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	09/08/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of complaints IN00389601 and IN00388756. Complaint IN00389601 - Unsubstantiated due to lack of evidence. Complaint IN00388756 - Substantiated. Federal/state deficiencies related to the allegations are cited at F656. Survey dates: September 7 & 8, 2022 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 21 Medicaid: 26 Other: 2 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 13 2022.	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 September 23, 2022 to the state findings of the Complaint Survey conducted on September 9, 2022.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 0656	*1.) The corrective action taken for*	09/23/2022

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	Based on interview, and record review, the facility failed to ensure individual plans of care were developed and updated for 3 of 4 residents reviewed for accidents. A resident at risk for falls lacked a plan of care to prevent falls, a resident lacked updated interventions to prevent falls, and a resident at risk for wandering lacked a plan of care to prevent wandering and/or elopement. (Resident C, Resident G, and Resident F). Findings include: 1. During record review on 9/8/22 at 9:30 A.M., Resident C's diagnoses included, but were not limited to; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Resident C's most recent quarterly MDS (Minimum Data Set) dated 8/6/22, indicated the resident had mild cognitive impairment, required extensive assistance with transfers, bed mobility, and toileting. A fall assessment for Resident C was completed on 9/3/22, and indicated the resident was at a high risk for falls. Resident C's nurse's notes dated, 9/7/22 at 8:49 P.M. included, Resident was observed with skin tears to right forearm... resident sustained a fall earlier in the week... A fall follow up assessment on 9/7/22 indicated Resident C had a fall on 9/6/22 at 4:43 P.M. Resident C's care plan included but was not limited to; Resident has self care deficits related to history of stroke with hemiplegia and need for assistance with activities of daily living (ADLs), revised on 7/19/22.		*those residents found to have been affected by the deficient practice is that* the resident identified as resident C has been reviewed by the interdisciplinary team. A care plan has been developed and implemented to address the resident's fall risks and appropriate fall prevention interventions have been put in place. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that the* resident identified as resident G has been reviewed by the interdisciplinary team. The fall risk care plan has been reviewed and revised to include new fall prevention interventions in an attempt to prevent future falls. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F no longer resides at this facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all comprehensive care plans has been completed to ensure that all resident issues/concerns, including fall risk and wandering risks have been addressed with	

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	The Resident lacked a plan of care regarding their risk for falls and lacked interventions to prevent falls. 2. During record review on 9/8/22 at 11:10 A.M, Resident G's diagnoses included, but were not limited to; dementia with behavioral disturbance, anxiety, and sleep disorder. Resident most recent quarterly MDS (Minimum Data Set) dated, 7/28/22, indicated the resident had severe cognitive impairment and required limited assistance with bed mobility and transfers and could walk in their room with supervision. Resident G's care plan included, but was not limited to; resident is at risk for fall due to actual falls and age related changes, unsteadiness, poor safety awareness, and poor judgement. Interventions included but were not limited to , encourage and assist to bed when fatigued and tired (last revised on 7/27/22). Resident G's initial fall assessments indicated the resident had a fall on 8/8/22 and 8/24/22. No updates to the plan of care were implemented following the latest falls. 3. During record review on 9/8/22 at , Resident F's diagnoses included, but were not limited to; Alzheimer's disease, dementia, disorientation, and altered mental status. Resident F's most recent quarterly MDS assessment dated, 5/8/22, indicated the resident has severe cognitive impairment and required limited assistance with transfers and supervision while walking in the corridor.		appropriate interventions put in place to address the risk factors. *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 the interdisciplinary team on the facility's comprehensive care plan policy. The staff was re-educated on their responsibility to ensure that the care plan addresses each of the resident's problems/concerns and is updated in a timely manner following any incident/accident or any newly identified concern. *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 completeness, accuracy and timely update of the resident's care plans. The tool will monitor to ensure that new interventions are implemented in a timely manner following any new problem/concern identified. This tool will be completed by the MDS coordinator and/or their designee daily for two weeks, then weekly for four weeks, then monthly for three months, 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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	Resident F's wandering assessment completed on 6/1/22 indicated the resident was at risk for wandering. Resident F's wandering assessment completed on 7/20/22 indicated the resident was at high risk for wandering. Resident F's nurses notes included the following: 6/27/22 at 11:15 P.M. - Up walking halls. Resident will not go to room. Resident in wheelchair to lounge chairs. Watching television at present. In and out of residents rooms on evening shift... 7/13/22 at 6:27 P.M. - Resident was witnessed by staff going out the door and attempting to walk down front driveway of facility. Staff attempted to redirect, but was unable. This nurse went to assist and resident stated he was "going home." Able to redirect resident easily back into facility. Resident continued to wander throughout the night... 7/14/22 at 5:05 A.M. - Up all night. In and out of rooms. Watched television some. Did not sleep. 7/20/22 at 4:33 A.M. - Up all night. Resident took mattress off bed and sheets were on floor and chairs moved around. Found Resident inside the closet in the old room. During an interview on 9/8/22 at 1:00 P.M., LPN 4 indicated if a resident has an event such as a fall, the nurse should assess, notify physician and family, document the instance in progress notes and conduct follow ups as necessary. The Assistant Director or Nursing (ADON) and Director of Nursing (DON) would update the plan of care as needed so to prevent a future incident. During an interview on 9/8/22 at 1:40 P.M., the			

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	DON indicated the residents plan of care are updated at least quarterly following an MDS assessment, and as needed. On 9/8/22 at the DON provided a facility policy titled Care Plans - Comprehensive, and dated 1/2/19. The policy included, "...Purpose of Care Plan 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; ...e. Reflect treatment goals, timetables and objectives in measurable outcomes;... Revisions 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." This Federal tag relates to complaint IN00388756. 3.1-35(a)			