STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	**305 E NORTH 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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on record review and interview, the facility failed to provide residents information regarding what services were not covered by Medicare, and what services they would be financially responsible for 3 of 3 residents reviewed. SNF ABNs (Skilled Nursing Facility Advanced Beneficiary Notice) were not issued to Resident 28, Resident 146, and Resident 147 until the services had exhausted and did not indicate an estimated amount the services would be. (Resident 28, Resident 146 , Resident 147) Findings include: 1. On 3/11/2020 at 1:28 p.m., the BOM (Business Office Manager) provided the SNF Beneficiary Protection Notification Review forms completed for Resident 28, Resident 146 , and Resident 147. The Review forms indicated the SNF ABN forms were not issued to Resident 28, Resident 146, and Resident 147 until after the services had been terminated and did not indicate the estimated cost of the items or services if the resident or responsible party had to pay for them themselves. 2. On 3/11/2020 at 1:28 p.m., the record for Resident 28 was reviewed and indicated admission on Medicare A Skilled Services on 10/22/19 and indicated the last day of Medicare A was on 12/15/19. The NOMNC (Notice of Medicare Non-Coverage) form was provided to and signed by Resident 28 on 12/16/19, which was after the Medicare services had been terminated. 3. On 3/11/2020 at 1:40 p.m., the record for Resident 146 was reviewed and indicated admission on Medicare A Skilled Services on 10/22/19 and indicated the last covered day was 11/7/19. The NOMNC (Notice of Medicare Non-Coverage) form was performed and signed by Resident 146 on 11/8/19, which was after the Medicare services had been terminated. 4. On 3/11/2020 at 1:45 p.m., the record for Resident 147 was reviewed and indicated admission on Medicare A Skilled Services started on 1/23/20 and last covered day was on 1/23/2020, due to election of the hospice benefit. The NOMNC (Notice of Medicare Non-Coverage) form was provided and signed by Resident 147's responsible party on 1/24/2020, which was after the Medicare services had been terminated. On 3/11/2020 at 2:00 p.m., the BOM indicated she was unaware the residents needed to provide the notices at least 2 days prior to their discharge or that the estimated cost for the services or items should be listed. The current facility policy, Resident/POA (Power of Attorney) NOMNC/ABM Notification, dated 1/4/2020, provided by the MDS (Minimum Data Set) Coordinator on 3/11/2020 at 3:30 p.m., included, but was not limited to, The NOMNC must be delivered at least two calendar days before Medicated covered services end or the second to last day of service if care is not being provided daily. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. 3.1-4(f)(3)
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the recommendation for 1 of 2 residents reviewed for Pre-Admission Screening and Record Review (PASARR). A resident with a recommendation on his PASARR level II review did not receive mental health services. (Resident 24) Finding includes: On 3/9/2020 at 10:28 a.m., Resident 24 was observed to be in his room with the door shut and the window blinds closed. The resident indicated he stayed in his room most of the time and received hospice services at this time. On 3/11/2020 at 3:21 p.m., Resident 24 was observed to be lying in bed. The resident indicated he was tired and had stayed in his room throughout the day. The clinical record for Resident 24 was reviewed on 3/10/2020 at 3:07 p.m. [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 1/10/2020, indicated the resident had slight cognitive impairment. A significant change MDS assessment, dated 4/12/19, indicated the resident had been evaluated by level II PASARR to have a serious mental illness. A care plan, initiated 2/20/19, indicated the resident had triggered a PASARR level II. Interventions included, but were not limited to, the following: Administer medications as ordered. Monitor,document for side effects and effectiveness, initiated 2/21/19. Answer any questions the resident may have, initiated 2/20/19. Assist resident as needed, initiated 2/20/19. Continue current mental health services, for example, (Name of Mental Health Service), initiated 2/20/19. Medication monitoring, initiated 2/20/19. Monitor for signs/symptoms of depression, anxiety, or sad mood by resident, initiated 2/21/19. Provide conversation as needed. Encourage resident to share and vent his feelings. Enjoys talking about his life before living in the facility, his religion, and sport, initiated 3/25/19. Review of the PASARR level II, dated 9/25/17, indicated the resident was to have mental health services continued. On 3/11/2020 at 3:00 p.m., the MDS Coordinator and Social Service Designee (SSD) indicated the resident had not received any mental health services since February, 2019. The MDS Coordinator indicated the resident had been visited by a different company from what was listed in the care plan. They did not know if the resident had received any mental health services since. On 3/12/2020 at 3:20 p.m., the Administrator provided Psychiatry Progress note, dated January 15, 2019. The note indicated the resident would benefit from continued behavioral health services, services should be continued, and the resident had some improvement with an increase in [MEDICATION NAME] (an antipsychotic medication.) The Administrator indicated the resident had not had any mental health services since January 15, 2019. The facility lacked documentation of a policy for following the PASARR level II recommendations.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a personalized plan of care for 1 of 5 residents reviewed for unnecessary medications, 1 of 1 resident receiving protein shake and 1 of 1 resident reviewed for smoking. (Resident 6, Resident 3, Resident 33) Findings include: 1. On 3/9/2020 at 9:25 a.m., Resident 6 was observed to be lying in bed. The resident indicated he did not know if he received an anticoagulant. The clinical record for Resident 6 was reviewed on 3/10/2020 at 10:46 a.m., [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 12/14/19, indicated the resident had slight cognitive impairment. physician's orders [REDACTED]. Aspirin 81 mg tablet 1 orally daily for anticoagulant, initiated 2/11/20. The facility lacked documentation of a care plan for the anticoagulant medications. On 3/11/2020 at 3:24 p.m., the MDS Coordinator indicated the resident should have had a care plan for the anticoagulants. 2. On 3/9/2020 at 2:28 p.m., Resident 3 was observed to be sitting in a chair in her room with her feet elevated. Resident 3 indicated she had lost a lot of weight recently, but did not know how much she had lost. The clinical record for Resident 3 was reviewed on 3/10/2020 at 2:30 p.m. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 12/6/19, indicated the resident had slight cognitive impairment and required supervision of 1 person

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

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) for eating. physician's orders [REDACTED]. Regular diet, regular texture, regular consistency, start date 12/6/19. The resident's weights included, but were not limited to, the following: 2/21/2020: 113.8 lbs. (pounds) 2/5/2020: 110.8 lbs. 1/28/2020: 108.8 lbs. 1/22/2020: 113.8 lbs. 1/13/2020: 111.6 lbs. 1/6/2020: 116.0 lbs. 12/24/19: 110 lbs. 12/19/19: 110.8 lbs. 12/9/19: 105 lbs. 12/2/19: 104 lbs 11/29/19: 115.4 lbs. On 3/11/2020 at 3:10 p.m., the Registered Dietician indicated the resident was starting to maintain her weight since having the Mighty Shakes ordered twice a day. She indicated the resident's BMI (Body Mass Index) was adequate for her height. The facility lacked documentation of a nutritional care plan. On 3/11/2020 at 3:21 p.m., the MDS Coordinator indicated she created the care plans for the residents. She indicated the resident lacked a nutritional care plan. 3. On 3/9/2020 at 3:27 p.m., Resident 33 was observed to go outside with other residents to smoke. On 3/9/2020 at 3:42 p.m., the medical record for Resident 33 was reviewed. The record contained a smoking assessment, dated 2/19/2020, which indicated Resident 33 was safe to smoke with supervision. The record lacked a care plan which referred to smoking. On 3/10/2020 at 2:49 p.m., the MDS (Minimum Data Set) Coordinator indicated Resident 33 did not have a care plan for smoking, and was going to put one in. The current facility policy, Care Plans-Comprehensive, dated 5/2/19, provided by the MDS Coordinator 3/11/2020 at 3:30 p.m., included, but was not limited to, an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs would be developed for each resident. 3.1-35(a)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to revise and individualize the care plans of residents for 1 of 1 residents reviewed for catheters, 1 of 1 resident reviewed for death, and 1 of 1 resident reviewed for [MEDICAL TREATMENT], interventions were not updated. (Resident 47, Resident 13, Resident 10) Findings include: 1. The clinical record for Resident 47 was reviewed on [DATE] at 3:23 p.m. Resident 47 was admitted to the facility on [DATE] and expired on [DATE]. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated [DATE], indicated Resident 47 had vision impairment and severe cognitive impairment. The resident could see large print but not regular print in newspapers or books. The resident required extensive assist of 2 persons for bed mobility, transfers, dressing and toilet use, limited assistance of 1 person for eating, extensive assistance of 1 person for toilet use, and total dependence of 1 person for bathing. The resident had no limitation in her range of motion (ROM). The resident required a wheelchair for mobility. An ADL (Activities of Daily Living) self-care performance deficit care plan, initiated [DATE], lacked documentation of any interventions. An impaired visual functional care plan, initiated [DATE], lacked documentation of any interventions. On [DATE] at 3:23 p.m., the MDS Coordinator indicated the resident should have had interventions for the care plans. 2. On [DATE] at 9:10 a.m., Resident 13 was observed to be lying in her bed, yelling out. Resident 13's roommate indicated the resident yells out frequently and did not sleep well at night at times. The roommate was unable to sleep at times due to the frequent yelling of the resident. On [DATE] at 11:22 a.m., Resident 13 was observed to be lying in bed, yelling out incoherently. The clinical record for Resident 13 was reviewed on [DATE] at 4:16 p.m. [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated [DATE], indicated the resident had severe cognitive impairment. On [DATE] at 2:00 p.m., LPN 1 indicated the resident yelled at times. physician's orders [REDACTED]. The clinical record lacked documentation of a care plan for the resident's [MEDICAL CONDITION]. 3. On [DATE] at 9:07 a.m., Resident 10 was interviewed and indicated she was receiving [MEDICAL TREATMENT] services and was not a fluid restriction. On [DATE] at 8:44 a.m., the medical record for Resident 10 was reviewed. [DIAGNOSES REDACTED]. The care plans included, but were not limited to, the resident has fluid overload or potential for fluid volume overload related to disease process heart failure, revised on [DATE]. Interventions included, but were not limited to, the resident will comply with diet and/or fluid restrictions daily through review date, revision on [DATE] fluid restriction of 1000 cc (cubic centimeters) per 24 hours, dated [DATE]. The physicians orders lacked a fluid restriction. The physicians orders included, but were not limited to, regular diet, regular texture, regular consistency, avoid high potassium food. The care plans included, but were not limited to, nutritional risk due to [DIAGNOSES REDACTED]. The care plan lacked monitoring related to [MEDICAL CONDITION] with [MEDICAL TREATMENT] treatments. On [DATE] at 1:08 p.m., the MDS (Minimum Data Set) Coordinator indicated she looked at the care plans quarterly, or more. She was removing the fluid restrictions from the care plans. She verified [MEDICAL TREATMENT] was not addressed with the nutritional care plan and she would review the dietician's notes. The current facility policy, dated [DATE], provided by the MDS Coordinator on [DATE] at 3:30 p.m., included but was not limited to, care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes. Assessments of residents were ongoing and care plans were revised as information about the resident's condition change. 3.1- 35(d)(2)(A) 3XXX,[DATE](d)(2)(B)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide necessary respiratory care and services for 1 of 1 resident reviewed for respiratory care. A resident's humidifier bottle was empty and outdated, and the oxygen tubing was not dated. (Resident 24) Finding includes: On 3/9/2020 at 10:30 a.m., Resident 24 was observed to be wearing oxygen (O2) at 3 L/min (liters per minute) via nasal cannula. The concentrator's humidifier bottle and nasal tubing were not dated. On 3/10/2020 at 8:59 a.m., Resident 24 was observed to be self-propelling himself in his wheelchair. The resident had portable oxygen on at 3 L/min via nasal cannula. The oxygen tubing lacked a date. On 3/10/2020 at 2:37 p.m., Resident 24 was observed to be lying in bed with his nasal O2 on. The oxygen concentrator's humidifier bottle and nasal tubing lacked a date on them. On 3/11/2020 at 3:11 p.m., Resident 24 was observed lying in bed. The concentrator's humidifier bottle was undated and empty and the nasal tubing lacked a date on it. The resident indicated he had a jug of distilled water to refill the humidifier bottle. A CNA and RN were observed to enter and exit the resident's room without refilling or checking the humidifier bottle. The clinical record for Resident 24 was reviewed on 3/10/2020 at 3:07 p.m. [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 1/10/20, indicated the resident had slight cognitive impairment. physician's orders [REDACTED]. On 3/11/2020 at 3:19 p.m., the Administrator indicated hospice supplied the resident's oxygen supplies. The humidifier bottles and nasal tubing should be dated and the bottles changed when they became empty. The current facility policy, Oxygen Administration, dated 5/20/19, provided by the MDS Coordinator on 3/11/2020 at 3:30 p.m., included, but was not limited to, be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Periodically re-check water level in humidifying jar. All oxygen equipment would be replaced weekly to prevent the spread of infection. Oxygen supplies such as cannulas and respiratory storage bags would be changed out weekly. 3.1-47(a)(6)
F 0727 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on record review and interview, the facility failed to provide a RN (Registered Nurse) working at least 8 hours a day, 7 days a week in the facility from February 9th thru March 8th on the weekends. Finding includes: On 3/9/2020 at 10:30 a.m., the Administrator provided the Nurse Work Schedule, dated February 23 thru March 7, 2020, and March 8 thru March 21, 2020. The schedule indicated a RN was not scheduled, or worked, on Saturday, March 7th or Sunday, March 8th. On 3/12/2020 at 10:14 a.m., the Director of Nursing indicated he was not aware of a RN (Registered Nurse) waiver. He had hired 3 RN's recently, and was actively looking for more. He indicated he was here frequently on the weekends, he was not covering a shift, but was helping out. On 3/12/2020 at 11:47 a.m., the Administrator provided the Nurses Work Schedule for February 9-22, 2020. The Sunday, February 9th lacked 4 hours of RN coverage, Saturday, February 15-Sunday February 16 lacked RN coverage, and Saturday, February 22 lacked RN coverage. On 3/12/2020 at 11:47 a.m., the Administrator provided the current facility policy, Staffing, revised 2/2007. The Policy indicated, but was not limited to, our facility maintains adequate

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F 0727 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 2) staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services .our facility furnishes information from payroll records setting forth the average numbers and types of personnel .to the appropriate state agencies as required. Such workweek (sic) is selected by the state survey agency. 3.1-17(b)(3)
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview, and record review, the facility failed to ensure the daily staffing posted the number of nursing staff by category (RN, LPN, and CNA) providing direct care to residents during each shift and the actual hours worked by the staff during each shift for 3 of 4 days of posted daily staffing was reviewed. Findings include: On 3/9/2020 at 11:51 a.m., the posted nursing staffing, Daily Staffing Plan, indicated a census of 43. Hours listed on evenings, west had 5.5 CNA hours. On 3/11/2020 at 8:49 a.m., the posted nursing staffing, Daily Staffing Plan, indicated a census of 44. Hours listed on evenings, west had 5.5 CNA hours. On 3/12/2020 at 8:47 a.m., the posted nursing staffing, Daily Staffing Plan, indicated a census of 44. Hours listed on days, west had 2 LPN with 22.5 hours. Evenings was listed as having on west, 1 CNA with 5.5 hours. The staffing hours lacked designation of when the half shift/hours were occurring. On 3/12/20 at 2:02 p.m., Administrator 2 indicated they were aware they had an issue with the formatting of the form and had been cited previously. On 3/12/2020 at 1:45 p.m., the Administrator provided the current facility policy, Posted Direct Care Daily Staffing Numbers, revised date 5/20/19. The Policy indicated, but was not limited to, the information recorded on the form shall include: .the actual time worked during that shift for each category and type of nursing staff .when computing hours of direct care staff working split shifts, count only the total number of hours the individual is actually scheduled to work for the shift information being posted.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were free from unnecessary medications for 3 of 5 residents reviewed. Behaviors were not monitored for residents receiving antipsychotic medications. (Resident 6, Resident 13, Resident 35) Findings include: 1. On 3/9/2020 at 9:25 a.m., Resident 6 was observed to be lying in bed, dozing. The resident indicated he did not participate in activities very often. On 3/10/2020 at 11:40 a.m., Resident 6 was observed to be lying in bed, dozing. On 3/11/2020 at 3:15 p.m., Resident 6 was observed to be resting in bed. The clinical record for Resident 6 was reviewed on 3/10/2020 at 10:46 a.m. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 12/14/19, indicated the resident had slight cognitive impairment. physician's orders [REDACTED]. [MEDICATION NAME] (an antianxiety) 1 mg tablet 1 po at bedtime for adjustment disorder, start date 1/21/20. A care plan, Mood problem related to disease process, adjustment disorder with mixed anxiety and depressed mood, initiated 1/21/2020, included, but was not limited to the following: Administer medications as ordered. Monitor, document for side effects and effectiveness, initiated 1/21/2020. Behavioral health consults as needed, initiated 1/21/2020. Monitor, record, report to physician as needed mood patterns, signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols, initiated 1/21/2020. On 3/11/2020 at 11:13 a.m , LPN 1 indicated behaviors were either tracked on the MAR (Medication Administration Record) or TAR (Treatment Administration Record) on a separate behavior sheet which was placed into the 24 hour report book. The behavior sheet went to IPOC (Intradepartmental Plan of Care) committee for review. She indicated the resident had not had his behaviors tracked. Review of the MAR/TAR, the 24 hour report book, and the Behavior binder was noted to contain no recent behavior monitoring for Resident 6. The facility lacked documentation of behavior monitoring for the resident. 2. On 3/9/2020 at 9:10 a.m., Resident 13 was observed to be lying in her bed, yelling out. Resident 13's roommate indicated the resident yells out frequently and did not sleep well at night at times. On 3/9/2020 at 11:22 a.m., Resident 13 was observed to be lying in bed, yelling out incoherently. The clinical record for Resident 13 was reviewed on 3/9/2020 at 4:16 p.m. [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 12/10/19, indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident had received antianxiety and antidepressant medications. physician's orders [REDACTED]. On 3/11/2020 at 2:00 p.m., LPN 1 indicated the resident yelled at times. Behaviors were either tracked on the MAR (Medication Administration Record) or TAR (Treatment Administration Record) on a separate behavior sheet, placed into the 24 hour report book, and then goes to IPOC (Intradepartmental Plan of Care) committee to review. She indicated the resident had not had her behaviors tracked. The clinical record lacked documentation of behavior tracking for the resident. 3. On 3/10/2020 at 8:23 a.m., the medical record for Resident 35 was reviewed. [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. A pharmacy recommendation dated 2/26/2020, contained note text from Resident 35's physician which read continue residents (sic) [MEDICATION NAME] 25 mg as (sic) current dosage and frequency due to psychiatric issues. Care plans included, but were not limited to, potential for agitation and atypical behavior related to poor impulse control, cursing at others, yelling out, pacing, dated 7/23/19. Resident 35 liked to crawl on the floor at times due to past occupation, dated 12/26/19. Progress note, dated 3/10/2020 at 11:24 p.m., indicated Res (resident) has been observed 3 times getting down on all four extremities and crawling around despite encouragement not to do so. Informs staff he is looking for his keys, looking for (wife), and going to the river . On 3/10/2020 at 2:32 p.m., the Director of Nursing indicated restlessness was not typically a [DIAGNOSES REDACTED]. Resident 35 had had an inpatient stay in (name of psychiatric unit), and we should have related it to his psych (psychiatric) diagnosis. On 3/11/2020 at 2:31 p.m., the Director of Nursing indicated behavior sheets were available at the front nurses station and they reviewed them in morning meeting. On 3/11/2020 at 2:47 p.m., the Director of Nursing (DON) and the MDS (Minimum Data Set) Coordinator indicated, during interview, they had seen behavior sheets recently, they reviewed them in morning meeting and gave to Medical Records. Review of the Behavior Binder was noted to contain no recent behaviors, and the DON indicated they had had a few, and denied Resident 35 had had any recent behaviors. The current facility policy, dated 4/5/19, provided by the MDS Coordinator on 3/11/20 at 3:30 p.m., included, but was not limited to, The facility will comply with regulatory requirements related to use of medications to manage problematic behavior. The physician will help verify that previously identified [DIAGNOSES REDACTED]. 3.1-48(a)(3) 3.1-48(a)(4)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly and 1 of 1 fire separation door was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 08/19/20 between 9:30 a.m. and 1:30 p.m. with the Administrator-in-Training (AIT), Director of Maintenance Services, Maintenance Assistant,and Administrator (sister facility) present, the facility was unable to provide documentation for the annual inspection of fire door assemblies, including one oxygen transfilling room fire door assembly and one separation fire door assembly (which separates the dining room from the Physical Therapy and Business Office hall). Based on interview at the time of record review, the AIT said there was no documentation available to show the oxygen room fire door assembly and the separation fire door assembly had been inspected annually during the past 12 months. Based on observations during a tour of the facility with the AIT, Director of Maintenance Services, Maintenance Assistant,and Administrator (sister facility) between 1:30 p.m. and 2:45 p.m., there was one oxygen transfilling room fire door assembly and one fire door separation assembly noted in the facility. This finding was reviewed with the AIT, Director of Maintenance Services, Maintenance Assistant,and Administrator (sister facility) at the exit conference. 3.1-19(b)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation,interview, and record review, the facility failed to provide a safe and sanitary environment for the food storage and food preparation area in 2 of 2 observations. The refrigerator contained expired ham slices, the dry storage had a scoop on top of the bin, the freezer had opened hot dogs and potato fries with no open date, and hand hygiene was not performed. (Kitchen) Findings include: During observation of kitchen on [DATE] beginning at 8:11 a.m., the following were observed: 1. The reach in refrigerator had an opened package of ham slices, dated ,[DATE]. Cook 1 discarded the package of ham. 2. The dry storage contained a clear bin of sugar with a scoop laying on the top of the bin. 3. The walk in freezer contained an opened package of hot dogs wrapped in cellophane, no opened date was observed. 4. The walk in freezer contained an opened bag of potato fries, opened to air, no opened date was observed. During tour, Cook 1 indicated packages should have an open date. 5. During second observation of the kitchen on [DATE], beginning at 10:54 a.m. and ending at 12:16 p.m, Cook 1 was observed to puree food, clean the robocoup and place in the dishwasher. Cook 1 obtained the clean robocoup from the dishwasher without performing hand hygiene. Cook 1 was observed to lay a scoop in the soiled area of the 3 compartment sink, no hand hygiene was performed, carry the diced chicken to the robocoup, and complete the pureeing process. On [DATE] at 9:19 a.m., the Dietary Manager indicated the opened ham slices were good for 7 days when opened. She planned on continuing with inservicing of the dietary staff. Scoops should clean and in a bag if on the bins. On [DATE] at 10:43 a.m., the Administrator provided the current facility policy, Preparation of Therapeutic Diets, revised date [DATE]. The Policy included, but was not limited to, dietary staff would adhere to acceptable standards of infection control practices in the preparation of all therapeutic diets, including pureed food items by performing hand hygiene and glove usage in accordance with acceptable standards of food service practices. The Administrator also provided the current facility policy, Food Receiving and Storage, revised on [DATE] (sic). The Policy included, but was not limited to, all foods stored in the refrigerator or freezer would be covered, labeled, and dated. 3XXX,[DATE](i)(2) 3XXX,[DATE](i)(3)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify a transcription error of a physician's order for a medication for 1 of 8 residents observed during medication administration. (Resident 7) Finding includes: On 3/11/2020 at 8:55 a.m., QMA (qualified medication aide) 2 was observed to be administering medications to Resident 7. QMA 2 obtained the medications from the medication cart and checked the medications against the electronic MAR (Medication Administration Record). The resident's blood pressure and pulse was obtained by the QMA. The QMA crushed the resident's medications, which included Aspirin EC ([MEDICATION NAME] coated) 81 mg (milligram) 1 tablet and placed the medications in applesauce. She discovered she had placed a [MEDICATION NAME] (a beta blocker) into the applesauce, which the resident was not to receive due to the blood pressure parameters that were in place for the medication. The QMA indicated she would need to dispose of the crushed medications. She notified the Director of Nursing that the resident required a new set of medications. The Director of Nursing retrieved the medications from the automatic medication dispenser. QMA 2 rechecked the medications against the MAR, opened and crushed the medications, and placed them into applesauce. The medications included Aspirin EC 81 mg 1 tablet. The medication were administered to the resident. The clinical record for Resident 7 was reviewed on 3/11/2020 at 9:05 a.m. A physician's order, dated 1/28/2020, indicated the resident was to receive Aspirin EC 81 mg tablet by mouth one time a day for anticoagulant. The order indicated the Aspirin EC was to end on 2/4/2020 and had a start date of 2/6/2020. Review of the Medication Administration Record [REDACTED]. The MAR, dated March, 2020, did not have an order for [REDACTED]. The resident was to have a procedure done and the [MEDICATION NAME] department had to wait to obtain clearance from the resident's cardiologist regarding the Aspirin EC being held prior to the resident's procedure. He indicated the medication was ordered to be discontinued on 2/4/2020, after the [MEDICATION NAME] department received the clearance from the cardiologist On 3/11/2020 at 9:30 a.m., the resident's pharmacy was notified and the pharmacy technician indicated the medication had been provided to the facility starting on 2/5/2020, and was to be started on 2/6/2020, according to how the physician's order was documented. The order was received on 1/28/2020, ended on 2/4/2020, and started on 2/6/2020. On 3/11/2020 at 9:45 a.m., the Director of Nursing indicated he should have transcribed the Aspirin EC order better. On 3/11/2020 at 9:51 a.m., the Administrator indicated the resident's physician had been notified and had ordered the resident to receive Aspirin EC 81 mg 1 tablet by mouth one time a day related to unspecified [MEDICAL CONDITION], beginning on 3/11/2020, after the medication had been given. The physician would be visiting the resident next week when he was visiting residents at the facility. The current facility policy, dated 5/7/19, provided by the Administrator on 3/12/2020 at 3:00 p.m., indicated all documentation was clear and concise and pharmacy orders would be followed as entered. 3.1-30(a)(2)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 8 observations of care. Hand hygiene and glove changes were not performed, soiled items were placed on the floor, and the facility did not have a surveillance plan in place. (QMA 1, Resident 4, Resident 32) Findings include: 1. On 3/9/2020 at 11:56 a.m., QMA (qualified medication aide) 1 was observed to don gloves and obtain Saniwipes x 3 to clean the medication cart. After wiping the top of the medication cart, QMA 1 dropped 2 of the Saniwipes on the floor. She picked them up and continued to clean the medication cart with them. On 3/12/2020 at 11:41 a.m., QMA 1 indicated if you drop something onto the floor, you should pick the items up, discard the items, and perform hand hygiene prior to continuing your task. 2. On 3/10/2020 at 9:24 a.m., CNA 1 and CNA 2 were observed to be providing Resident 4 with a complete bed bath. Both CNAs performed hand hygiene and donned gloves. After lowering the resident head of the bed and elevating the bed, CNA 1 obtained a clean wet cloth and wiped the resident's face. She gave a clean wet cloth to CNA 2 who wiped the resident left eye area. Both CNAs removed the resident's gown. CNA 1 obtained a wet, soapy cloth and washed the resident's right arm, right shoulder, right axilla, and right side of the abdomen. The cloth was handed to CNA 2 who washed the same areas on the resident's left side. The areas were rinsed by each CNA using separate wet cloths. CNA 1 dried the resident. CNA 1 changed her gloves and performed hand hygiene. CNA 2 obtained the resident's clean clothes from the bathroom. CNA 1 washed the resident's right hip, leg, and foot with a clean soapy cloth and handed the cloth to CNA 2 who washed the resident's left hip, leg, and foot. The process was repeated with a clean wet cloth to rinse, and the areas were dried. CNA 1 changed the resident's water, obtained clean, soapy cloth and washed the resident's right groin, left groin, penis, and scrotum. The areas were rinsed and dried. CNA 1 obtained a clean, soapy cloth and washed the resident's back, buttocks, and rectal area. The resident had a soft bowel movement which CNA 1 wiped with the cloth. The areas were rinsed and dried by CNA 1. CNA 1 changed her gloves and applied a clean brief. CNA 1 was observed to apply a bootie to the resident's right foot, run her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	**305 E NORTH 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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) entire right arm with her uniform scrub jacket on, up the resident's clean right pant leg, obtain the resident's right leg and apply the pants. CNA 1 assisted with applying the resident's shirt. No hand hygiene was observed. CNA 2 changed her gloves and performed hand hygiene. She removed a gait belt from around her waist and applied the belt around Resident 4. Both CNAs were observed to transfer the resident to his wheelchair. CNA 2 removed the belt from the resident and placed the gait belt around her waist. CNA 1 applied the leg rests to the wheelchair and CNA 2 placed a pillow to the right side of the wheelchair. CNA 1 removed her gloves, obtained a comb, and combed the resident's hair. CNA 2 removed the bag of soiled linens and exited the room. CNA 1 transported the resident to the lobby, returned to the resident's room, emptied the wash water, and wiped the basin out. No hand hygiene was observed by either CNA prior to exiting the room. On 3/10/2020 at 9:59 a.m., CNA 1 indicated hand hygiene should be performed when you changed gloves, before providing care, after washing the top half of a resident, after washing the resident's feet, after providing pericare and washing the resident's buttocks and rectal area, and after finishing care. 3. On 3/12/2020 at 10:05 a.m., the Director of Nursing indicated he was the Infection Control contact person and was working on obtaining the Infection Preventionist certification. He indicated the facility had 4-5 residents who had tested positive for influenza in December, 2019, and he only had 1 resident at this time who had a urinary tract infection. He indicated he did not know where to locate a surveillance log. He thought the MDS (Minimum Data Set) Coordinator may know where to locate the surveillance log as she had been the person doing the infection control program prior to him starting employment at the facility. On 3/12/2020 at 11:45 a.m., the Director of Nursing and MDS Coordinator indicated they had not completed any surveillance for the facility. The MDS Coordinator indicated she had not put the process into place when she was overseeing the infection control program. The DON indicated he would start doing infection surveillance monitoring with the threat of the Coronavirus now and had already begun the process. 4. On 3/10/2020 at 2:11 p.m., CNA 3 was observed to propel Resident 32 to her room. CNA 3 and CNA 2 washed their hands, applied gloves, and applied a gait belt to Resident 32. With assist of 2, Resident 32 was sat on the side of the bed and assisted to lay down on her back on the bed. CNA 3 removed Resident 32's shoes, socks, and pants. CNA 2 removed her gloves and left the room to obtain disposable wipes, no hand hygiene was observed, returned, and applied gloves, with no hand hygiene observed. CNA 3 bagged the soiled pants and washed her hands. CNA 3 applied gloves and loosened Resident 32's brief. CNA 2 washed the anterior peri area, and with assist of 2, Resident 32 was rolled on her side. CNA 3 removed Resident 32's brief from under her, folded it in on itself, and placed it on the floor. CNA 3 washed Resident 32's buttocks and placed the soiled wipe on top of the brief, picked both items up from the floor and placed them in the trash. No hand hygiene was observed. CNA 3 and CNA 2 pulled Resident 32 up in bed and covered her with a sheet. CNA 3 and CNA 2 removed their gloves. CNA 2 left the room and walked up the hallway, no hand hygiene was observed. CNA 3 carried the bag of soiled items to the soiled utility and washed her hands. On 3/10/2020 at 2:21 p.m., CNA 3 indicated she was to wash her hands before care, when taking gloves off, and when leaving the room. The brief should have gone in the trash can, not on the floor, and should have moved the trash can closer. On 3/10/2020 at 2:25 p.m., CNA 2 indicated she was to wash her hands when entering the room, with glove changes, and at the end when you leave the room. The current facility policy, Antibiotic Stewardship, dated 11/3/17, obtained from the Administrator on 3/10/2020 at 9:00 a.m., indicated the Infection Preventionist would be responsible for infection surveillance tracking. The current facility policy, Infection Control, dated 5/6/19, provided by the Administrator on 3/12/2020 at 1:45 p.m., indicated the purpose of infection control was to provide guidelines for general infection control while caring for residents. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water before and after direct contact with residents, after removing gloves, and after handling soiled or used linens . 3.1-18(b)(1) 3.1-18(l)