

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

PRINTED: 02/21/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/05/2024	
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	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	<p>This visit was for the Investigation of Complaint IN00427637, IN00427030, IN00426889, and IN00426916.</p> <p>Complaint IN00427637: No deficiencies are cited related to the allegations.</p> <p>Complaint IN00427030: No deficiencies are cited related to the allegations.</p> <p>Complaint IN00426889: State deficiencies related to the allegations are cited at F9999.</p> <p>Complaint IN00426916: State deficiencies related to the allegations are cited at F9999.</p> <p>Survey dates: February 5, 2024</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Census Bed Type: SNF/NF: 56 Total: 56</p> <p>Census Payor Type: Medicare: 8 Medicaid: 47 Other: 1 Total: 56</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p>			F 0000	<p>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 February 22, 2024 to the state findings of the Complaint Survey conducted on February 5, 2024.</p>		

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

TITLE

(X6) DATE

Robin L McCarty

Executive Director

02/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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F 9999 Bldg. 00	<p>Quality review completed on February 8, 2024.</p> <p>3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents.</p> <p>This rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to report to the state agency an unusual occurrence for 1 of 4 reportable incidents reviewed. The State Agency was not notified when the facility's heating system failed on the South wing of the West unit, requiring residents to be relocated to another wing of the facility for approximately 6 days. (Resident B, West Unit)</p> <p>Finding includes:</p> <p>During an interview on 2/5/24 at 10:45 A.M., Resident B indicated that the heat went out on the back hallway (West unit) and that she was moved to the front hall while the heat was repaired.</p> <p>During an interview on 2/5/24 at 11:50 A.M., LPN 4 indicated that West units heating system had</p>			F 9999	<p><i>The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident B has had their heating unit on the West wing repaired and it is functioning properly. Resident B has returned to their original room on the West wing. It should be noted that at no time was Resident B's welfare, safety or health threatened as the resident was promptly moved to another area of the facility where the heating unit was functioning properly.</i></p> <p><i>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 and only eleven residents were transferred to another area of the facility due to the heating unit on the West wing not functioning properly. All eleven of those residents were promptly transferred to another area of the facility where the heating units were functioning properly. Since that time the heating unit on the West wing has been repaired and all residents have been returned to their original rooms on the West wing. It</i></p>		02/22/2024

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	<p>went out and that residents on the unit were moved to the front unit of the building for almost a week.</p> <p>During an interview on 2/5/24 at 1:00 P.M., the Facility Administrator indicated that the South hall of the West unit had lost heat due to a boiler system malfunction on 12/13/23. The administrator did not report the incident to the State Agency due to the residents in that part of the building being moved to another open wing of the East unit while the facility made the repairs.</p> <p>On 2/5/24 at 1:20 P.M., the Facility Administrator supplied an undated facility policy titled, Unusual Occurrence Reporting. The policy included, "As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors... 1. Our facility will report the following events to appropriate agencies: ...e. ...interruption of essential services (e.g., heating, air conditioning...) provided by the facility..."</p> <p>This citation relates to complaints IN00426916 and IN00426889.</p>				<p>should also be noted that at no time did any of the eleven identified residents' welfare, safety or health were threatened.</p> <p><i>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 the Executive Director on the State's reportable unusual occurrences regulation to ensure their understanding of the requirement. The Executive Director was advised that it is their responsibility to ensure that all unusual occurrences are promptly reported to the appropriate agencies in accordance with the regulation.</i></p> <p><i>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 facility's unusual occurrences to ensure that all reportable events have been reported timely to all appropriate agencies as required by the State regulation. 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.</i></p>		

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