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 _____	**06/04/2020**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 implement and monitor infection control practices to protect 1 of 1 residents visiting with the window open and no facial masks were in use during the Covid-19 crisis. (Resident 1) Finding includes: On 6/4/20 at 10:06 A.M., the Season's Unit (secure unit) was observed. Upon entry to the unit, Resident 1 was observed to be visiting with four family members from room [ROOM NUMBER]. The window was observed to be open. Masks were not observed to be worn by the resident or the family members. At 10:08 A.M., QMA 1 was notified of Resident 1 visiting with family through an open window in room [ROOM NUMBER]. QMA 1 indicated that was how they were supposed to conduct family visits. QMA 1 did not intervene to close the window. On 6/4/20 at 10:10 A.M., the Administrator indicated family visits were conducted from a window but the window should be closed. At that time, Resident 1's family visit was observed with the Administrator. The Administrator indicated she would close the window and educate the family. On 6/4/20 at 11:14 A.M., the Administrator indicated the family of Resident 1 indicated they could not hear the resident through the window so they opened it. On 6/4/20 at 10:42 A.M., Resident 1's clinical record was reviewed. The Admission MDS (Minimum Data Set) assessment, dated 5/22/20, indicated Resident 1 had severe cognitive impairment A Social Service Note, dated 5/15/20, indicated Resident 1 was impulsive. On 6/4/20 at 1:18 P.M., the Administrator provided the COVID-19 Screening Process policy, dated 4/6/20. The policy included, but was not limited to: Visitation at the facility is not permitted until the COVID-19 virus crisis has been lifted by the Center for Disease Control and the Indiana State Department of Health. 3.1-18(b)(1)

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