PRINTED: 10/26/2023
FORM APPROVED

AND PLAN OF CORRECTION INSTITUTE TO DEATHER THE ADDRESS, CITY, STATE 2IP COD 725 S SECOND ST BOONVILLE, IN 47601 SUMMARY STATEMENT OF DEFICIENCE PREFIX TAG REGULATORY OR 1SC IDENTIFYING INFORMATION FORD Bidg. 00 Bidg. 00 This visit was for the investigation of complaint INO0417535. Complaint IN00417535 - Federal/state deficiencies related to the allegations are cited at F604. Survey dates: September 19 & 20, 2023 Facility number: 000451 Provider number: 155508 AIM number: 10026640 Census Bed Type: SNF/NH: 55 Total: 55 Total: 55 Total: 55 Total: 55 This deficiency reflects State Findings cited in uccordance with 410 IAC 16.2-3.1. Quality review in September 29, 2023. Bed Tipy (1), 483.12(a)(2) SSPD Bidg. 00 Bed NTG SIRRET ADDRESS, CITY, STATE 2IP COD 725 S SECOND ST BOONVILLE, IN 47601 SPREIX TAG SPREIX TAG SPREIX TAG PREFIX TAG SPREIX TAG PREFIX TAG TAG PREFIX TAG PREFIX TAG TAG	CENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039			
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their underlying medical condition. ### The resident has a right to be free from any ### The r					safe, functional positioning du	e to			
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SS=D Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any									
SS=D Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any	F 0604	483.10(e)(1) 483	.12(a)(2)						
Bldg. 00 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any									
The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any		_							
respect and dignity, including: §483.10(e)(1) The right to be free from any	Blug. 00								
§483.10(e)(1) The right to be free from any			_						
		respect and dignit	y, including:						
physical or chemical restraints imposed for		physical or chemic	cal restraints imposed for						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Jacqueline K Morris Executive Director 10/13/2023

Any defiency statement 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 disclodays 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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10/26/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2023 155508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 725 S SECOND ST TRANSCENDENT HEALTHCARE OF BOONVILLE BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record F 0604 F - 604 10/16/2023 review, the facility failed to ensure residents were The corrective action taken for free from physical restraints for 1 of 1 residents those residents found to have reviewed for restraints. A resident was placed in a been affected by the deficient new wheel chair that restricted mobilization and practice is that the resident was strapped into the wheelchair without identified as resident C has now documented clinical rational for the need of the had a pre-restraining assessment wheelchair with straps, assessments, or a plan of completed to support the use of a care for the use of restraints. (Resident C) specialty wheel chair. The therapist has also completed an Finding includes: assessment to support the use of the specialty wheel chair to aide

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During an observation on 9/19/23 at 9:20 A.M.,

Resident C was sitting in front of the West hall's

nurse's station in a Tilt-in-Space wheelchair.

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the resident in proper positioning

and trunk control. The foot straps

were removed from the wheel chair

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> CC		COMPL	ETED
		155508	B. W	ING _		09/20/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
	T		ı		,		ave.
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		aring a lap belt and foot straps around both ankles.			during survey. A foot buddy h		
	that were wrapped	around both ankles.			been added to the specialty c	nair	
	Duning and and	ew on 9/19/23 at 11:00 A.M.,			to assist with proper foot	41	
	_	oses included, but were not			positioning without restricting		
	_	palsy, epilepsy, abnormal			resident's movement. The lap		
		d convulsions, schizophrenia,			is in place to aide in trunk con		
		isorders, anxiety, and mild			however it is not considered a		
	intellectual disabili	-			restraint as the resident clearl demonstrates the ability to rer	•	
	mieneciaai aisabili	ues.			_	IIOVE	
	Resident C's most r	recent quarterly MDS			the lap belt upon command. The corrective action taken for	r the	
		t) assessments, dated 8/28/23,			other residents that have the	ı ın c	
		sident had moderate cognitive			potential to be affected by the		
		ysical behavioral symptoms			same deficient practice is that		
		hers, verbal behavioral			housewide audit has been	. a	
		towards others, and did not			conducted to identify any other	ar.	
	use physical restrai				devices that could be conside		
	use physical restrai	nts.			restraint. No additional device		
	Resident C's physic	cian orders included, but were			were identified during this aud		
		use self releasing seatbelt on			a restraint.	iit as	
		9/19/23), occupational therapy			The measures that have beer	nut	
		d treatment for self-care,			into place to ensure that the	r put	
		e, neuromuscular reeducation			deficient practice does not red	cur is	
	_	e activities for treatment of			that a mandatory in-service ha		
	, ,	ordinated (started 8/8/23),			been provided for all nursing		
		air with pummel cushion			therapy staff on the facility's p		
		and may use specialty			related to the use of a restrair	-	
	wheelchair (started				The staff was educated on the		
	Ì	,			required assessments that mu		
	Resident C's wande	ering assessment dated 8/28/23,			be completed prior to the use		
		cluded that the resident can			any type of device that is		
	1	tance while in wheelchair.			considered a restraint or any		
					device that could potentially		
	Resident C's progre	ess notes included:			restrict a resident from freedo	m of	
					movement.		
	7/29/23 at 12:26 P.	M "Resident in vending			The corrective action taken to)	
		atening to throw himself on			monitor to ensure the deficien		
		yelling at staff. Ramming into			practice will not recur is that a		
		elchair. Not redirectable at this			Quality Assurance tool has be		
	time. Resident attempted to tip self out of chair				developed and implemented t		

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CO		COMPL	COMPLETED	
		155508	B. WING 09/20/2023			/2023	
		<u> </u>	1	OTT PET	DDDEGG CHTV CT TT TD COT		
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
TDANCO		CARE OF BOOK!			SECOND ST		
IRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOON	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ver staff stopped him from			ensure that any type of restrai	nt or	
	doing so"				any type of device that could		
					potentially restrict a resident's		
		I., - "has been to SSD (Social			movement has the proper		
	·	office multiple times today due			assessment completed prior to		
	_	g behavior. Starting this			the application of the device to)	
		hat he wanted to go home and			support the medically justified		
		nis mother, then crying			need for the device. This tool		
	1	n threatening to call the cops			be completed by the Director		
		ning job duties. SSD was then			Nursing and/or their designee		
		ng smoke break due to			weekly for four weeks, then		
	1	ng his wheelchair into the			monthly for three months and		
		ate and attempting to escape			quarterly for three quarters. T	he	
	and/or hurt himself	"			outcome of this tool will be		
	0/15/0000 111 45				reviewed at the facility's qualit	-	
		A.M., - "Resident was seen			assurance meetings to determ	nine	
		ng wall. This writer attempted			if any additional action is		
		d find out why he was upset.			warranted.		
		is stupid (explicit) wheelchair is					
		noticed wheelchair brake was					
		and attempted to assist with					
	getting wheelchair	wheel brake					
	8/15/2022 of 2:22 D	P.M 15:23 - "Resident has					
		y. Striking at staff and other					
	_	did not make contact with					
		ates he's tired of people,					
	1 -	nit.' Resident upset that he is					
	_	e anymore due to him					
	_	himself and refusal to wear					
	proper safety gear v						
		ent doing prior to the					
	behavior: Propelling in wheelchair around						
	facility."						
	8/24/2023 at 10:30	A.M"Resident cursing out					
	loud about another	resident's behavior. Nurse					
	asked resident to pl	ease calm down and talk to					
	her [approximate]	ly] 5 [minutes] post speaking					
		was noted propelling himself					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		l í	UILDING	nstruction 00	(X3) DATE COMPI 09/20	LETED	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 725 S SECOND ST BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE	
		dent to run into them with his attempted to strike another						
	nursing staff that [R aggressive and need residents to calm do office and attempted. C] then rammed his door attempting to be 8/24/2023 12:00 P.J. Resident attempting attempting to redire wheelchair against a from [Medical Doceeval/treatment related. Resident C's care pleased as exhibited by yell or walls with his fiss. Resident C's record to the lap seatbelt at Resident C's record the use of a lap seat During an interview 23 indicated that Reseatbelt as he was gwheelchair, that he himself, and that he with his new wheelchair an interview During an interview During an interview and the seatbelt as he was gwheelchair, that he himself, and that he with his new wheelchair and interview During an interview and	M "Behaviors escalating. g to hit staff member cet him and ramming his a glass door. Order obtained tor] to send out for ed to uncontrolled behaviors." Ian included, Resident aviors of being inappropriate ing, cursing and hitting doors at and or wheelchair. Iacked assessments for the use and foot/ankle straps. Iacked a plan of care regarding belt and foot/ankle straps. Ion 9/19/23 at 9:23 A.M., QMA esident C was wearing a metting used to his new could remove the lap seatbelt was working with therapy chair.						
		23 pushed Resident C in his common area in front of the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
155508		B. W	ING		09/20/	/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ECOND ST		
TRANSCENDENT HEALTHCARE OF BOONVILLE					/ILLE, IN 47601		
				<u> </u>			ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ation to his room. Resident C					
		ew wheelchair is more					
		is old wheelchair, but that he					
	_	eel himself around in the chair					
	-	ly able to do. Resident C atbelt himself, QMA 23					
	_	nkle straps and assisted the					
		wheelchair. Following					
		C was assisted back to his					
	*	seat belt and foot/ankle straps					
	were put back on by	-					
	ware pur such an a	, (20)					
	During an interview	v on 9/20/23 at 9:48 A.M., OT 4					
	indicated working v						
	_	positioning. Resident C had					
		Tilt-in-Space wheelchair that					
		sed to be in highback					
	wheelchair with cus	shion and foot pedals, he was					
	mobile in the previo	ous wheelchair. Resident C is					
	unable to be mobile	e in the new wheelchair but it					
	does help with his p	position. Therapy staff did not					
	recommend the Tilt	t-in-Space wheelchair nor did					
	they recommend the	e use of the straps on the					
		nt C had been using the new					
		3 weeks and therapy staff have					
		assessments for the use of the					
		for the use of the straps. OT 4					
	_	going to add a new foot					
		elchair so that the resident's					
		e to be strapped into the					
	wheelchair.						
	Daning a 1 t 1						
	-	v on 9/20/23 at 10:40 A.M., the					
		Resident C was seen for an					
		y program a few weeks prior.					
		uation, a new wheelchair was					
		t C to help with his posture.					
	_	using the new wheelchair right					
		ved Resident C back to his old					
	wneeichair but then	the next day he was using the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2023
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
	his new wheelchair however he is unab	in. Resident C appears to like and appears more comfortable, le to wheel himself in the chair. where he wants to go.			
	7 indicated that if a straps, they should and the resident should belt/strap release should time, but Resident Coumentation in hiresident has a change	resident is utilizing a belt or per released every two hours and be documented every to does not have any is record. Normally when a ge in equipment, staff would nent and discuss a plan as a			
	supplied a facility p Assessment, dated 1 "The purpose of this safety or postural st injury to the resider has medical symptor restraints A Pre-re to be completed to a of the resident's wel either medication in restraining devices restrictive intervent the licensed nurse should be recorded record: 1. The date applied. 2. The nam who applied the res restraint applied. 4. restraint was applier restraint will be use released for residen position change. 7.	A.M., the facility administrator olicy titled, Physical Restraint 1/20/19. The policy included, is procedure is to provide apport of a resident to prevent at or others when the resident in that warrant the use of estraining assessment form is adequately assess all aspects all-being prior to the use of atterventions or physical and order to identify the least ion. It is to be completed by The following information in the resident's medical and time the restraint was are and title of the individual(S) traint. 3. The type of physical The specific reason the d. 5. The length of time the d. 6. Each time the device is the exercise, toileting, and Each time the resident is ity policy. 8. All assessment			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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ľ		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2023	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE				725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the resident particip changes in the resid the procedure. 10. A made by the resider application"	g the procedure. 9. If and how ated in the procedure or any ent's ability to participated in any problems or complaints at related to the restraint ates to complaint IN00417535.					

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