STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00449082, IN00449097, and IN00446323. Complaint IN00449082: No deficiencies related to the allegations are cited. Complaint IN00449097: Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00446323: Federal/State deficiencies related to the allegations are cited at F921. Unrelated deficiencies are cited. Survey dates: December 13 & 16, 2024 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 8 Medicaid: 52 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 18, 2024.	F 0000	By submitting the enclosed materials, 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 requests the plan of correction be considered our allegation of compliance effective January 15, 2025, to the state findings of the Complaint Survey conducted on December 16, 2024.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin L McCarty	Executive Director	01/02/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Based on observation, interview, and record review, the facility failed to ensure medications and syringes were stored safely and securely during a random observation during the survey. Discontinued medications along with an unsecured sharps container with unused syringes were stored in an unlocked conference room. (Resident J) Finding includes: During an observation on 12/13/24 at 12:30 P.M., a cardboard box that contained Resident J's medications included the following: Levofloxacin 500 mg (milligrams) - 19 tablets Vitamin D3 50,000 IU (International Unit) - 3 tablets 1 bag of Juven Oral Packets (nutritional supplement) - 20 packets Scopolamine Base Patch 1.5 mg - 1 patch An unsealed sharps container was also observed next to the box of medications. The container held 30 unused syringes that were accessible through an opening at the top of the box. During an interview on 12/13/24 at 12:35 P.M., the Director of Nursing (DON) indicated the medications would be removed from the conference room. During an observation at 1:40 P.M., the medications were no longer stored in the unlocked conference room. An unsealed sharps container with 30 unused syringes that were accessible through an opening at the top of the box remained in the conference room. During an interview on 12/13/24 at 2:00 P.M., LPN 8 indicated that all medications and syringes	F 0761	F - 761 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the medications belonging to the resident identified as resident J were immediately destroyed. All unused syringes and sharps containers are now properly stored in a secured area. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All medications, syringes (used and unused) are properly stored in a secured area along with all sharp's containers. *The measures 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 policy and procedure on medications, biologicals, syringes and sharps containers handling and storage. All staff was reminded of their responsibility to properly handle and store these items in accordance with the facility policy and procedures as well as the Federal regulations *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	01/15/2025

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	should be stored securely either in a locked medication room or locked medication cart. During an interview on 12/13/24 at at 2:30 P.M., the Minimum Data Set (MDS) Nurse indicated the syringes had been placed in the conference room the day prior and that they should not be left unsecured. On 12/16/24 at 8:30 A.M., the Facility Administrator supplied an undated facility policy titled, Medication Labeling and Storage. The policy indicated, "The facility stores all medications and biologicals in locked compartments under proper temperature humidity and light controls. Only authorized personnel have access to keys... 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items..." 3.1-25(m)		developed and implemented to monitor the compliance of the proper handling and secure storage of medications, biologicals, syringes and sharps containers. This tool will be completed by the Director of Nursing and/or their designee weekly for four 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 meetings to determine if any additional action is warranted.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 2 of 2 resident halls observed. Resident areas had holes in walls, floors were in disrepair, specimen collection hats were stored uncovered, resident trash receptacles were full, and odors were present during 2 of 2 days of the survey. (East Hall, West Hall, room 48, Room 25, Room 7) Finding includes: 1. During an observation on 12/13/24 at 9:40 A.M.,	F 0921	F - 921 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the flooring identified in front of the West Hall nursing station near the wall mounted heating/air conditioning unit has now been repaired and is no longer cracked and uneven. *2.) The corrective action taken for those residents found to have been affected by the deficient*	01/15/2025

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	the flooring in front of the West Hall nurse's station near a wall mounted heating/air unit was cracked and uneven. During an observation and interview on 12/16/24 at 8:25 A.M., the Maintenance Director observed the uneven floor and indicated that the heating/air units had been leaking. The floor had already been repaired near the West Hall's nurse's station, but was not repaired well and that the floor was left uneven. 2. During an observation on 12/13/24 at 9:45 A.M., Room 48's shared restroom contained a hole in the drywall across from the commode and sink. The floor in front of the sink was soft and depressed when bearing weight. During an observation and interview on 12/16/24 at 8:30 A.M., the Maintenance Director indicated that she was unaware of the hole in room 48's shared restroom and that the floor has been an ongoing issue and that the facility is addressing the flooring soon. No specific details for how or when the flooring for room 48's shared restroom would be repaired were provided. 3. During an observation on 12/13/24 at 9:15 A.M., the East hall had a damp/mildew odor. During an observation on 12/16/24 at 7:00 A.M., the East hall had a damp/mildew odor. During an observation and interview on 12/16/24 at 7:55 A.M., a resident in room 25 on the East Hall indicated that the hall smells like a "sewer" especially after a rain. The room was missing flooring near the room door with plywood exposed.		*practice is that* the shared bathroom identified with Room 48 has now had the hole in the drywall across from the commode and sink repaired and painted. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the flooring near the room door of the room identified as room 25 has been replaced and the plywood is no longer exposed. The East hallway has also been thoroughly cleaned and there are no unpleasant odors present. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the flooring has now been repaired on the service hall off of the West hallway between the emergency food supply room and the storage room door and is now solid with no soft spots. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the doorway leading into part of the West hall has now been repaired and the drywall is no longer exposed. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the shared bathroom in room 7 has been thoroughly cleaned. All personal care items identified as a urine	

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	During an interview on 12/16/24 at 8:10 A.M., the Maintenance Director indicated that part of the facility had a significant water leak and that repairs will be starting in January 2025. The maintenance director indicated that heating and air units had not been "bled" or drained routinely and many of the units had leaked and caused damage to the floors. The facility had quotes for repairs to be made to 5 resident rooms that were unoccupied. Those repairs were expected to extend into the resident halls and into other rooms currently occupied by residents. 4. During an observation on 12/16/24 at 6:10 A.M., a service hall off the West hallway had a soft spot in the floor between an emergency food supply room and storage room door. The area depressed when bearing weight. 5. During an observation on 12/16/24 at 6:15 A.M. the doorway into part of the West Hall was damaged near the floor exposing drywall. 6. During an observation and interview on 12/16/24 at 7:45 A.M., Room 7's shared restroom contained an uncovered urine collection hat and an empty, uncovered basin on the floor next to the commode. Several napkins were on the floor around the commode, and the trash can was full with paper towels and briefs. The resident indicated the shared restroom is typically "a mess." During an interview on 12/16/24 at 8:35 A.M., the Maintenance Director indicated she is also the head of housekeeping. The Maintenance Director indicated that old briefs should not be left in resident restroom trash and that bed pans and urine collection hats should be covered when stored.		collection hat and wash basin have been removed and stored appropriately. The trash can has been emptied and all paper towels and briefs have been properly disposed of. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide environmental and housekeeping audit has been conducted to identified any cleanliness and safety issues. All identified issues have been promptly corrected. All areas of the facility are now clean, sanitary, in good functional and comfortable condition. *The measures 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 staff on their individual responsibilities of ensuring that all areas of the facility are maintained in a safe, sanitary and homelike environment. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the condition of the facility's environment to ensure all areas remain, safe, sanitary and	

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	On 12/16/24 at 8:30 A.M., the Facility Administrator supplied an undated facility policy titled Homelike Environment. The policy indicated, "Residents are provided with a safe, clean, comfortable and homelike environment... 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The characteristics include: ...f. pleasant, neutral scents..." This citation relates to complaints IN00449097 and IN00446323. 3.1-19(a)(4) 3.1-19(f)(5)		homelike. This tool will be completed by the Executive Director and/or their designee weekly for four 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 meetings to determine if any additional action is warranted.	