STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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 IN00407919. Complaint IN00407919: Federal/State deficiencies are cited at F600 and F609. Survey date: May 17, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicaid: 40 Other: 11 Total: 51 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 18, 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 6/7/2023 to the state findings of the Complaint Survey conducted on May 17, 2023.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Douglas Roberts	COO	06/02/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse. A staff member handled a resident roughly during a transfer and was verbally abusive toward the resident. (Resident D) Finding includes: During record review on 5/17/23 at 9:15 A.M., Resident D's diagnoses included, but were not limited to; hemiplegia and hemiparesis affecting left dominant side, type 2 diabetes, major depressive disorder, anxiety, and pain. Resident D's most recent annual MDS (Minimal Data Set) assessment, dated 3/22/23, indicated the resident had no cognitive impairment and required extensive assistance with transfers. During an observation on 5/17/23 at 10:20 A.M., Resident D was observed in the dining room in a wheelchair. CNA 5 assisted Resident D to her room. During an interview on 5/17/23 at 10:25 A.M., Resident D indicated that a staff member had been abusive towards them, but no longer worked at the facility. Resident D indicated CNA 13 had screamed and cursed at her and had jerked and twisted her left arm and leg. CNA 13 had made her cry, CNA 13 told her she can cry all she wants.	F 0600	*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is now receiving care and services by staff members who treat the resident with dignity and respect and are not abusive to them in any manner. The resident indicates that they are comfortable in their environment and the care that they are receiving by all staff members. The CNA identified as CNA 13 no longer works 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 has been conducted by the facility and no other resident has reported any allegations of any type of abuse by staff members. All residents are free of any type of abuse, neglect and/or exploitation. *The measures that have been put into place to ensure that the deficient practice does not recur is*	06/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	Other staff had witnessed CNA 13 being abusive and she along with the staff reported CNA to the Social Service Director and to the Facility Administrator. CNA 13 was terminated from employment. During an interview on 5/17/23 at 10:35 A.M., CNA 5 and CNA 7 indicated they had witnessed an incident with CNA 13 and Resident D. CNA 5 indicated "this wasn't the first time but it was the worst." CNA 5 indicated that CNA 13 was "just mean." During an interview on 5/17/23 at 10:40 A.M., CNA 9 indicated that they had also witnessed an incident with CNA 13 and Resident D and that CNA 13 was verbally abusive. During an interview on 5/17/23 at 12:00 P.M., the DON (Director of Nursing) indicated that CNA 13 could be perceived as being rude, and that CNA 13 was unprofessional. CNA 13 was terminated from employment. During an interview on 5/17/23 at 12:10 P.M., Resident D's roommate, Resident G, indicated that she had witnessed CNA 13 "being mean" to Resident D. On 5/17/23 at 1:00 P.M., the facility Administrator supplied an undated written statement from CNA 9 that included, "[CNA 13] and I (CNA 9) were changing [Resident D] in the shower room. [CNA 13] was saying to [Resident D] several times stop acting like you can't stand, I'm tired of your bullshit. This is all behaviors. We got the sit to stand [lift] she was yelling at her to pick up her effected (sic) foot. [Resident D] kept telling her she couldn't. [Resident D] told her to stop yelling at her it was making it worse. She started crying		*that* a mandatory in-service has been provided for all staff members on the facility's abuse policy. The in-service explained all definitions of the type of abuse as well as the facility's policy on the employee's responsibility on immediately reporting all allegations of abuse to the Executive Director. *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 on monitoring the residents for any type of abuse allegations. This tool will be completed by the social service director 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	and [CNA 13] said oh here we go with the crying. She started 'baby talking' [Resident D], asked her if that was better way (sic) to talk to her since that is what she was acting like... [CNA 13] and I (CNA 9) were giving care to [Resident D] putting her to bed. CNA 13 kept saying you can do this, stop acting like you can't, you have to hurry, get in bed, come on [Resident D] we are using the sit to stand and your (sic) over the weight limit. Resident D kept telling [CNA 13] she was hurting, [CNA 13] replied with no pain no gain. We got her into the bed, [Resident D] started crying from all the hollering and screaming [CNA 13] was doing. [CNA 13] told her to go ahead and cry it's good for you, it will make you tougher..." On 5/17/23 at 12:40 P.M., the Facility Administrator supplied a facility policy titled, Resident Rights, dated 2010, and a policy titled Abuse Prevention Program, dated 1/1/19. The policies included, "Employees shall treat all residents with kindness, respect, and dignity... Our residents have the right to be free from abuse..." This federal tag relates to complaint IN00407919. 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure staff immediately reported abuse to the administrator for 1 of 1 abuse allegations reviewed. The facility Administrator was unaware of staff to resident abuse allegations. (Resident D) Finding includes: During an interview on 5/17/23 at 10:25 A.M., Resident D indicated that a staff member had been abusive towards them, but no longer worked at the facility. Resident D indicated CNA 13 had screamed and cursed at her and had jerked and twisted her left arm and leg. CNA 13 had made her cry, CNA 13 told her she can cry all she wants. Other staff had witnessed CNA 13 being abusive and she along with the staff reported CNA 13 to the Social Service Director and to the Facility	F 0609	*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D is now receiving care and services by staff members who treat the resident with dignity and respect and are not abusive to them in any manner. The CNA identified as CNA 13 no longer works at this facility. All allegations of abuse are now being promptly reported to the Executive Director. No new allegations have been reported. *The corrective action taken for the other residents that have the potential to be affected by the*	06/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	Administrator. CNA 13 was terminated from employment. During an interview on 5/17/23 at 10:40 A.M., CNA 9 indicated that they had also witnessed an incident with CNA 13 and Resident D and that CNA 13 was verbally abusive. CNA 9 reported this incident to the charge nurse. CNA 9 also indicated they had reported CNA 13 several times before to the DON and to the previous administrator and that nothing was ever done about it until the new administrator came. During an interview on 5/17/23 at 10:45 A.M., the facility Administrator indicated being aware that Resident D and CNA 13 butted heads. CNA 13 was loud and rough around the edges. Complaints about her were received but she specifically asked if her behavior was seen as abusive and she was told no. The facility administrator indicated CNA 13 was terminated from employment, but not for abuse, or she would have reported it to the state agency. On 5/17/23 at 1:00 P.M., the facility Administrator supplied an undated written statement from CNA 9 that described CNA 13's verbally abusive behavior toward Resident D. The statement included, "...This is not the only time, we have reported and reported this..." On 5/17/23 at 3:00 P.M., the Facility Administrator supplied a facility policy titled, Reporting Abuse to State Agencies and Other Entities/Individuals, dated 2010. The policy included, "...Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse... be reported, the facility Administrator or his/her designee, will promptly notify the following person or agencies (verbally		*same deficient practice is that* all residents have the potential to be affected by this deficient practice. Based on the completion of a housewide audit, no new allegations of abuse have been reported to the Executive Director. Based on interviews with multiple staff members, the staff members are knowledgeable concerning their responsibility to immediately report to the Executive Director all allegations of abuse. *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 staff members on the facility's abuse policy. The in-service explained all definitions of the type of abuse as well as the facility's policy on the employee's responsibility on immediately reporting all allegations of abuse to the Executive Director. *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 all allegations of abuse are being reported immediately to the Executive Director. This tool will be completed by the social service director weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING 00 B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH 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
	and written) of such incident..." This federal tag relates to complaint IN00407919. 3.1-28(c)		reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	