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	06/03/2024

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 IN00435502, IN00434692, and IN00433712. Complaint IN00434692: Deficiencies related to the allegations are cited at F689. Complaint IN00435502: No deficiencies are cited related to the allegations. Complaint IN00433712: No deficiencies are cited related to the allegations. Survey dates: May 30, 31, & June 3, 2024 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 10 Medicaid: 41 Other: 1 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 5 2024.	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 June 3, 2024, to the state findings of the Complaint Survey conducted on June 3, 2024.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record	F 0689	F - 689	06/03/2024

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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	review, the facility failed to ensure adequate supervision was provided to prevent a resident with dementia and a history of elopement from exiting the facility and leaving the property for 1 of 4 residents reviewed for elopement and risk for wandering. This deficient practice resulted in an elopement that occurred during the night of 5/14/24 and early morning hours of 5/15/24, after being last seen by facility staff around 10:00 P.M. on 5/14/24, a resident exited the facility and was not realized to be missing until approximately 1:00 A.M. on 5/15/24. The resident was located by local law enforcement at a previous residence approximately 22 miles from the facility. (Resident C) This Immediate Jeopardy began on 5/15/24 when the facility failed to ensure Resident C did not exit the facility through a window in the resident's room. Following a search in and around the facility property, local law enforcement was notified and located the resident. The resident was admitted to a local hospital for monitoring due to having had an APS (Adult Protective Services) court order filed on 4/11/24 for placement in a healthcare facility. The Facility Administrator and DON (Director of Nursing) was notified of the Immediate Jeopardy on 5/31/24 at 10:20 A.M. The Immediate Jeopardy was removed on 5/31/24, but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: During a review of facility reported incidents on 5/30/24 at 9:55 A.M., an IDOH (Indiana Department of Health) Reportable Incident form completed by the facility administrator, with an		*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C, 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 each resident's elopement risk assessments have been conducted. The assessments were reviewed and updated to ensure they are accurate based on the resident's current status and condition. Each resident that has been identified as a high elopement risk (score of eleven or higher) has had their picture and identifying information placed in the facility's elopement risk binder which is maintained at the nurses' station. Each resident identified as a high elopement risk has had a care plan developed and implemented to address the resident's elopement risk including appropriate safety interventions. Each resident identified as an elopement risk with a score of eleven or higher has now had a white arm band placed on their wrist to assist the staff in identifying that resident is an elopement risk. *The measures that have been put*	

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	incident dated 5/15/24 at 1:30 A.M., indicated that Resident C had a history of mental health complications related to dementia and delusional disorder. At 2:16 A.M., the Facility Administrator was notified by facility staff that Resident C was not in his room and could not be located within the parameters of the facility. Staff reported that Resident C was last seen in his bed during a medication pass at 10:00 P.M. Upon entering Resident C's room, staff observed the room window to be open and the screen to the window had been cut. The local police department was notified and came to the facility. A neighboring police department located Resident C at his previous address. Resident C was admitted to a local hospital for evaluation and treatment. During record review on 5/30/24 at 10:10 A.M., a court emergency protective services order, filed 4/11/24, indicated that Resident C was an endangered adult and in need of the proposed emergency protective services. The objectives of the emergency protective order were to secure the safety and well-being of Resident C. That a medical provider delivers the least restrictive protective services necessary to attain the objective of the adult protective services protective order. The medical provider shall place the endangered adult, Resident C, in a medical facility with 24-hour care for the duration of 45 days or until the order is terminated by the petitioner. Resident C's diagnoses included, but were not limited to dementia, delusional disorder, and mood disorder. Resident C's most recent admission MDS (Minimum Data Set) assessment, dated 5/15/24, indicated the resident had moderate cognitive		*into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all staff on the facility's elopement risk policy and procedures to ensure their knowledge level on the policy as well as to ensure the staff members understand their responsibility of ensuring that each resident's safety interventions are in place in accordance with their individualized plan of care. The staff has also been educated on their responsibility to ensure that each resident identified as an elopement risk and wearing a white arm band is being monitored in accordance with their individualized plan of care. The nursing staff is also responsible to check the resident each shift to ensure their white arm band is in place each shift and document this check in the resident's MAR/TAR each shift. *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 ensure that any resident identified as an elopement risk has the appropriate plan of care developed and implemented in an effort to keep the resident in a secure environment. This tool will monitor to ensure that the interventions developed for the resident's safety	

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	impairment and that his wandering placed him at significant risk of getting to a potentially dangerous place. A risk for wandering assessment completed 5/3/24 indicated Resident C was at high risk for wandering. Resident C's initial baseline care plan included, but was not limited to, resident has an ADL (Activities of Daily Living) self-care performance deficit due to activity intolerance, dementia, fatigue, and impaired balance (initiated 5/3/24), resident anticipates long term care as he is unable to provide his own personal care (initiated 5/4/24), and resident has a potential of psychosocial well-being concern related to new placement in healthcare nursing facility (initiated 5/4/24). Resident C's initial baseline care plan did not reference Resident C's high risk for wandering or include interventions to minimize or prevent wandering. A social service note, dated 5/4/24, indicated that Resident C refused to answer questions for assessments. When the Social Service Director (SSD) asked if they could return later to complete the assessments, Resident C stated, "doesn't matter, I won't be here later." A behavior note, dated 5/5/24, indicated that Resident C went out with the smokers for a breath of fresh air. During the smoke break, Resident C took off through a break in the fence. A staff member initially gave chase to stop Resident C but slipped in water and could not catch up to the resident. Other staff members gave chase in their personal vehicles. An ambulance was called, and the resident was eventually detained on the		are in place in accordance with their individualized plan of care. 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 regularly scheduled Quality Assurance meetings to determine if any additional action is warranted.	

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	property located next to the facility. Resident C was taken to a local hospital where he was admitted. Resident C stated that if he was brought back, he would try to escape until he succeeded. An admission note, dated 5/9/24, indicated that Resident C had re-admitted to the facility following discharge from the local hospital. A risk for wandering assessment completed 5/9/24 indicated Resident C was at high risk for wandering. Following Resident C's return to the facility on 5/9/24, no interventions were added to prevent or minimize the residents wandering risk and ensure safety or to prevent another elopement attempt. A nurse's "alert note," dated 5/15/24, indicated at 2:16 A.M., the Facility Administrator was notified by facility staff that Resident C was not in his room and could not be located within the parameters of the facility. Staff reported that Resident C was last seen in his bed during a medication pass at 10:00 P.M. Upon entering Resident C's room, staff observed the room window to be open and the screen to the window had been cut. The local police department was notified and came to the facility. A neighboring police department located Resident C at his previous address. Resident C was admitted to a local hospital for evaluation and treatment. During an observation and interview on 5/30/24 at 9:25 A.M., Resident C and Resident D's names were listed outside of Room 29. Resident D indicated that Resident C had been his roommate, but that he had "escaped" by breaking through their room window. Resident D indicated he had witnessed Resident C going out the window			

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	around 10:00 to 11:00 P.M. and did not notify staff. The mesh wire of the window screen in the resident room appeared to have been torn apart and contained a large hole. During an interview on 5/30/24 at 10:00 A.M., the Facility Administrator indicated that Resident C had used a taxi service to return to his previous address after exiting the building on 5/15/24. During an observation and interview on 5/30/24 at 1:30 P.M., Maintenance 4 indicated that window stops were on all windows to prevent them from fully opening as that would be an elopement risk to have window that fully opened. Screws were observed in the window frames that prevented the windows from fully opening as well as in the window latches to prevent the windows from tilting open. Maintenance 4 then demonstrated how Resident C was able to get out of his room window by grabbing the top portion of the bottom double-hung window and pulling it inward. Maintenance 4 indicated that Resident C was able to break the window latches which allowed the window to fall forward. Resident C was then able to break through the window screen and exit the facility. During an interview on 5/31/24 at 1:00 P.M. the MDS nurse indicated that an interim 48-hour care plan should be completed for all new admissions by using completed assessments, the resident's history if available, and what the nurse initially observed from the resident. If a resident demonstrated a new behavior after the interim 48-hour care plan was completed, the care plan should be updated to address the new behavior. The MDS nurse indicated that Resident C's care plan should have been updated following his readmission to the facility on 5/9/24.			

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	On 5/31/24 at 12:15 P.M., the Facility Administrator supplied an undated facility policy titled Wandering and Elopements. The policy included, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety..." An undated Care Plans - Baseline policy was also provided, and included, "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care... 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan ... The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. The Immediate Jeopardy, that began on 5/15/24, was removed on 5/31/24 when the facility in-serviced the staff on elopement prevention and ensured all windows were secured with latches and window stops but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, the facility continues to monitor residents at risk for elopement, continued staff education and elopement drills.			

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	This citation relates to complaint IN00434692. 3.1-45(a)(2)			