STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00417903 completed on September 25, 2023. This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on September 25, 2023. This visit was in conjunction with the Investigation of Complaint IN00420028. Complaint IN00417903 - Not corrected. Survey dates: November 2 & 3, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 1 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 8, 2023.	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 11/23/23 to the state findings of the Post Survey Review conducted on November 3, 2023.	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Van Hoy	Administrator	11/21/2023

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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Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 1 of 3 residents reviewed. A resident with a history of falling, did not have care plan interventions in place prior to a fall as indicated in written care plan. (Resident P) Finding includes: On 11/2/23 at 10:50 A.M., LPN (Licensed Practical Nurse) 9 indicated Resident P had fallen the previous day, on 11/1/23, but she had not been in the building when the fall took place. At that time, Resident P was observed sitting in the common area in a wheelchair facing away from the nurses station. LPN 9 demonstrated that the pull alarm attached from the back of the wheelchair to the resident's shirt was functional, and sounded when pulled. Resident P was observed with a pair of black fuzzy socks on that were not non-skid. LPN 9 indicated the resident was supposed to have non-skid socks on, and directed another staff member to obtain a pair to put on Resident P. Resident P was sitting on a blue cushion that came up between the legs, separating the knees. On 11/2/23 at 12:17 P.M., Resident P's clinical record was reviewed. The most recent annual	F 0689	F – 689 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has been reviewed by the interdisciplinary team related to their fall risks. In addition, the resident's medication regimen has been reviewed by the nurse practitioner and medication adjustments have been implemented. It should also be noted that due to the resident's overall declining condition related to the resident's primary diagnosis that the family has chosen to add hospice services at this time. All safety interventions are now in place in accordance with the resident's current plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has also been conducted to ensure all safety interventions are in place according with each resident's current plan of care. Upon	11/23/2023

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	MDS (Minimum Data Set) Assessment, dated 10/13/23, indicated a cognition status could not be assessed, and Resident P had no behaviors during the assessment period, and had not experienced any falls since the previous assessment on 9/15/23. Diagnosis included, but were not limited to, nontraumatic brain dysfunction, Alzheimer's disease, anxiety, and repeated falls. Resident P required total dependence for bed mobility, toileting, and transfers for the previous 14 days. Current physician orders included, but were not limited to: SAFETY - pommel cushion (a cushion designed to keep the knees apart and limit forward sliding in a wheelchair), dated 3/21/23. A current risk for falls care plan included, but was not limited to, the following interventions: Assistive device wheelchair for locomotion on and off the unit, dated 10/12/22. Non skid footwear at all times, dated 10/12/23. Pelvic tilt cushion in wheelchair, dated 1/8/23. Pull tab alarm in wheelchair while up, dated 1/8/23. An initial fall incident report, dated 11/1/23, indicated Resident P fell 11/1/23 at 3:08 P.M. and experienced a 2cm (centimeter) x 2cm laceration on the forehead from hitting above the left eye on the floor. Resident was restless in wheelchair and pulled self forward out of wheelchair hitting face on the floor. Alarm was sounding. Fall was witnessed and resident was sent to the Emergency Room (ER) for evaluation.		observation of each resident, their safety interventions are in place in accordance with their individualized plan of care. *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 conducted for all nursing staff on their responsibility to ensure that each resident's safety interventions are in place in accordance with the resident's individualized plan of care. *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 use of safety interventions in accordance with the resident's plan of care in an attempt to prevent future falls. This tool will be completed by the Director of Nursing and/or their designee daily for seven days, then twice a week for two weeks, then 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 Quality Assurance meetings to determine if any additional action is warranted.	

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	A fall follow up, dated 11/2/23 at 3:05 P.M., indicated bruising had started on the left side of face especially above the left eye, and steri strips (a type of bandage) were in place for head laceration. Resident will continue to be monitored while in bed. Staff to check every 15 to 30 minutes since hospital return. CT (computed tomography) of head negative. Progress notes included, but were not limited to, the following: 11/1/23 at 6:12 P.M. Transfer/Discharge Information Resident was transferred to (hospital) due to fall with head injury and hypoxic. 11/2/23 at 12:47 A.M. "[Hospital] ER called; vitals have been stable, all tests/scans were negative. Abdominal scan showed constipation. N/o [new order] for bacitracin [topical antibiotic] for forehead, colace [a stool softener] for constipation. Resident being sent back to facility via ambulance" 11/2/23 at 11:34 A.M. "The IDT [interdisciplinary team] has reviewed post fall documentation and agrees that an appropriate intervention following this fall is have the NP [Nurse Practitioner] review meds [medications]" On 11/2/23 at 12:54 P.M., Resident P was observed lying in bed with the top half of the body hanging off of the bed, that was in the lowest position, with their head rested on the fall mat beside it. The lower part of the body was in the bed covered by a blanket. On 11/2/23 at 1:02 P.M., LPN 5 indicated she was here at the time of Resident P's fall the previous day, but was in another resident's room at the			

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	time. A CNA (Certified Nurse Aide) came to get her. When she came into the common area, Resident P was on the floor with her wheelchair beside the recliner. LPN 5 indicated Resident P was dressed in a shirt, pants, and non-skid socks. She further indicated staff did not provide Resident P with anything to play or fidget with because it would not work. She indicated prior to the fall, Resident P had a blanket over her lap, and had not been any more agitated than normal, and in fact was not agitated at all at the time of the fall. On 11/2/23 at 1:25 P.M., Housekeeper 3 indicated she had been in the common area at the time Resident P had fallen the previous day, and witnessed the fall. She indicated she turned around to look at the resident when another staff member got up and yelled the resident's name. Upon turning around, the resident was sliding slowly out of the wheelchair with both legs on the same side of the middle divider of the cushion, falling almost sideways. When the resident hit the floor, it was a little under the recliner that was beside the wheelchair. She indicated the resident landed on the forehead. She further indicated there was an alarm box hanging from the back of the wheelchair, and the other end was clipped to the resident, but not sounding, which was odd because the pull cord was short and alarmed several times during the day from the resident fidgeting and moving. She indicated Resident P was not agitated prior to the fall. On 11/2/23 at 1:48 P.M., QMA (Qualified Medication Aide) 7 indicated she had been standing at the medication cart by the common area when Resident P had fallen the previous day. She heard a staff member say "Oh!" and when she turned around, Resident P was on the floor on the left side with a wheelchair behind them. She			

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	indicated Resident P was dressed with blue pants, a striped shirt, and non-skid socks. There was a blanket on the floor with the resident. She indicated she immediately went to the resident, applied pressure to an open area on the forehead, and yelled for the nurse. She indicated Resident P had the pull alarm attached to her, but was not sounding. She further indicated Resident P was unable to get one leg over the hump between the legs independently, and was not sure how that happened. On 11/3/23 at 9:30 A.M., the Administrator provided a current non-dated Managing Falls and Fall Risk policy that indicated "The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls" This deficiency was cited on 9/25/23. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Complaint IN00417903. 3.1-45(a)			
F 9999 Bldg. 00		F 9999	F – 689 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident P has been reviewed by the interdisciplinary team related to their fall risks. In addition, the resident's medication	11/23/2023

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			regimen has been reviewed by the nurse practitioner and medication adjustments have been implemented. It should also be noted that due to the resident's overall declining condition related to the resident's primary diagnosis that the family has chosen to add hospice services at this time. All safety interventions are now in place in accordance with the resident's current plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has also been conducted to ensure all safety interventions are in place according with each resident's current plan of care. Upon observation of each resident, their safety interventions are in place in accordance with their individualized plan of care. *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 conducted for all nursing staff on their responsibility to ensure that each resident's safety interventions are in place in accordance with the resident's individualized plan of care. *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	

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			monitor the use of safety interventions in accordance with the resident's plan of care in an attempt to prevent future falls. This tool will be completed by the Director of Nursing and/or their designee daily for seven days, then twice a week for two weeks, then 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 Quality Assurance meetings to determine if any additional action is warranted.	