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	09/20/2023

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 complaint IN00417535. 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: 100266240 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 4 Medicaid: 51 Total: 55 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review in September 29, 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 October 16, 2023 to the state findings of the Complaint Survey conducted on September 20, 2023. Please let the record show that this device was in no way a restraint for this resident but only being utilized as a positioning device due to the resident's diagnoses of cerebral palsy and epilepsy. Based on the facility's assessment of the resident, the resident had poor trunk control and the device was only being utilized to assist the resident with safe, functional positioning due to their underlying medical condition.	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) 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 physical or chemical restraints imposed for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline K Morris	Executive Director	10/13/2023

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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	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 review, the facility failed to ensure residents were free from physical restraints for 1 of 1 residents reviewed for restraints. A resident was placed in a new wheel chair that restricted mobilization and was strapped into the wheelchair without documented clinical rational for the need of the wheelchair with straps, assessments, or a plan of care for the use of restraints. (Resident C) Finding includes: 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.	F 0604	F - 604 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C has now had a pre-restraining assessment completed to support the use of a specialty wheel chair. The therapist has also completed an assessment to support the use of the specialty wheel chair to aide the resident in proper positioning and trunk control. The foot straps were removed from the wheel chair	10/16/2023

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	Resident C was wearing a lap belt and foot straps that were wrapped around both ankles. During record review on 9/19/23 at 11:00 A.M., Resident C's diagnoses included, but were not limited to, cerebral palsy, epilepsy, abnormal posture, unspecified convulsions, schizophrenia, major depressive disorders, anxiety, and mild intellectual disabilities. Resident C's most recent quarterly MDS (Minimum Data Set) assessments, dated 8/28/23, included that the resident had moderate cognitive impairment, had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, and did not use physical restraints. Resident C's physician orders included, but were not limited to; may use self releasing seatbelt on wheelchair (started 9/19/23), occupational therapy (OT) evaluation and treatment for self-care, therapeutic exercise, neuromuscular reeducation (NMR), therapeutic activities for treatment of weakness and uncoordinated (started 8/8/23), high back wheelchair with pummel cushion (started 10/19/19), and may use specialty wheelchair (started 9/6/23). Resident C's wandering assessment dated 8/28/23, under "mobility" included that the resident can move without assistance while in wheelchair. Resident C's progress notes included: 7/29/23 at 12:26 P.M. - "Resident in vending machine area. Threatening to throw himself on floor. Agitated and yelling at staff. Ramming into machines with wheelchair. Not redirectable at this time. Resident attempted to tip self out of chair		during survey. A foot buddy has been added to the specialty chair to assist with proper foot positioning without restricting the resident's movement. The lap belt is in place to aide in trunk control however it is not considered a restraint as the resident clearly demonstrates the ability to remove the lap belt upon command. *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 been conducted to identify any other devices that could be considered a restraint. No additional devices were identified during this audit as a restraint. *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 nursing and therapy staff on the facility's policy related to the use of a restraint. The staff was educated on the required assessments that must be completed prior to the use of any type of device that is considered a restraint or any device that could potentially restrict a resident from freedom of movement. *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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	purposefully however staff stopped him from doing so..." 7/31/23 at 3:21 P.M., - "...has been to SSD (Social Service Director's) office multiple times today due to attention seeking behavior. Starting this [morning] stating that he wanted to go home and wanted to be with his mother, then crying uncontrollably, then threatening to call the cops on staff for performing job duties. SSD was then called outside during smoke break due to [Resident C]ramming his wheelchair into the locked courtyard gate and attempting to escape and/or hurt himself..." 8/15/2023 at 11:47 A.M., - "Resident was seen... kicking and punching wall. This writer attempted to calm resident and find out why he was upset. Resident yelled "this stupid (explicit) wheelchair is stuck. This writer noticed wheelchair brake was locked on one side and attempted to assist with getting wheelchair wheel brake..." 8/15/2023 at 3:23 P.M. - 15:23 - "...Resident has been agitated all day. Striking at staff and other residents however did not make contact with anyone. Tearful. States he's tired of people, 'treating him like shit.' Resident upset that he is unable to go smoke anymore due to him threatening to burn himself and refusal to wear proper safety gear while smoking. What was the resident 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 please calm down and talk to her... [approximately] 5 [minutes] post speaking with nurse resident was noted propelling himself		ensure that any type of restraint or any type of device that could potentially restrict a resident's movement has the proper assessment completed prior to the application of the device to support the medically justified need for the device. 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.	

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	toward another resident to run into them with his wheelchair; he then attempted to strike another resident..." 8/24/2023 at 11:32 A.M. - "SSD was notified by nursing staff that [Resident C] was becoming aggressive and needed to be separated from other residents to calm down. SSD brought him to the office and attempted to speak to him. ...[Resident C] then rammed his wheelchair into SSD office door attempting to break it..." 8/24/2023 12:00 P.M. - "Behaviors escalating. Resident attempting to hit staff member attempting to redirect him and ramming his wheelchair against a glass door. Order obtained from [Medical Doctor] to send out for eval/treatment related to uncontrolled behaviors." Resident C's care plan included, Resident sometimes has behaviors of being inappropriate as exhibited by yelling, cursing and hitting doors or walls with his fist and or wheelchair. Resident C' record lacked assessments for the use of the lap seatbelt and foot/ankle straps. Resident C's record lacked a plan of care regarding the use of a lap seatbelt and foot/ankle straps. During an interview on 9/19/23 at 9:23 A.M., QMA 23 indicated that Resident C was wearing a seatbelt as he was getting used to his new wheelchair, that he could remove the lap seatbelt himself, and that he was working with therapy with his new wheelchair. During an interview and observation on 9/19/23 at 10:10 A.M., QMA 23 pushed Resident C in his wheelchair from a common area in front of the			

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	West hall nurse's station to his room. Resident C indicated that his new wheelchair is more comfortable than his old wheelchair, but that he could no longer wheel himself around in the chair as he was previously able to do. Resident C removed the lap seatbelt himself, QMA 23 removed the foot/ankle straps and assisted the resident out of the wheelchair. Following peri-care, Resident C was assisted back to his wheelchair, the lap seat belt and foot/ankle straps were put back on by QMA 23. During an interview on 9/20/23 at 9:48 A.M., OT 4 indicated working with Resident C for strengthening and positioning. Resident C had recently received a Tilt-in-Space wheelchair that was donated. He used to be in highback wheelchair with cushion and foot pedals, he was mobile in the previous wheelchair. Resident C is unable to be mobile in the new wheelchair but it does help with his position. Therapy staff did not recommend the Tilt-in-Space wheelchair nor did they recommend the use of the straps on the wheelchair. Resident C had been using the new wheelchair for 2 or 3 weeks and therapy staff have not completed any assessments for the use of the new wheelchair or for the use of the straps. OT 4 indicated they were going to add a new foot cushion to the wheelchair so that the resident's feet would not have to be strapped into the wheelchair. During an interview on 9/20/23 at 10:40 A.M., the SSD indicated that Resident C was seen for an evaluation for a day program a few weeks prior. Following the evaluation, a new wheelchair was donated to Resident C to help with his posture. The CNA's began using the new wheelchair right away. Therapy moved Resident C back to his old wheelchair but then the next day he was using the			

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	new wheelchair again. Resident C appears to like his new wheelchair and appears more comfortable, however he is unable to wheel himself in the chair. He can alert staff to where he wants to go. During an interview on 9/20/23 at 11:00 A.M., LPN 7 indicated that if a resident is utilizing a belt or straps, they should be released every two hours and the resident should be assessed. The belt/strap release should be documented every time, but Resident C does not have any documentation in his record. Normally when a resident has a change in equipment, staff would complete an assessment and discuss a plan as a team. On 9/20/23 at 11:40 A.M., the facility administrator supplied a facility policy titled, Physical Restraint Assessment, dated 1/20/19. The policy included, "The purpose of this procedure is to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptom that warrant the use of restraints... A Pre-restraining assessment form is to be completed to adequately assess all aspects of the resident's well-being... prior to the use of either medication interventions or physical restraining devices in order to identify the least restrictive intervention. It is to be completed by the licensed nurse... The following information should be recorded in the resident's medical record: 1. The date and time the restraint was applied. 2. The name and title of the individual(S) who applied the restraint. 3. The type of physical restraint applied. 4. The specific reason the restraint was applied. 5. The length of time the restraint will be used. 6. Each time the device is released for resident exercise, toileting, and position change. 7. Each time the resident is monitored, per facility policy. 8. All assessment			

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	data observed during the procedure. 9. If and how the resident participated in the procedure or any changes in the resident's ability to participated in the procedure. 10. Any problems or complaints made by the resident related to the restraint application..." This Federal tag relates to complaint IN00417535. 3.1-3(w) 3.1-26(b) 3.1-26(f)			