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 _____	**10/06/2020**

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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to continue to notify families of COVID-19 updates, including each time a new resident or staff developed a confirmed COVID-19 infection, for 2 of 2 family members interviewed regarding notification. Findings include: On [DATE] at 10:10 A.M., during an interview with Corporate LPN 1, she indicated there were currently 32 residents who were COVID positive in the facility. There was 1 resident in the hospital with the COVID-19 infection, and 4 residents had died . The highest number of COVID positive residents was 47. There were 7 staff who currently were COVID positive, with the highest number of positive staff at 17. The total number of residents in the facility was 77. On [DATE] at 10:25 A.M., the Social Services Director (SSD), provided a document which indicated, To Whom It May Concern, We at (name of facility) use (name of computer system) to notify the families of our residents of our covid status. Notifications are sent out M-F (Monday-Friday), by the Director of Social Services. At this time our notifications (sic) reads as: '(Name of facility) is continuing to follow CDC and Indiana State Health Department recommendations and guidelines. We are continuing weekly staff and resident testing due to increased COVID-19 numbers in our community area. Residents continue to be on COVID-19 precautions and numbers are decreasing.' At that time, the SSD indicated this was a fairly new notification system which had been started the previous week. The notification was the only notification that she knew of which families received. She indicated she did not call families and notify them of the number of residents, or if any new staff or residents developed COVID-19. On [DATE] at 11:15 A.M., during an interview with the SSD and Corporate Administrator, the Corporate Administrator indicated the Administrator had been ill and off work, but thought she had been sending out messages to families. The SSD explained the notification system as a phone call that was automatically sent to families every day. The Corporate Administrator and SSD indicated they were unsure what they were supposed to be telling families. During a confidential interview with a family member, the family member indicated she had received text messages from the facility regarding COVID positive residents. She indicated, They told me they had cases. She indicated, What are their numbers now? She had not received a phone call from the facility. During a confidential interview with a family member, the family member indicated she had received text messages from the facility regarding COVID positive residents. She indicated she was last told the number of positive residents was in the 20's. She did not indicate she had received a phone call from the facility. On [DATE] at 9:15 A.M., Corporate LPN 1 provided the current facility policy, Resident Family Notification - COVID-19, dated [DATE]. The policy included: (Name of facility) will notify residents and their representatives by 5 PM the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or mores residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. This information must .Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either; each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other 3XXX,[DATE](a)(2)
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure complete and accurate documentation of the Covid 19 testing, the results and actions taken for 1 of 3 staff reviewed for Covid 19 testing documentation (QMA2). Finding Includes: On 10/5/20 at 8:45 A.M., QMA 2 (Qualified Medication Aid) indicated that she tested positive for Covid 19 on 9/27/20 and had been working on the Covid unit. On 10/5/20 at 10:10 A.M., the Corporate LPN 1 provided a document that identified all Covid positive staff members. The facility reported 7 staff members as currently Covid positive and an additional 10 staff members that had recovered. QMA 2 was not listed on the document as a current Covid positive staff member or as a recovered Covid positive staff member. On 10/5/20 at 10:38 A.M., Corporate LPN 1 indicated she was unaware of QMA 2's positive Covid test and did not have her on the record as positive. The Corporate LPN had been responsible for maintaining the records of staff testing. On 10/5/20 at 11:15 A.M., the Corporate Administrator provided a form, dated 9/20/20, that indicated a Covid 19 test was performed by the DON (Director of Nursing) and resulted as positive for QMA 2. On 10/5/20 at 12:19 P.M., the Corporate Administrator provided an additional form, dated 9/27/20, that indicated that a Covid 19 test was performed and resulted as positive on 9/27/20 for QMA 2. On 10/5/20 at 12:55 P.M., during a phone interview with QMA 2, she indicated that she tested positive for Covid 19 on 9/27/20 and that was her first positive test historically. She indicated that she was tested using the Point of Care testing device and the test was completed by the DON (Director of Nursing). QMA 2 indicated that she had been tested multiple times, but was negative. On 10/5/20 at 4:00 P.M., the Corporate Administrator provided a piece of notebook paper that she had found on the Administrator's desk that indicated that QMA 2 was tested by the DON on 9/27/20 for Covid 19 and resulted as positive at that time. The Corporate Administrator indicated at that time that QMA 2 tested positive for Covid 19 on 9/27/20. There was no other documentation of QMA 2 being tested on [DATE]. On 10/6/20 at 10:50 A.M., Corporate LPN 1 provided the current facility policy, COVID Testing Guidance, dated 8/30/20. The policy included, For staff routine testing .document the date(s) that testing was performed for all staff, and the results of each test 3.1-18(b)(1)(A)

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.