STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING _____ B. WING _____	**09/18/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices for COVID-19 were followed during the pandemic to prevent the spread of [MEDICAL CONDITION] for residents with potential exposure from COVID-19 positive staff members and 3 COVID-19 positive residents (Resident 6, Resident 7, and Resident 17) on the West unit. The 3 roommates (Resident 1, Resident 2, Resident 13) of the 3 positive residents, as well as the other residents on the unit, including Resident 5 who developed COVID-19 symptoms, were not placed in transmission-based precautions. Staff were observed not using all recommended PPE, resident room doors were open, and residents were observed outside of their rooms. This potentially affected all 41 residents who resided on the West unit as of [DATE]. The Immediate Jeopardy began on [DATE], when the facility failed to initiate transmission based precautions (TBP) for residents exposed to a COVID-19 positive staff member and again failed to initiate TBP after 3 residents tested positive on [DATE]. The positive staff member worked on the West unit and 3 residents resided on the West unit with roommates. On [DATE], 12 additional residents and one additional staff member tested positive for COVID-19 on the West unit, and 7 residents tested positive on the East unit. On [DATE] and [DATE], staff were observed not using all recommended PPE, resident room doors were open, and residents were observed outside of their rooms. The Administrator and Regional RN were notified of the Immediate Jeopardy on [DATE] at 10:51 A.M. The Immediate Jeopardy was removed on [DATE] at 2:47 P.M., but noncompliance remained at the lower scope and severity level of patten, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: During an interview on [DATE] at 9:30 A.M., the Administrator indicated on [DATE] four staff members had tested positive for COVID-19 during routine staff testing. The Administrator indicated the Business Office Manager (BOM), Director of Maintenance, QMA 1, and Housekeeper 1 had tested positive for COVID-19. The Administrator indicated the BOM and the Director of Maintenance had not had direct contact with any residents. The Administrator indicated QMA 1 had worked the Season's unit (locked dementia unit) on [DATE]. The Administrator indicated Housekeeper 1 had limited contact with residents residing on the West unit on [DATE]. The Administrator indicated in response to the positive staff members, all residents were tested for COVID-19 on [DATE] and had negative [MEDICATION NAME] test results. The Administrator indicated on [DATE] the hospital notified the facility that Resident 6, Resident 7, and Resident 17, who had been admitted to the hospital, were positive for COVID 19. The Administrator indicated all three residents resided on the West Unit. The Administrator indicated on [DATE] Resident 1, Resident 2, and Resident 13 were retested for COVID 19 because they were roommates to Resident 6, Resident 7, and Resident 17, and all three retested residents had negative [MEDICATION NAME] test results. The Administrator indicated that no residents in the facility were on any isolation precautions. On [DATE] at 10:20 A.M., the door to Resident 1's room was closed. No signs were posted on Resident 1's door to indicate the resident was in droplet isolation. No isolation supplies were located at the resident's door. On [DATE] at 10:21 A.M., the door to Resident 2's room was open, and the resident was sitting in his wheelchair in the door way. Resident 2 was not wearing a mask at that time. No signs were posted on Resident 2's door to indicate the resident was in droplet isolation or any other transmission based precautions. No isolation supplies were located at the resident's door. On [DATE] at 10:22 A.M., the door to Resident 13's room was open, and the resident was lying in bed with her eyes closed. No signs were posted on Resident 13's door to indicate the resident was in droplet isolation or any other transmission based precautions. No isolation supplies were located outside the resident's door. On [DATE] at 10:30 A.M., CNA 1 indicated no residents on the West Hall were assigned isolation precautions. CNA 1 indicated Resident 13's roommate was in the hospital for COVID-19, but Resident 13 had no orders for precautions. CNA 1 said, We treat her just like everyone else on this hall. The door is always open. CNA 1 said she did not have safety glasses or a face shield to wear while providing care for the residents. CNA 1 indicated she did not know where safety glasses and face shields were located. On [DATE] at 10:45 A.M., LPN 2, indicated there were no residents currently residing on the West Hall who were assigned isolation precautions. LPN 2 indicated she was unsure where PPE supplies were located if needed. LPN 2 indicated she needed to ask the Administrator or Director of Nursing for the location of the supplies. On [DATE] at 10:45 A.M., Resident 5's call light was lit above his door. CNA 1 entered his room and asked what he wanted. He said he wanted a lemonade and indicated at that time he didn't feel well. He was taking short, shallow breaths, and said he had been very tired for days. CNA 1 departed the resident's room and left the door open. On [DATE] at 11:05 A.M., LPN 2, who was wearing a surgical mask, entered Resident 5's room and asked him if he wanted a breathing treatment. Resident 5 was taking short, shallow breaths and appeared to be short of breath. Resident 5 said he did not want a breathing treatment at that time. He told LPN 2 he had been very fatigued and had body aches over the weekend, but thought maybe he felt a little better today. Resident 5's temperature was 100.8. Oxygen saturation was 96. Heart rate was 116. LPN 2 told the resident she would return with [MEDICATION NAME]. LPN 2 departed the resident's room, leaving the door open. LPN 2, who was wearing a surgical mask, returned to the resident's room at 11:20 A.M. and administered an [MEDICATION NAME]. On [DATE] at 9:30 A.M., the Administrator indicated residents had been tested for COVID-19 Monday evening ([DATE]), and Resident 5 had tested COVID positive. On [DATE] at 10:30 A.M., Resident 5's clinical record was reviewed. The Progress Notes included, but were not limited to: [DATE] at 9:38 A.M., [MEDICATION NAME] tablet (anti-pyretic medication), give 800 milligrams by mouth every six hours, as needed for pain-temperature 100.8 degrees Fahrenheit. [DATE] at 11:39 A.M., follow up temperature 97.4. [DATE] at 4:26 P.M., Resident this morning had temperature of 100.8 degrees Fahrenheit and weak. Has [MEDICATION NAME] as needed which was given and effective. Patient states feels better now. MD notified. New order for rapid COVID-19 test. Results were negative. Resident 5's record indicated the facility did not initiate transmission based precautions as soon as the resident began exhibiting symptoms of COVID-19 on [DATE] at 10:45 a.m. On [DATE] at 11:32 A.M., the Administrator indicated Resident 1, Resident 2, and Resident 13 were in quarantine because their roommates had tested positive for COVID-19. The Administrator indicated the residents were to stay in their rooms and standard precautions were utilized. The Administrator indicated that Resident 1, Resident 2, and Resident 13 were not on full transmission based precautions. At that time, the Administrator and Corporate Nurse indicated that Resident 1, Resident 2, Resident 13 and perhaps the entire West Unit should be placed on full transmission based precautions for COVID-19. On [DATE] at 11:35 A.M., Resident 2's door was open and the resident was sitting in the doorway saying he had a right to be out of his room. LPN 2 told the resident his roommate had tested positive for COVID-19 and therefore he needed to stay inside his room. Wearing only a surgical mask, LPN 2 entered the resident's room to administer medications, but the resident refused the medications. On [DATE] at 11:39 A.M., the Nurse Practitioner (NP) approached LPN 2 and asked if Resident 2 needed a new prescription. LPN 2 told the NP that Resident 2 was in 14 day quarantine now and was very upset about being restricted to his room. Wearing only a mask and no other protective gear, the NP entered the resident's room and started talking with the resident. On [DATE] at 12:57 P.M., Resident 1's clinical record was reviewed. The clinical record lacked an order for [REDACTED].M., Rapid COVID-19 test completed in house, negative. MD notified. On [DATE] at 1:00 P.M., Resident 6's clinical record was reviewed. The Progress Notes included, but were not limited to: [DATE] at 4:24 P.M., COVID-19 Point of Care test, one time for surveillance [DATE]

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) at 1:39 A.M., Resident discharged to hospital for temperature of 103.4, decreased oxygen saturation, and lethargy. [DATE] at 4:28 P.M., Received word that resident tested positive for COVID-19. We will continue precautions. On [DATE] at 1:05 P.M., Resident 13's clinical record was reviewed. The clinical record lacked an order for [REDACTED].M., Received word that resident roommate tested positive for COVID-19. We tested her again today after obtaining an order from MD. She had a rapid test in house and was negative. On [DATE] at 1:15 P.M., Resident 2's clinical record was reviewed. The clinical record lacked an order for [REDACTED].M., MD notified that resident's roommate tested positive for COVID-19. MD gave order for COVID testing. COVID testing conducted and resident results negative. On [DATE] at 1:42 P.M., Resident 6's clinical record was reviewed. The Progress Notes included, but were not limited to: [DATE] at 3:51 P.M., Resident has had a change in status. Resident has increased drowsiness. Resident not as alert and oriented as normal. He has not been up out of bed. [DATE] at 4:43 P.M., (Name of X-ray Company) here to do chest x-ray. [DATE] at 4:46 P.M., lab called again for stat lab notification [DATE] at 10:55 A.M., Lab called and notified we need the stat labs sent. Labs sent and reviewed by physician. New order to send to hospital of choice. [DATE] at 11:14 A.M., Resident discharged to hospital for critical labs and change in condition. No further notes were documented related to Resident 6's COVID-19 status. On [DATE] at 2:53 P.M., Resident 2 was observed sitting in his wheelchair in the nurses' lounge. He said he did not want to stay in his room. Resident 2 had his mask pulled down to his chin while talking. CNA 1 redirected Resident 2 as she returned the resident to his room. CNA 1 walked out of the resident's room and left the door open. No hand hygiene was observed. No disinfecting around the area was observed at that time. On [DATE] at 2:55 P.M., the door to Resident 13's room was open and the resident was lying in bed with her eyes closed. The were no signs posted on Resident 13's door to indicate the resident was in droplet isolation or any other transmission based precautions. No isolation supplies were located outside the resident's door. On [DATE] at 2:56 P.M., Resident 11's door was closed, but no signs were posted which indicated isolation precautions were assigned and no isolation station was observed outside the door. On [DATE] at 9:28 A.M., the Administrator indicated that on the evening of [DATE] all residents were retested for COVID-19. The Administrator indicated 19 additional residents had tested positive on [DATE]. The Administrator indicated 7 residents resided on the East Unit and 12 residents resided on the West Unit. The Administrator indicated that one additional staff member, LPN 5, had tested positive for COVID-19 as well. The Administrator indicated that LPN 5 worked the West Unit. The Administrator indicated the West Long Hall was now the active COVID-19 red unit. The Administrator indicated that Resident 2 (roommate of original positive resident) was now positive for COVID-19. On [DATE] at 9:40 A.M., on the West unit, the following residents' doors were open: Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24 and Resident 25. On [DATE] at 9:57 A.M., the Administrator indicated that all other residents in the facility were considered on droplet precautions, except the Season's Unit (locked dementia unit). The Administrator indicated that residents were on droplet precautions, not droplet isolation and were not restricted to their rooms. The Administrator indicated that facility staff was utilizing face shields, gloves, masks and the residents were not restricted to their rooms. On [DATE] at 11:30 A.M., the Administrator provided the current Isolation-Initiating Transmission-Based Precautions policy, revised [DATE]. At that time the policy was reviewed and included, but was not limited to: Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease . On [DATE] at 10:00 A.M., the Administrator indicated that Resident 1 and Resident 13 (both roommates of the original positive residents) had tested positive for Covid 19 on that morning ([DATE]). On [DATE] at 9:45 A.M., the Administrator indicated that 30 residents had tested positive for Covid 19: Four were hospitalized , one resident had died , and 25 residents were still in the facility. The Administrator indicated 10 staff members had tested positive for Covid 19. Review of CDC guidance, Responding to Coronavirus (COVID-19) in Nursing Homes, Considerations for the Public Health Response to COVID-19 in Nursing Homes, dated as updated [DATE], included the following: Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with [REDACTED]. Exposed HCP should be assessed for risk and need for work exclusion. If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing .If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above. Resident with new-onset suspected or confirmed COVID-19 Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible,should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. Counsel all residents to restrict themselves to their room to the extent possible. HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents. Maintain all interventions while assessing for new clinical cases (symptomatic residents): Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions. If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing Review of CDC guidance, Considerations for Use of [DIAGNOSES REDACTED]-CoV-2 [MEDICATION NAME] Testing in Nursing Homes, [DIAGNOSES REDACTED]-CoV-2 [MEDICATION NAME] Testing in Nursing Homes, dated as updated Aug. 27, 2020, included the following: This document provides a summary of considerations for use of [DIAGNOSES REDACTED]-CoV-2 ([MEDICAL CONDITION] that causes COVID-19) [MEDICATION NAME] testing in nursing homes and is intended for nursing home providers and state and local public health departments. [MEDICATION NAME] tests are available as point-of-care (POC) diagnostics for [DIAGNOSES REDACTED]-CoV-2. They have a rapid turnaround time, which is critical to the identification of [DIAGNOSES REDACTED]-CoV-2 infection and rapid implementation of infection prevention and control strategies. These tests can augment other testing efforts, especially in settings where RT-PCR testing capacity is limited or testing results are delayed (e.g., >48 hours) .As the sensitivity of [MEDICATION NAME] tests is generally lower than RT-PCR, FDA recommends that negative POC [MEDICATION NAME] tests be considered presumptive. Clinical staff in nursing homes should consider when confirmatory RT-PCR testing might be needed prior to making clinical decisions, cohorting residents, or excluding HCP from work. When interpreting the results of [MEDICATION NAME] tests, test characteristics and probability of infection should be considered. This document guides the interpretation of results when [MEDICATION NAME] tests are used in the following circumstances: Testing of asymptomatic residents and HCP in facilities as part of a COVID-19 outbreak response, and testing of asymptomatic HCP in facilities without a COVID-19 outbreak as required by CMS recommendations. [MEDICATION NAME] tests should not be utilized to determine the duration of Transmission-Based Precautions nor when HCP can return to work. Test-based strategies are not generally recommended to determine duration of transmission-based precautions, nor to determine when HCP may return to work. If used, test-based strategies should rely only on RT-PCR. Testing of asymptomatic residents or HCP in nursing homes as part of an outbreak response* If an [MEDICATION NAME] test is positive, no confirmatory test is necessary. Residents should be placed in transmission-based precautions, and HCP should be excluded from work. If an [MEDICATION NAME] test is presumptive negative, residents should be placed in appropriate precautions for facilities with an outbreak. HCP should be allowed to continue to work with continued symptom monitoring. The facility should continue serial [MEDICAL CONDITION] testing ([MEDICATION NAME] or RT-PCR) every ,[DATE] days until no new cases are identified for a 14-day period. *A COVID-19 outbreak response in a nursing home is triggered when a resident or HCP tests positive for [DIAGNOSES REDACTED]-CoV-2. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility educated staff about transmission based precautions and the proper use of PPE. The Immediate Jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been educated about transmission based precautions (TBP) and proper use of PPE. Staff and resident monitoring was continued for the proper implementation of TBP, observations and assessments were ongoing to ensure the health and safety of the residents. 3XXX,[DATE](a)

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