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 _____	**03/10/2020**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent sexual abuse from occurring when a male staff member had anal intercourse with a male resident for 1 of 3 abuse allegations reviewed. The state agency received videos and picture evidence of two males, one identified as a male employee and the other identified as a resident. (Resident B, CNA 7). This Immediate Jeopardy began on March 6, 2020, when the facility failed to prevent sexual abuse from occurring when a male staff member had anal intercourse with a male resident. The Administrator, DON (Director of Nursing), and MDS Coordinator were notified of the Immediate Jeopardy on March 6, 2020 at 9:00 P.M. The Immediate Jeopardy was removed on 3/9/20 at 3:24 P.M., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: On 3/6/20 at 12:29 P.M., the Indiana State Department of Health received videos and a picture. The videos depicted a staff member wearing royal blue scrubs, having anal intercourse with another individual in a teal colored T-shirt. The picture depicted a penis of an individual wearing a teal colored T-shirt and a staff member in royal blue scrubs with multiple bracelets on the left wrist. The wrist with the bracelets appeared to be up close and directly underneath the testicles of the individual in the teal colored T-shirt. On 3/6/20 at 6:15 P.M., and on 3/8/20 at 9:10 A.M., an observation of Resident B's former room included, but was not limited to: Valances and additional sheer drapes as seen in the videos Ceiling fire detector, light fixture, and sprinkler head as seen in the videos A side chair, with a brown metal frame as seen in the videos White clothes basket with Resident B's name On 3/6/20 at 3:25 P.M., Resident B's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 12/1/19, indicated Resident B was cognitively intact and had a [DIAGNOSES REDACTED]. The Care Plans included, but were not limited to: I have behavioral issues and frequently make false truths, initiated 6/28/19. The intervention included, staff to go in room of resident with two staff members at all times, initiated 6/28/19. The Progress Notes included, but were not limited to: 3/3/20 at 8:00 A.M., Updated resident that (name of aging council) would be here to interview him today. Resident voiced understanding. 3/4/19 at 7:00 P.M., Returned from LOA. meds (medications) given and went to bed. 3/4/20 at 8:33 P.M., Resident came to nurses (sic) desk to speak to this nurse. Resident visibly shaking. Asked if he was cold, resident state no that he has been like this since returning because being here makes him anxious. Making statements to staff presenting as being very paranoid. Making statements that staff is accusing resident of several different behaviors. States that he is going to be arrested tomorrow because of what staff is accusing. Reassurance given but resident remains paranoid & anxious. 3/4/20 at 10:42 P.M., Resident pacing between units. Remains paranoid & (and) anxious. Continues to make paranoid statements regarding staff making accusations about him. 3/5/20 at 12:08 A.M., Upset left the building. 3/5/19 at 9:05 A.M., ED and DNS (Director of Nursing Services) were both contacted by floor nurse about resident and his increased behaviors. It was reported resident was anxious and showing increased signs of paranoia. ED instructed floor nurse to educate resident on leaving AMA (Against Medical Advice) if that was his wishes and have him sign them. Res (resident) did sign them and left the building. 3/6/20 at 2:36 P.M., Resident has texted the ED (Executive Director) multiple times in the last three days. It started with needing to come back for an appointment with (Name of aging council) for a continued level of care after leaving on LOA (leave of absence). These text messages were increased in paranoia and accusatory towards staff. When staff was interview (sic) about accusations, staff knew nothing about it. It was discovered the resident had told staff members different stories than he would tell the ED and management. Resident had been close to a preacher the entire time here. When resident missed his appointment, the ED called the preacher to see if he had known where he was. Upon talking with him, it was discovered the information the resident had been telling the ED was different then (sic) the information he had been telling the preacher. Today, the resident had continued to text the ED accusatory statements. ED informed management and floor staff if resident comes on to the property to immediately call her. During an interview on 3/6/20 at 3:17 P.M., the Administrator indicated there was one other abuse reportable involving Resident B. The Administrator provided the abuse allegation from 7/4/19. During an interview on 3/6/20 at 4:40 P.M., QMA 8 indicated on the night of 3/4/20 she was in the facility visiting a coworker. CNA 7 told QMA 8 she should go check on Resident B. QMA 8 indicated Resident B was anxious and rambling about being in trouble for stealing medications from the facility. QMA 8 indicated Resident B's paranoia was worse on the night of 3/4/20. QMA 8 indicated Resident B and CNA 7 were close. QMA 8 indicated CNA 7 would bring his dog in to visit Resident B. During a telephone interview on 3/6/20 at 4:56 P.M., Resident B indicated he was the resident in the video provided to the Indiana State Department of Health and CNA 7 was the staff member. Resident B indicated the sexual abuse had been ongoing from November 2019 until approximately one week prior to that date (3/6/20). Resident B indicated he had attempted to tell the Administrator multiple times but was told he was being dramatic. Resident B indicated that was the reason he left AMA (Against Medical Advice) on 3/4/20. During the telephone interview, Resident B indicated he had electronic messages where had indicated to several staff members he was being abused. On 3/6/20 at 5:39 P.M., Resident B forwarded electronic messages he had shared with facility staff members regarding the abuse. From 2/11/20 to 3/2/20 Resident B shared electronic messages with RN 11 and CNA 12. On three occasions Resident B alleged abuse and on two occasions included that he had videos and pictures to prove the abuse occurred. The information shared with RN 11 and CNA 12 was not shared with facility administration or addressed in the clinical record. On one occasion time stamped 2/17/20, Resident B electronically messaged the Social Service Director, regarding bloody stools and bloody vomit. Resident B listed the names of four employees working who knew he was sick, RN 13, LPN 14, CNA 14, and CNA 12. There was no assessment or notification included in the clinical record. During an interview on 3/6/20 at 6:22 P.M., LPN 9 indicated she was working on the night of 3/4/20. LPN 9 indicated Resident B had come to the nursing station on the West unit and was visibly shaking. LPN 9 indicated she asked Resident B if he was okay, to which Resident B replied it was his nerves. LPN 9 indicated Resident B was rambling about staff talking about him and the police being called because he was stealing drugs. LPN 9 indicated this behavior was unusual for Resident B and was very concerning. During an interview on 3/6/20 at 6:52 P.M., a photo was shown of the arm with bracelets, edited to exclude the male genitalia. CNA 10 indicated the bracelets in the picture were familiar but could not say which employee wore the bracelets. During an interview on 3/6/20 at 7:06 P.M., CNA 7 came to the facility and indicated he had met Resident B on a phone sex application prior to becoming employed with the facility. CNA 7 indicated Resident B had been to his apartment prior to CNA 7 working at the facility where they had hooked up. CNA 7 indicated he had not had sexual contact with Resident B since he began working at the facility on 11/7/19. CNA 7 indicated those were his bracelets in the photo of the arm with bracelets. (Edited to exclude the male genitalia) During an interview on 3/7/20 at 11:06 A.M., Resident J indicated that Resident B and CNA 7 were close. Resident J indicated that at one time, Resident B and CNA 7 had dated but was unsure if it had occurred after CNA 7 had begun working at the facility. Resident J indicated

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) CNA 7 would take Resident B out of the facility for lunch, as friends. Resident J indicated CNA 7 had terminated his friendship with Resident B recently. On 3/6/20 at 4:00 P.M., the DON provided the current Reporting Abuse to Facility Management policy, revised 1/1/19. The policy was reviewed at that time and included, but was not limited to: Our facility does not condone resident abuse by anyone, including staff members. Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Sexual abuse is non-consensual sexual contact of any type with a resident. On 3/8/20 at 2:00 P.M., Facility Owner provided the current Employee Handbook, undated. The Employee Handbook included, but was not limited to: The selected colors and styles of acceptable uniforms will be the same for all facilities and are as follows: Certified Nursing Assistants, Royal blue scrub tops and pants. The Immediate Jeopardy that began on 3/6/20 was removed on 3/9/20 when the facility educated staff about abuse, reporting abuse, and social media policies. The Immediate Jeopardy was removed on 3/9/20, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been educated about abuse, reporting abuse, and social media policies and monitoring implemented and observations made to ensure the safety of the residents. This Federal tag relates to Complaint IN 823. 3.1-28(a)
F 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report allegations of abuse for 3 of 3 abuse allegations reviewed. Allegations of abuse were not immediately reported to the Administrator and state survey agency. Resident B's allegations were not reported timely, leading to further abuse. (Resident C) This Immediate Jeopardy began on February 11, 2020, when the facility failed to ensure allegations of abuse were immediately reported to the Administrator resulting in a male staff member having anal intercourse with a male resident. The Administrator, DON (Director of Nursing), and Facility Owner were notified of the Immediate Jeopardy on March 9, 2020 at 3:52 P.M. The Immediate Jeopardy was removed on 3/9/20 at 4:24 P.M., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. On 3/6/20 at 12:29 P.M., the Indiana State Department of Health received videos and a picture. The videos depicted a staff member wearing royal blue scrubs, having anal intercourse with another individual in a teal colored T-shirt. The picture depicted a penis of an individual wearing a teal colored T-shirt and a staff member in royal blue scrubs with multiple bracelets on the left wrist. The wrist with the bracelets appeared to be up close and directly underneath the testicles of the individual in the teal colored T-shirt. On 3/6/20 at 6:15 P.M., and on 3/8/20 at 9:10 A.M., an observation of Resident B's former room included, but was not limited to: Valances and additional sheer drapes as seen in the videos Ceiling fire detector, light fixture, and sprinkler head as seen in the videos A side chair, with a brown metal frame as seen in the videos White clothes basket with Resident B's name On 3/6/20 at 3:25 P.M., Resident B's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 12/1/19, indicated Resident B was cognitively intact and had a [DIAGNOSES REDACTED]. The Progress Notes included, but were not limited to: 3/6/20 at 2:36 P.M., Resident has texted the ED (Executive Director) multiple times in the last three days. It started with needing to come back for an appointment with (council on aging) for a continued level of care after leaving on LOA (leave of absence). These text messages were increased in paranoia and accusatory towards staff. When staff was interview (sic) about accusations, staff knew nothing about it. It was discovered the resident had told staff members different stories than he would tell the ED and management. Resident had been close to a preacher the entire time here. When resident missed his appointment, the ED called the preacher to see if he had known where he was. Upon talking with him, it was discovered the information the resident had been telling the ED was different then (sic) the information he had been telling the preacher. Today, the resident had continued to text the ED accusatory statements. ED informed management and floor staff if resident comes on to the property to immediately call her. During a telephone interview on 3/6/20 at 4:56 P.M., Resident B indicated he was the resident in the video that was provided to the Indiana State Department of Health and CNA 7 was the staff member. Resident B indicated the sexual abuse had been ongoing from November 2019 until approximately one week prior to that date (3/6/20). Resident B indicated he had attempted to tell the Administrator multiple times but was told he was being dramatic. Resident B indicated that was the reason he left AMA (Against Medical Advice) on 3/4/20. During the telephone interview, Resident B indicated he had electronic messages where he had indicated to several staff members he was being abused. On 3/6/20 at 5:39 P.M., Resident B forwarded electronic messages he had shared with facility staff members regarding the abuse. From 2/11/20 to 3/2/20 Resident B shared electronic messages with RN 11 and CNA 12. On three occasions Resident B alleged abuse and on two occasions included that he had videos and pictures to prove the abuse occurred. The information shared with RN 11 and CNA 12 was not shared with facility administration or addressed in the clinical record. On one occasion time stamped 2/17/20, Resident B electronically messaged the Social Service Director, regarding bloody stools and bloody vomit. During an interview on 3/9/20 at 2:15 P.M., RN 11 was shown a copy of electronic messages provided to the state survey agency, which included, but was not limited to: Just done with the bull**** here and the [MEDICATION NAME] out abuse and nothing gets done I can't do it no more. RN 11 indicated those were electronic messages between her and Resident B. RN 11 indicated she did not report the allegation of abuse because it was crap. RN 11 indicated she had called the facility to check on residents but had not notified the Administrator of the allegation of abuse. During an interview on 3/9/20 at 4:50 P.M., RN 11 indicated she had to look on her phone for the time and date of the following electronic message, Just done with the bull**** here and the [MEDICATION NAME] out abuse and nothing gets done I can't do it no more. RN 11 walked back to the medication cart, picked up her phone, and scrolled thru her messages and said, The date is February 11 at 7:00 P.M. During an interview on 3/6/20 at 6:22 P.M., LPN 9 indicated she was working on the night of 3/4/20. LPN 9 indicated Resident B had come to the nursing station on the West unit and was visibly shaking. LPN 9 indicated she asked Resident B if he was okay, to which Resident B replied it was his nerves. LPN 9 indicated Resident B was rambling about staff talking about him and the police being called because he was stealing drugs. LPN 9 indicated this behavior was unusual for Resident B and was very concerning. This was not reported to the ED. During an interview on 3/6/20 at 7:06 P.M., CNA 7 came to the facility and indicated he had met Resident B on a phone sex application prior to becoming employed with the facility. CNA 7 indicated Resident B had been to his apartment prior to CNA 7 working at the facility where they had hooked up. CNA 7 indicated he had not had sexual contact with Resident B since he began working at the facility on 11/7/19. CNA 7 indicated those were his bracelets in the photo of the arm with bracelets. (Edited to exclude the male genitalia) During an interview on 3/6/20 at 3:17 P.M., the Administrator indicated there was one other abuse reportable involving Resident B. The Administrator indicated the incident was not reported to the state survey agency because other staff members had witnessed the incident and it was not abuse. On 3/6/20 at 3:30 P.M., the Administrator provided the abuse allegation from 7/4/19 involving Resident B. The incident investigation included, but was not limited to: Resident B, current BIMS (Brief Interview for Mental Status) score of 9 (moderate cognitive impairment). Description of alleged incident: Resident reported that he was in the hallway in front of his room. The resident asked the employee, How's it going. The employee responded, I hate this f****** place and f*******hate the people who work here. CNA 30's statement included, but was not limited to, (Name of Employee 1) came onto Season's (locked dementia unit) telling (Name of Employee 2) that (Name of QMA 8) was sending her home and called her mommy (name of Administrator) using profanity and the f-word and bull**** (Name of employee 2) agreed and said that it was f****** bull****. 2. During an interview on 3/6/20 at 3:35 P.M., Resident C indicated RN 13 had been verbally abusive to her a couple of weeks ago. Resident C indicated that when RN 13 came into her room, she (Resident C) had asked him (RN 13) to turn her TV on. Resident C said, RN 13 said, 'Do it yourself that's not my problem' . Resident C indicated she told RN 13, Go to h----. Resident C indicated RN 13 motioned with his hands up in the air, Come on baby, bring it on. Resident C indicated she told RN 13 to get out of her room. Resident C said, I told a nurse about it later. I don't know her name, but she had brown hair. Resident C indicated no one had come to talk to her about the incident. Resident C indicated the interview was not confidential and could be reported to the administrator using her name. During an interview on 3/6/20 at 4:00 P.M., the Administrator was notified of an allegation of verbal abuse by Resident C. The Administrator indicated that no allegations of verbal abuse had been reported to her in the last 2 weeks. The clinical record for Resident C was reviewed on 3/6/20 at 11:11 A.M. The record indicated Resident C was admitted to the facility on [DATE]. Resident C's [DIAGNOSES REDACTED]. The Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident C experienced mild cognitive impairment. The assessment further indicated Resident C required the assistance of two staff for bed mobility,

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F 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) toileting and transfers and was only able to stabilize with staff assistance. During an interview on 3/8/20 at 10:21 A.M., The Housekeeping Supervisor (HK 1) indicated that, whenever a Resident complained of abuse, the allegation should be reported immediately to the Administrator. Even if staff members heard about an abuse allegation of a resident at the facility when staff members were off work, HK 1 indicated staff members should still contact the facility and report the abuse allegation to the Administrator. On 3/9/20 at 4:02 P.M., the Administrator provided the current Reporting Abuse to Facility Management policy, revised 3/7/20. At that time the policy was reviewed and included, but was not limited to: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse. All personnel are required to report incidents of resident abuse or suspected incidents of abuse. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. The Executive Director is responsible for immediately notifying all appropriate state agencies of any allegation of abuse. Notification shall be made to the Indiana State Department of Health, local law enforcement, and Adult Protective Services The Immediate Jeopardy that began on 2/11/20 was removed on 3/9/20 when the facility educated staff about abuse, reporting abuse, and social media policies. The Immediate Jeopardy was removed on 3/9/20, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been educated about abuse, reporting abuse, and social media policies. This Federal tag relates to Complaint IN 823. 3.1-28(c)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure skin assessments, reassessments, and treatments were provided for 3 of 5 residents reviewed for skin rashes. (Resident N, Resident M) Findings include: 1. On 3/7/20 at 10:37 A.M., Resident N was observed with LPN 45. On Resident N's bilateral lower extremities multiple reddened areas were observed in a line. Resident N indicated he had the rash for a while. Resident N indicated a physician had looked at the rash but was not sure what it was. LPN 45 indicated Resident N had an order for [REDACTED]., Resident N's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 11/14/19, indicated Resident N had moderate cognitive impairment. The clinical record lacked a care plan related to Resident N's skin rash. The physician's orders [REDACTED]. Domeboro Packet, apply to bilateral lower extremities, feet, and calves, topically, one time a day for red rash, for seven days, start date 1/28/20, end dated 2/4/20, order status completed. Domeboro Packet, apply to both feet topically one time a day for itching for seven days, start date 2/28/20, end date 2/25/20, order status discontinued. [MEDICATION NAME] Cream (brand name for Permetherin cream, a medication used to treat head lice and scabies), apply to body topically, one time only for itching for one day. Apply to body from neck down to toes, leave on for 24 hours, then shower to remove from body, start date 2/29/20, end date 2/29/20, order status completed. The Progress Notes included, but were not limited to: 3/4/20 at 9:33 P.M., Refused shower, wants different cream for rash. 2/28/20 at 5:06 P.M., New orders for [MEDICATION NAME] cream to be applied for 24 hours, then shower off. 2/6/20 at 7:48 P.M., States rash on legs and private area worse. 1/27/20 at 11:47 P.M., Domeboro Packet, apply to bilateral lower extremists, feet, and calves topically one time a day for red rash for seven days, waiting on deliver from pharmacy. 1/26/20 at 8:51 P.M., Domeboro Packet, apply to bilateral lower extremities, feet, calves topically one time a day for red rash for seven days, waiting on delivery from pharmacy. 1/24/20 at 2:40 P.M., Physician answered fax regarding rash on bilateral lower extremities and feet. See treatment order. 1/24/20 at 10:09 A.M., Physician faxed due to resident complaints of increased itching on bilateral lower legs. Examined and he does have red rash on bilateral lower legs and feet only. He was being treated for [REDACTED]. He refuses to let bilateral lower legs and feet open to air. The Progress Notes lacked any documentation of how the [MEDICATION NAME] cream was applied, its effectiveness, and the laundering of residents linens and clothing. The March 2020 MAR/TAR (Medication Administration Record/Treatment Administration Record), included, but was not limited to: A weekly skin assessment completed on 3/3/20. The February 2020 MAR/TAR, included, but was not limited to: Domeboro Packet, Apply to both feet topically one time a day for itching for seven days, start date 2/18/20, discontinue date, 2/23/20. The medication was given on 2/18/20, 2/19/20, 2/21/20, and 2/23/20. The medication was refused on 2/20/20. [MEDICATION NAME] Cream, apply to body topically one time only, start date, 2/29/20, not documented as given. Domeboro Packet, apply to bilateral lower extremities, feet, and calves topically for seven days, no start date or discontinue date. The medication was given 2/1/20, 2/2/20, and 2/3/20. A weekly skin assessment was completed on 2/4/20, 2/11/20, 2/18/20, and 2/25/20. 2. On 3/6/20 at 3:58 P.M., Resident M indicated he had a rash on his body since November of 2019. Resident M indicated he had been treated with a cream and provided a tube of permetherin cream (a medication used to treat head lice and scabies) from his bathroom that he had been treated with. On 3/10/20 at 10:20 A.M., Resident M was observed with LPN 45. LPN 45 indicated Resident M had been treated with permetherin cream. Resident M had light red areas on his right lower extremities. Resident M indicated he had areas on both of his legs and in his groin. On 3/9/20 at 11:46 A.M., Resident M's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 1/26/20, indicated Resident M had mild cognitive impairment. The clinical record lacked care plan related to Resident M's skin rash. The physician's orders [REDACTED]. Permetherin Cream, apply to entire body topically one time only for rash until 3/4/20, leave on for twelve hours , then shower, start date 3/3/20, end date 3/4/20, order status completed. Sarna Lotion, apply to right hip and calf and left shin topically two times a day for itching for 14 days, start date 3/8/20 The Progress Notes included, but were not limited to: 3/8/20 at 4:44 P.M., Resident complained to staff about itching and rash like areas. This nurse went to assess areas. There are two areas, one on right hip and one on right calf which are dry, patchy areas and the front of his left calf appears flaky and scaly as well. No redness noted at the sites. Physician notified and new order for Sarna lotion obtained. 3/4/20 at 7:38 P.M., Cream applied as ordered. 2/17/20 at 2:14 P.M., Bendaryl Itch Stopping Gel 2 percent. Apply to legs and groin topically three times a day for itching. May keep at bedside. The Progress Notes lacked any documentation of how the [MEDICATION NAME] cream was applied, its effectiveness, and the laundering of residents linens and clothing. The March 2020 MAR/TAR (Medication Administration Record/Treatment Administration Record) included, but was not limited to: Permetherin Cream, apply to entire body topically one time only for rash until 3/4/20, leave on for twelve hours, then shower. The medication was administered on 3/4/20 at 9:06 P.M. [MEDICATION NAME] Itch Stopping Gel, apply to legs and groin topically three times a day for itching. The medication was administered 3/1/20-3/9/20. A weekly skin assessment was completed on 3/3/20. The February 2020 MAR/TAR included, but was not limited to: [MEDICATION NAME] Itch Stopping Gel, apply to legs and groin topically three times a day for itching. The medication was administered 2/7/20 and 2/17/20-2/29/20. A weekly skin assessment was completed on 2/4/20, 2/11/20, 2/18/20, and 2/25/20. The Progress Notes lacked any documentation of how the permetherin cream was applied, its effectiveness, and the laundering of residents linens and clothing. 3. During an interview on 3/6/20 at 1:00 P.M., Resident L indicated he had been itching all over his body for 6 months. Resident L indicated the doctor had looked at his rash and indicated it looked like bug bites. Resident L indicated CNA 17 had applied a cream from his neck to his feet the other night and then washed it off 12 hours later. Resident L indicated the staff did not take his clothes to the laundry nor did they change the sheets after he had showered and washed the medicine off. During an interview on 3/6/20 at 1:10 P.M., RN 11 reviewed Resident L's medical record and indicated there was no documentation which indicated that the resident had his clothing laundered and his sheets changed after the treatment with the [MEDICATION NAME] cream on 3/5/20. RN 11 indicated CNA 17 had completed the application of the treatment. During an observation on 3/6/20 at 1:20 P.M., RN 11, without washing her hands or donning gloves, assisted Resident L from his recliner to his bed and assisted Resident 11 with pulling his pants down. RN 11 touched the resident's leg while pointing to the resident's area of skin irritation. Red rash was scattered on Resident 11's legs and buttocks and some areas were scabbed. RN 11 assisted the resident with pulling his pants up without having donned gloves. RN 11 exited the Resident 11's room without washing her hands. The medical record of Resident L was reviewed on 3/6/20 at 9:38 A.M. The record indicated the [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) assessment, dated 1/9/20, indicated Resident L experienced no cognitive impairment and required the assistance of one staff for transfers, bed mobility,

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	155508	A. BUILDING _____ B. WING _____	**03/10/2020**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) bathing and hygiene. A care plan titled, .I am at risk for skin breakdown . , date initiated 10/18/19, reviewed on 1/22/20, included, but was not limited to, the following interventions: .Skin inspections weekly and as needed .Dated 10 /18/19 . A physician's orders [REDACTED].[MEDICATION NAME] Cream 5% Apply to body topically one time only for itching for 1 Day . completed A physician's orders [REDACTED].[MEDICATION NAME] Cream 5% Apply to Body from neck down topically one time only for itching for 1 Day .Completed A Treatment Administration Record (TAR) dated 2/1/2020 thru 2/29/2020 lacked documentation the [MEDICATION NAME] cream was applied to Resident L on 2/27/20. A Treatment Administration Record (TAR) dated 3/1/2020 thru 3/31/2020 indicated a [MEDICATION NAME] cream was applied to Resident L on 3/5/20. The progress notes lacked any documentation on how the [MEDICATION NAME] cream was applied, whether the linens were changed, whether all the resident's clothing was sent to the laundry, and the effectiveness of the treatment. During a confidential interview on 3/10/20 at 2:30 P.M., Confidential Interview 1 (CI 1) indicated that, whenever residents were prescribed [MEDICATION NAME] cream, the staff applied the cream to the resident from the neck to their feet, then washed the cream off 12 hours later. The CI 1 indicated the staff were not instructed to change the linens or send all the resident's clothes to the laundry. During an interview on 3/10/20 at 12:46 P.M., the DON indicated he had just started tracking skin rashes on the prior Thursday (3/5/20). The DON provided a skin rash tracking sheet that included, but was not limited to: Resident L: Bilateral lower extremities Resident N: Bilateral lower extremities Resident M: Right calf, right thigh, left shin On 3/10/20 at 12:50 P.M., the DON provided the list of residents with skin rashes who had been scheduled to see a dermatologist. Resident M and Resident N were not on the list. During an interview on 3/10/20 at 1:30 P.M., Laundry 1 and Laundry 2 indicated they had not received any linens or clothing that required bagging, washing, and drying separately. Instructions for the use of Permetherin Cream from Medline Plus included, but was not limited to: After using [MEDICATION NAME], sanitize all the clothing, underwear, pajamas, hats, sheets, pillowcases, and towels you have used recently. These items should be washed in very hot water or dry-cleaned. You should also wash combs, brushes, hairs clips and other personal care items in hot water. The facility was cited on 11/6/19 for adequate monitoring and treatments of skin infections. The facility Plan of Correction, dated 11/29/19, indicated the facility had developed a quality assurance tool to ensure all skin conditions were identified, documented in the clinical record, and continued monitoring until the issues resolved. The quality assurance tool would be utilized weekly for four weeks, monthly for three months, and quarterly for three quarters. A review of the quality assurance tool included, but was not limited to: 11/29/19: Completed, but no residents identified. 12/6/19: Completed, but no residents identified. 2/7/20: Completed, but no residents identified. 3/2020: (no specific date documented) On 3/10/20 at 1:23 P.M., the General Manager indicated there was no specific residents identified on those quality assurance tools and the person completing the audits should have skin assessments documented. The General Manager indicated if there was a skin issue it should have been documented in the progress notes. This Federal tag relates to Complaint IN 750. 3.1-38(b)(6)
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe, functional, and sanitary environment for 2 of 3 units. The carpet on West long hall was dirty, the soiled laundry room floor was wet and dirty, debris was strewn about the shower room floor, and pervasive odors of urine were observed. (Seasons Unit, West Unit) Findings include: 1. During an observation on 3/6/20 at 3:25 P.M., dirt and debris were observed on the West hall carpet. 2. During an observation on 3/6/20 at 4:35 P.M., a large puddle of an unidentified liquid substance was observed on the floor near the leg of the couch in the West hall TV room. 3. During an observation on 3/9/20 at 10:32 A.M., straw paper wrappers and debris were observed on the West hall carpet. 4. An uncovered laundry basket containing a resident's clothes was positioned on the floor in the hall outside of room [ROOM NUMBER]. 5. On 3/9/20 at 10:35 A.M., the West hall soiled laundry room door was propped open with the white lid of the soiled laundry containers. No staff were observed around the open room. The floor was wet, sticky and observably dirty. The spray sink contained light brown colored water with multiple soiled washcloths floating in it. The wall behind the sink was splashed with a brown substance around the area and down to the floor. An uncovered toilet plunger was positioned underneath the stainless steel sink. The front panel of the wooden sink cabinet was hanging and only secured by one side. A bag of soiled laundry sheets smeared with brown stains was positioned on the floor. The bag was open and laundry was coming out of the bag onto the floor. A pair of red gripper socks were on the floor behind the door. An overfilled trash can was observed in the hall outside the laundry room. The lid was sitting on top of bagged trash where it was not possible to be secured to the can. During an interview on 3/9/20 at 10:40 A.M., Laundry 1 indicated the soiled laundry room should always be locked when not attended by staff. Laundry 1 indicated she was unsure what the moisture was on the floor, but indicated the floor looked dirty. Laundry 1 said the socks and sheets should not be on the floor. During an interview on 3/9/20 at 10:48 A.M., CNA 20 indicated the laundry room door should not be propped open. CNA 20 indicated the brown soiled dirty washcloths should have been sprayed out and placed in the dirty laundry containers immediately after residents' incontinence care. CNA 20 indicated the floor looked dirty but was unsure what the substance was that made the floor sticky. On 3/9/20 at 10:55 A.M., the West hall shower room door was propped open. Brown clumps of an unidentified substance were scattered throughout the hall floor leading to the commode and sink. The unlocked shower cabinet contained body soaps, toothpaste, 6 disposable razors, shaving cream, nail clippers, body lotion, zinc oxide ointment, comet all-purpose cleaner (used to clean the shower and shower chairs), and one opened can of cola. During an observation and interview on 3/9/20 at 11:00 A.M., CNA 18 wheeled a resident into the West hall shower room to use the commode. CNA 18 wheeled the resident over a large amount of unidentified debris located in the middle of the shower room hallway. CNA 18 indicated she thought the debris might be breakfast sausage on the floor, but was unsure. CNA 18 was made aware the resident personal shower supplies cabinet attached to the wall of the shower room was unlocked. CNA 18 looked at the lock, which was hanging from the cabinet, indicated the cabinet should be locked, and indicated she did not know why the cabinet was left open. CNA 18 completed toileting the resident. CNA 18 then wheeled the resident out of the shower room and down the shower room hallway while leaving the the shower room supplies cabinet unlocked and debris scattered on the floor. During an interview on 3/9/20 at 11:10 A.M., QMA 8 indicated the shower room cabinet did not need to be locked because there were no razors in the cabinet. QMA was made aware that there were 6 razors, nail clippers, and all-purpose cleaner used to sanitize the shower inside the open cabinet. 7. During an observation on 3/9/20 at 1:12 P.M., straw paper wrappers and debris were observed on the West hall carpet. During an observation on 3/10/20 at 2:20 P.M., a disposable glove with blood noted on the finger of the glove was laying in the middle of the hall. Two staff walked by the glove without picking it up and disposing it properly. 8. On 3/6/20 at 2:20 P.M., a strong urine odor was observed on the Season's Unit. On 3/7/20 at 11:14 A.M., a strong urine odor was observed on the Season's Unit. 9. On 3/10/20 at 8:50 A.M., the Season's Unit was observed. In the hallway, dirt and debris was scattered on the floor. A dried wet substance was observed on the floor. 10. On 3/10/20 at 9:00 A.M., Resident R indicated she was upset her trash had not been emptied in the bathroom. 11. On 3/10/20 at 9:10 A.M., the West Hall supply closet was observed. A cloth incontinence brief and blanket were observed on the floor. During an interview on 3/10/20 at 1:15 P.M., Housekeeping Manager (HK 1) indicated the floors in the common areas were supposed to be swept or vacuumed every day, but HK 1 indicated that CNA's should clean up after themselves. During an interview on 3/10/20 at 1:58 P.M., the General Manager (GM) indicated it was the facility's policy to keep the soiled laundry room locked at all times, to keep the clean laundry covered at all times whenever the cart was in the facility's hallway, soiled laundry should not be left on the floor, soiled washcloths should not be left in the utility sink, shower room floors should be cleaned at the time debris was dropped on the floor, and the cabinet in the shower room which stored the resident's personal items (like razors and shaving cream) should be locked whenever staff was not present in the room. This Federal tag relates to Complaint IN 750 and IN 823. 3.1-19(f)