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	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	305 E NORTH ST BOONVILLE, IN 47601

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00420028 This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on September 25, 2023. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00417903 completed on September 25, 2023. Complaint IN00420028 - Federal/state deficiencies related to the allegations are cited at F740. Survey dates: November 2 & 3, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 4 Medicaid: 43 Other: 1 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 8, 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 11/23/23 to the state findings of the Complaint Survey conducted on November 3, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Van Hoy	Administrator	11/21/2023

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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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to complete thorough assessments and to provide behavioral monitoring for 2 of 4 residents reviewed for behaviors. Lack of monitoring led to an altercation between residents. (Resident K, Resident H) Findings include: 1. On 11/3/23 at 8:25 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia affecting right dominant side, pseudobulbar effect, anxiety disorder, and major depressive disorder. The most recent annual MDS (Minimum Data Set) Assessment, dated 10/3/23, indicated Resident K was cognitively intact, required limited assistance of 1 staff for bed mobility, transfers, eating, and toileting, and had no behaviors. Current physician orders included, but were not limited to: Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 150 mg (milligrams) - Give 1 capsule by mouth in the morning related to major	F 0740	F -740 *1. The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident K has had behavior monitoring added to the MAR/TAR. The nursing staff is recording the number of behaviors that occur each shift and transcribes a progress note when behaviors occur which identifies the specific behavior that occurred and the interventions attempted to address the behavior. A behavioral care plan has been developed and implemented to address the resident's identified behaviors. The interdisciplinary team will review and prepare an IDT note if any additional altercations occur. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident	11/23/2023

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	depressive disorder, dated 9/28/23 Nuedexta Capsule 20-10 mg (dextromethorphan-quinidine) - Give 1 capsule by mouth two times a day related to pseudobulbar affect, dated 10/31/22 Buspirone HCl Oral Tablet 7.5 mg - Give 7.5 mg by mouth two times a day for anxiety, dated 7/12/23 The clinical record lacked orders related to behavior monitoring. A current psychotropic medications care plan contained the intervention "observe/record occurrence of for [sic] target behavior symptoms, disrobing, inappropriate response to verbal communication, verbal aggression towards staff/others and document per facility protocol". The clinical record lacked a care plan related to identified and monitored behaviors. Progress notes included, but were not limited to: 11/13/22 Behavior Note: "Past 2 days res (resident) has had urine in trash cans found by housekeepers. Floor staff have observed and stopped res few times sitting on edge of bed and urinating into trash can. Res has been easily agitated and yelling obscenities slapping bedside table and banging on wall. Will continue to monitor and encourage proper b/r (bathroom) protochol [sic]". 11/15/22 Behavior Note: "res continues to urinate in trash can. States she can't make it to b/r in time and doesn't want to wear a brief. States other residents do it and that is what staff is here for to clean up after them. Will report to [name of provider] and updated SSD (Social Services		identified as resident H has had behavior monitoring added to the MAR/TAR. The nursing staff is recording the number of behaviors that occur each shift and transcribes a progress note when behaviors occur which identifies the specific behavior that occurred and the interventions attempted to address the behavior. A behavioral care plan has been developed and implemented to address the resident's identified behaviors. The interdisciplinary team will review and prepare an IDT note if any additional altercations occur. *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 of all residents has been conducted to identify any residents who display behaviors. Any resident with identified behaviors has now had monitoring of those behaviors added to the MAR/TAR. The resident with identified behaviors has had a care plan developed and implemented to address those identified behaviors. In addition, the IDT team will review any and all resident-to-resident altercations and document that review in the resident's clinical record. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	

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	Director)". 11/20/22 Behavior Note: "Pt (patient) has pulled sheets off of bed claiming that they are wet and when informed that they aren't she has engaged in several instances of verbal assault to both RN (Registered Nurse) and CNA (Certified Nurses Aide) together and separately. Pt refuses to wear brief yet will not allow CNA or RN to change her sheets and is now sitting on bed with no sheets. Pt states that she does not need RN or CNA's "F"ing [sic] help and that she is being neglected even though either staff member has answered her call light and attempted to aid patient several times throughout this shift". 11/20/22 Behavior Note: "Pt continues to antagonize staff and has changed her speech to personal insults about appearances and lifestyle choices and is, from what this RN can gather, hearing voices as she stated that she heard this RN and a CNA yelling at one another in the hallway, which to both accounts did not happen. The CNA that she states she heard yelling is not on staff this shift and was not here prior to this shift on this calendar day. Pt informed that her hateful language is not appreciated and asked to please refrain from such to which she replies "Go back to where you belong, you "F"ing [sic] drag-queen." Will advise RN on next shift and management of these behaviors on Monday morning 11/21/22". 8/18/23 [name of hospital] called with report "this resident came into ER (emergency room) last night due to suicidal thoughts but no action on resident part, ER did lab work up and nothing was off, she tested positive for opiates and cannabites [sic] in her urine, no med (medication) changes needed at this time".		been conducted for all nursing and social service staff members as well as the interdisciplinary team members on the facility's behavioral management program. The staff has been instructed on their responsibility for identifying and monitoring behaviors. The staff was also instructed on their responsibilities related to developing and implementing a care plan to address any identified behaviors. The IDT team was also instructed on their responsibility to review and address any resident-to-resident altercations and to document their findings along with interventions when those type of events occur. *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 resident behaviors. The tool will monitor to ensure that behaviors are tracked and that care plans are in place to address behaviors. The tool will also monitor to ensure that the interdisciplinary team is monitoring behaviors to determine if any additional interventions are warranted. This tool will be completed by the Director of Social Services 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	

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	8/21/23 Encounter note: "During session, resident was minimally cooperative. She endorsed depressed mood w/ (with) sad/dysphoric affect. Staff reports that resident has been crying for the past several days. Resident verbalizes active SI (suicidal ideation) with identified plan. She reports history of suicide attempt by "taking a whole bottle of pills" and remorse that her son came home to find her/save her life. She stated "I want out of this world" "I don't want to be here anymore." She began hitting self in head and speech became difficult to understand due to her emotional state. Utilized redirection, calm interaction, education on depressed brain to promote adaptive management of negative affect". 9/12/23 Behavior Note: "this resident has an appointment today for her cataract surgery, attempts made to get her up and ready and she refuses until 6:30 am [sic], several attempts to explain the need to get up and dressed in clothes that she didn't sleep, she turned away from me and is not cooperative at this moment". 9/12/23 Behavior Note: "this resident is up with assist of 1 CNA, she is in clean clothes but refused to take a shower". 10/5/23 Behavior Note "res came to desk around 1810 (6:10 P.M.) stating her and roommate had an altercation over a/c (air conditioning). Event was unwitnessed though both residents are agitated and continued with a verbal exchange out of room. Both were separated and evaluated. Each resident blaming the other for altercation. Both assessed for injury. light marks on face noted. No c/o (complaint of) pain dizziness nausea or any other sx (symptoms). Both are angry. Reported incident to ED (Executive Director) immediately as		reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	well as SSD who is coming [sic] in to help de-escalate the situation. Residents both are put on 15 min (minute) checks and this resident is being moved to another room until IDT (Interdisciplinary Team) team can determine further resolution. [Name of provider] called and ordered covid test and u/a (urine analysis) to r/o (rule out) possible illness. No recent med changes have occurred with either resident. Will continue to monitor and keep each in safe environment. Mother who is POA (power of attorney) was notified of situation". The clinical record lacked an IDT note regarding the event that occurred on 10/5/23. On 11/3/23 at 11:00 A.M., LPN (Licensed Practical Nurse) 13 indicated Resident K had behaviors in the past such as yelling and verbal aggression. At that time, she indicated it depended on the trigger as to which behavior Resident K had.2. On 11/3/23 at 8:30 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, Dementia in other diseases classified elsewhere with behavioral disturbance, cerebral infarction, vascular dementia, and depression. The most current quarterly MDS Assessment dated 9/14/23 indicated Resident H was mildly cognitively impaired and needed supervision with mobility, transferring, toileting, and dressing. Current physician orders included, but were not limited to: Aricept Tablet 10 mg (Donepezil HCL) - Give 10 mg by mouth, at bedtime related to dementia other diseases classified elsewhere with behavioral disturbance, dated 4/26/21 Celexa Tablet 10 mg (Citalopram Hydrobromide) -			

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	Give 1 tablet by mouth a day related to major depressive disorder, recurrent moderate, dated 2/9/22 A current care plan indicated the resident took psychotropic medications as ordered. Interventions included, but were not limited to, observe/document/report PRN (as needed) and adverse reactions of psychotropic medications: behavior symptoms not unusual to the person. The clinical record lacked a care plan related to identified and monitored behaviors. An encounter note, dated 12/15/22, indicated that the resident had an altercation with her roommate who was making disruptive noises while the reside was trying to watch TV. A behavior note, dated 10/5/2023 at 7:14 P.M., indicated the resident had an unwitnessed altercation with her roommate around 6:10 P.M. over air conditioning. Both residents were agitated and had verbal altercations out of the room. Each resident blamed each other for the altercations and thus required the residents to be separated. There were no reported injuries. There would be IDT follow up. The progress notes lacked IDT follow up. On 11/3/23 at the 11:30 A.M., the SSD provided a behavior binder that lacked documentation of behavior encounters for Resident K and Resident H. On 11/3/23 at 10:51 A.M., the Administrator indicated the event that occurred on 10/5/23 was a "one time thing" and did not warrant a change in care plans. At that time, he indicated he could not			

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	provide IDT notes for that event. On 11/3/23 at 11:10 A.M., the SSD indicated she was unaware of any behaviors for Resident K or Resident H. She indicated that if a resident had behaviors, staff was supposed to fill out a report in the behavior binder, the nurse would create a progress note or behavior alert, and it would get discussed in the daily IPOC (interdisciplinary plan of care) meeting. She indicated behavior notes were located by filtering progress notes to behavior notes. She indicated behaviors were not tracked anywhere else, and if behaviors were to occur more than once, a care plan would be made. At that time, she indicated the behaviors with Resident K and Resident H were new to her. On 11/3/23 at 11:20 A.M., a Behavioral Assessment, Intervention and Monitoring Policy, undated, indicated "The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly ... Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum, a description of the behavioral symptoms, including frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations ... targeted and individualized interventions for the behavioral and/or psychosocial symptoms ... the rational for the interventions and approaches ... specific and measurable goals for targeted behaviors, and ... how staff will monitor for effectiveness of the interventions."			

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	This citation relates to Complaint IN00420028. 3.1-37(a)			