Unsure if resident hit...head. Complains of right wrist pain...EMS here to get resident..."</p> <p>A "Progress Note" dated 3/8/16 at 12:39 P.M., "... Returned from hospital admitted to room 1...f/u appointment...with orthopedics for distal fx [fracture] Rt arm..."</p> <p>An Orthopedic doctor's note dated</p>		warranted.	

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	<p>3/16/16 read as follows, "...intraarticular fracture of lower end of right radius...fracture of lower end of right ulna..."</p> <p>During an interview on 3/18/16 at 9:10 A.M., PT #6 indicated Resident G was evaluated by Physical Therapy on 1/28/16. At that time, Resident G had an unsteady gait, experienced decreased safety awareness, and should use the call light to obtain assistance from staff for transferring and ambulating. PT #6 indicated Resident G was not assessed to be "up ad lib" and was at a high risk to experience a fall. PT#6 indicated Resident G returned from the hospital after the fall on 2/9/16 and was non-weight bearing, in a wheelchair and experienced an increase in confusion which was possibly related to dementia.</p> <p>During an interview on 3/18/16 at 9:45 A.M., LPN #12 indicated upon admission Resident G was up ad lib, did not use a walker, ambulated and transferred without assistance from staff until her 1st fall on 2/8/16 which resulted in a pelvic fracture. LPN #12 indicated that after Resident G returned from the hospital she was in a wheelchair, was non-weight bearing and needed the assistance of one staff for transfers. LPN #12 indicated on the morning of 3/8/16 Resident G had</p>			

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	<p>been sitting in the wheelchair in the TV lounge when LPN #12 left the area and walked up the hall. LPN #12 indicated half way up the hall she heard Resident G say, "Help, I fell." LPN #12 indicated she returned to the TV lounge and Resident G was observed on the floor, lying on her back, in the middle of the room and complained of pain in the right wrist.</p> <p>During an interview on 3/18/16 at 10:20 P.M., the Director of Nursing (DON) indicated Resident G was assessed upon admission to be at a high risk to experience a fall. The DON further indicated Resident G was up ad lib without any assistance from staff for ambulation and transfers until her fall on 2/9/16. The DON indicated the communication between staff needs to improve.</p> <p>2. On 3/16/16 at 11:50 A.M., Resident C was observed sitting in a wheel chair in the main dining room (MDR). Resident C was observed to have a large circular shaped wound with intact stitches extending from above his/her right eye up into the hairline and ending above his/her left eye. Resident C was observed to be in no apparent distress.</p> <p>The clinical record for Resident C was</p>			

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	<p>reviewed on 3/17/16 at 8:10 A.M. The record indicated Resident C was readmitted to the facility on 12/22/15 and his/her diagnoses included, but were not limited to, dementia, and a history of falls and a cervical spine fracture.</p> <p>The Admission care plans included, but were not limited to, a care plan for falls related to confusion, vision/hearing problems, gait/balance problems. The interventions included but were not limited to, Anticipate and meet the resident 's needs (2/10/15), bed and chair alarms (2/10/15), therapy evaluation and treatment for posture and proper wheel chair alignment upon return from hospital (12/22/15).</p> <p>A care plan for pain, related to recent fall and fracture of Resident C's spine initiated 12/20/15. Interventions included, but were not limited to, anticipate Resident C's needs for interventions related to pain (12/20/15).</p> <p>A care plan for self-care deficits initiated 2/10/15. The interventions included, but were not limited to anticipate and meet needs (2/10/15), monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed (2/10/15).</p>			

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	<p>A care plan for impaired cognition and impaired thought process initiated 12/20/15. The interventions included, but were not limited to, provide comfort (2/10/15).</p> <p>The nursing notes for Resident C were reviewed and included but were not limited to:</p> <p>On 2/16/17 at 12:48 P.M., "Res [resident] crying out confused looking for [name of town]. Unable to calm res, offered food, fluids, one on one ref to lay down activities unable to redirect. MD [medical doctor] notified and received order for Ativan [an antianxiety medication] .5 mg [milligrams] po [by mouth] 1x for anxiety. given at 1145 [sic]. Res currently calm and eating lunch. Cont [continues] on ATB [antibiotic] for UTI [urinary tract infection]..."</p> <p>Fall # 1- 2/17/16 at 10:47 A.M., "Fall Report: Heard resident fall resident found face down on floor in hallway. Blanket wrapped around wheels of wheelchair. Resident has a raised area on forehead and an abrasion to nose. Alarms were sounding...MD and family aware. New intervention is to get resident a shorter blanket that will not get caught in wheels of wheelchair."</p>			

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	<p>On 2/17/16 at 1:21 P.M., "Resident continues to yell, moan, attempt to get up, does not follow commands. MD notified. Staff requested MD come to facility to eval [evaluate] patient for continued decline. Awaiting orders."</p> <p>On 2/17/16 at 6:23 P.M., "1700 [5:00 P.M.] [name of physician] here to see res...Received orders to send res to [local hospital] direct admit for observation. Schedule to CT scan at hospital...Res lethargic now. bump on head has not increased."</p> <p>The Fall care plans were updated to include the intervention "lap robe in lap instead of blanket" (2/18/16)</p> <p>The Emergency Room [ER] report dated 2/17/16 was reviewed and included, but were not limited to, " 98 year old...lives at [name of facility]...history of dementia...increased confusion the past few days...was found to have urinary tract infection...has history of falling....fell this morning...sustained bruising to forehead and abrasion to nose..."</p> <p>The nurse's notes continued and included:</p> <p>Fall #2- 3/11/16 at 9:10 A.M., Resident had witnessed fall at this time in the dining [sic]. Resident did hit [his/her]</p>			

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	<p>head has a laceration approx. [approximately] 10 cm [centimeters] x [by] 10 cm moon shaped...EMS [Emergency Medical Services] and MD were called. Pressure applied to head laceration..."</p> <p>On 3/11/16 at 9:20 A.M., "Alarm was sounding at the time of incident, resident leaned forward and fell straight forward and hit forehead, no other injuries noted".</p> <p>On 3/11/16 at 11:30, "Resident arrived back to facility via EMS orders to remove sutures in 10 days...EMS and staff assisted resident back to bed, alarm on and functioning..."</p> <p>On 3/11/16 at 6:50 P.M., "area [sic] on head has 10-12 sutures...very anxious this evening looking for mother. No change in level of confusion prior to fall..."</p> <p>The fall care plan was updated to include the intervention "therapy to check positioning and tilt set back to help [name] sit up more straight (3/11/16)."</p> <p>An ER report dated 3/11/16 included but was not limited "Head Injury, Laceration...Stitches can be removed in 10 days in the ED... Keep wound clean and dry, medications as prescribed..."</p>			

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	<p>During an interview with the Director of Nursing (DON) on 11:10 A.M., she indicated she considered all residents in the facility at risk for falls. She indicated Resident C was readmitted to the facility on 12/23/15 following a hospitalization from a previous fall. She indicated Resident C had experienced a cervical fracture after falling from his/her wheel chair on 12/21/15. She indicated Resident C had previously had alarms and these were reinitiated and was to be evaluated by therapy as interventions. She further indicated a fall risk assessment for Resident C was completed on 1/19/15 and Resident C received a score of 14 indicating he/she was a high risk to experience falls.</p> <p>The DON indicated fall #1 occurred on 2/17/15 at 10:15 A.M., She indicated it was an unwitnessed fall that occurred when Resident C was propelling his/herself and his/her blanket became caught in the wheels on the wheel chair and pulled resident C from the wheelchair. She indicated Resident C experienced a bump and bruising on his/her forehead and an abrasion to the nose. She indicated Resident C was sent to the hospital and a CAT scan (CT) of the head was negative. She indicated the intervention at this time was to provide Resident C with a lap blanket so the</p>			

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	<p>length would not be a problem. The DON indicated no documentation as to the size of the bump or bruising Resident C had experienced could be provided.</p> <p>The DON indicated Fall #2 occurred on 3/11/16 in the facility's Main Dining Room (MDR) at 9:00 A.M. She indicated this fall was witnessed (no staff names were provided). She indicated Resident C went to reach for an item on the floor and fell forward out of the chair striking his/her head and received a laceration to the forehead. She indicated first aid was provided and Resident C was sent to the local hospital where she received 10 to 12 stitches. She indicated the intervention was to have therapy evaluation for wheelchair positioning. At that time the DON indicated documentation Resident C had been evaluation for wheel chair positioning was lacking.</p> <p>During an interview with Occupational Therapist (OT) #3 on 3/17/16 at 11:40 A.M., she indicated another OT had made adjustments to Resident C's wheel chair upon his/her return from the hospital. OT #3 was unable to provide any documentation of the evaluation and adjustments that were made at that time.</p> <p>The Administrator and the Director of</p>			

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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>nursing were made aware of the issues concerning adequate supervision and the implementation of effective interventions to prevent falls for Resident C on 3/17/16 at 12:20 P.M. During an interview with the DON at that time, the DON indicated she was unaware of how Resident C's falls could have been prevented on 3/11/16. The DON indicated Resident C was in the dining room in a supervised activity on the day Fall #2 occurred, 3/11/16. The DON was unable to recall what activity was going on at that time.</p> <p>During an interview on 3/17/16 at 2:30 P.M. with the Activity Coordinator (AC) she provided the March activity schedule. She indicated on 3/11/16 at 9:00 A.M., she provided 1 on 1 visits to residents. The AC indicated 1 on 1 activities are activities done with residents who are unable or unwilling to come to the group activities. She indicated she conducts these 1 on 1 visits in the residents' rooms and not in the main dining room.</p> <p>The activity attendance schedule for Resident C was provided by the AC on 3/17/16 at 2:29 P.M., at that time during an interview she indicated Resident C attends most group activities so she is not care planned and has not received 1 on 1 visits. She indicated there were no activities provided in the MDR on</p>			

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	<p>3/11/16.</p> <p>3. A random observation occurred during an interview with the Activities Coordinator (AC) on 3/17/16 at 2:30 P.M. A set of fire doors located on the west long hall were observed to be closed. Located behind the closed fire doors were 4 residents' rooms where residents were asleep. These residents' rooms were not visible to the nurses' station on the west long hall. A second set of fire doors located further down the west long hall were observed to be closed as well. Resident R was observed seated in a wheelchair and knocking on the 2nd set of closed fire doors, requesting to talk with a nurse. The AC indicated she was unaware of the location of the west hall staff at that time. No staff were observed providing supervision for the residents on the west long hall whose rooms were located behind the 2 sets of closed fire doors.</p> <p>The clinical record for Resident R was reviewed on 3/17/16 at 2:40 P.M. Diagnoses included, but were not limited to dementia, heart failure, hypertension and anxiety.</p> <p>A Quarterly MDS dated 1/25/16 indicated Resident R had a BIMS of 3, indicating he/she was severely</p>			

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	<p>cognitively impaired.</p> <p>The MDS listed Resident R as requiring extensive assist of 1 person for personal hygiene, locomotion on and off the unit, and ambulation.</p> <p>During an interview with the Administrator on 3/17/16 at 2:35 P.M., the Administrator indicated the facility had contractors on site to inspect and repair any issues with the facility's fire alarm system. He indicated the magnetic door hardware which held the fire doors open were not working at this time. The Administrator further indicated he had instructed the staff to post at least one staff member on each hall during the scheduled repair. The Administrator indicated it was the facility's policy to provide adequate supervision to all residents.</p> <p>The facility policy titled "Falls and Fall Risk, Managing" dated 3/4/15 was provided on 3/17/16 at 1:15 P.M. by the administrator. "...the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...The staff, with input of the Attending Physicians, will identify appropriate interventions to reduce the</p>			

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	<p>risk of falls....initial approaches might include exercise and balance training...If falling recurs despite initial intervention, staff will implement additional or different interventions...If underlying causes cannot be readily identified, staff will try various interventions, based on ...nature or category of falling, until reduced or stopped....If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change intervention..."</p> <p>This Federal tag relates to Complaint IN00195866.</p> <p>3.1-45(a)(2)</p>				