

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Transcendent Healthcare of Boonville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision, and a secure environment was provided to prevent a resident with dementia from exiting the facility and leaving the property for 1 of 3 residents reviewed for elopement risk. This deficient practice resulted in an elopement that occurred during the early morning hours on 3/15/25 after being last seen by facility staff at approximately 2:00 A.M. A resident exited the facility through an unsecured window and was not realized to be missing until approximately 5:00 A.M. The resident was located by local law enforcement at approximately 6:00 A.M. in a field near the facility wet and shivering and required hospitalization . (Resident C)</p> <p>Finding includes:</p> <p>During record review on 3/26/25 at 9:10 A.M., Resident C's diagnoses included, but were not limited to dementia, anxiety disorder, schizoaffective disorder, and heart failure.</p> <p>Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/17/25, indicated the resident had severe cognitive impairment, could walk 10 feet with partial to moderate assistance, and could walk 50 feet with substantial to maximal assistance.</p> <p>A risk for elopement assessment, completed 1/15/25, indicated Resident C was not at risk for elopement.</p> <p>Resident C's care plan included but was not limited to, resident had late loss Activity of Daily Living (ADL) self-care performance deficit due to dementia (initiated 10/17/24) with an intervention of resident required assistance with bed mobility. Resident C had impaired cognitive function/thought processes related to dementia (initiated 2/25/25) with an intervention of cue, reorient, and supervise as needed. Resident at risk for elopement (initiated 3/24/25).</p> <p>Resident C's physician orders included, but were not limited to, turn and reposition every two hours for prevention every shift (started 10/10/24).</p> <p>Resident C's progress notes included, but were not limited to:</p> <p>(A previous note was dated 3/12/25 with no other documentation made prior to the note on 3/15/25 at 6:36 A. M. in the resident's record.)</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3/15/25 at 6:36 A.M. - Resident sent out to hospital for evaluation and treatment.</p> <p>3/15/25 at 11:29 A.M. - Resident admitted to the hospital with altered mental status.</p> <p>3/21/25 at 3:13 P.M. - Resident was admitted to hospital (on 3/15/25) with altered mental status and urinary tract infection (UTI). Facility to pick up from hospital around 4:00 P.M.</p> <p>During an observation on 3/26/25 at 9:30 A.M., Resident C was sitting on the couch in a common area near the back hall nurse's station watching television.</p> <p>During an interview on 3/26/25 at 9:40 A.M., CNA 2 indicated Resident C could walk without assistance but was not always steady. Resident C often kept to himself and had not displayed any behaviors of wandering or exit seeking that she was aware of.</p> <p>During an interview on 3/26/25 at 9:55 A.M., Police Sergeant 4 indicated that Resident C had exited the facility during the morning hours of 3/15/25. Resident C had apparently slipped out of a window of the facility, crossed a ditch on the facility property and then fell and was found by police lying on the ground near a neighboring middle school, in the rain.</p> <p>During an interview on 3/26/25 at 10:10 A.M., LPN 6 indicate that she worked the morning of 3/15/25 but was late arriving to work due to the bad weather during the morning hours of 3/15/25. LPN 6 indicated that she had received a report from Resident C's night shift nurse and was told the resident had been sent to the hospital for altered mental status. LPN 6 indicated she was not aware of anything unusual that occurred during the night shift morning hours of 3/15/25 and that Resident C did not have any history of exit seeking or elopements.</p> <p>During an interview on 3/26/25 at 10:25 A.M., Police Sergeant 4 indicated that Emergency Medical Services (EMS) was called to the scene the morning of 3/15/25, after Resident C was located in the rain, shivering.</p> <p>A local police report, dated 3/15/25 at 5:57 A.M., indicated an officer was dispatched in reference to a person down in the grass. An officer arrived at the scene to find Resident C with his clothes completely wet. The facility called and indicated that Resident C was a resident at the facility. EMS was called due to the unknown timeframe of which the resident was outside, cold and wet. The facility staff indicated that Resident C was last seen during a 2:00 A.M. bed check. Staff then noticed the resident was missing around 5:00 A.M. Staff never called for police on a missing person. A local weather search indicated, at 3:00 A.M., the area received heavy rain and wind gusts from 14 to 23 miles per hour.</p> <p>During an interview on 3/26/25 at 10:55 A.M., the Facility Administrator indicated that she was notified by the night shift nurse on 3/15/25 that Resident C was missing and then had been found by local police outside of the facility. The Facility Administrator indicated that Resident C was found on facility property and that the night nurse had called the local police department after being unable to locate the resident in or around the facility. Resident C was then sent to the hospital for a change in mental status. The resident had been able to slip out of a bedroom window after construction crews had removed the screws that secured the windows while doing repairs in the facility to vent the facility during the construction. It was not known that the bedroom window was unsecured.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident C's Emergency Department Medical Doctor (MD) exam, dated 3/15/25 at 7:06 A. M., indicated Resident C presented via EMS. Resident C apparently eloped from a nursing facility and was found lying in a football field in the rain.</p> <p>During an interview on 3/27/25 at 8:25 A.M., RN 10 indicated that Resident C had eloped from the facility on the morning of 3/15/25 and was found by local police. Resident C was last seen by staff around 2:00 A.M. during a bed check. RN 10 could not recall the exact time but being notified that the resident was not in his room, a search was initiated inside and outside of the facility. RN 10 notified the Facility Administrator and was told to call the local police department. RN 10 indicated he called the police to report the missing resident, and the police called the facility shortly after to alert them that the resident was found outside of the building.</p> <p>During an interview on 3/27/25 at 8:50 A.M., CNA 8 indicated she was the staff member that realized Resident C was not in his room during the early morning hours of 3/15/25. CNA 8 indicated Resident C was observed in his room during the 2:00 A.M. bed check. During a bed check at around 5:00 A.M., CNA 8 observed that Resident C's room had been rearranged, and the resident was not in his room. CNA 8 indicated a window in the room was opened, but was not completely open and it was not obvious at the time that the resident may have gone out the window. CNA 8 immediately notified the nurse, and staff began checking all rooms and closets on the unit. Staff then searched in and around the entire building until the local police notified them that the resident had been found.</p> <p>During an interview on 3/27/25 at 9:30 A.M., the Facility Administer indicated she was called by RN 10 at 5:46 A.M. and notified that Resident C was missing. The Facility Administrator instructed RN 10 to call the local police. At 6:12 A.M., RN 10 called to notify the Facility Administrator that Resident C had been located by the local police.</p> <p>On 3/26/25 at 2:05 P.M., the Facility Administrator supplied an undated facility policy titled Wandering and Elopements. The policy included, .3. If a resident is missing, initiate the elopement/missing resident emergency procedure: .b. initiate a search of the building(s) and premises; and c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials . f. document relevant information in the resident's medical record.</p> <p>This citation relates to complaint IN00456171.</p> <p>3.1-45(a)(2)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39130</p> <p>Based on interview and record review, the facility failed to ensure resident records were complete and accurate for 1 of 3 residents reviewed for elopement risks. Resident records contained no documentation of an elopement event, and the Medication Administration Records (MAR) was documented inaccurately. (Resident C)</p> <p>Findings includes:</p> <p>1. During record review on 3/26/25 at 9:10 A.M., Resident C's diagnoses included, but were not limited to dementia, anxiety disorder, schizoaffective disorder, and heart failure.</p> <p>Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/17/25, indicated the resident had severe cognitive impairment, could walk 10 feet with partial to moderate assistance, and could walk 50 feet with substantial to maximal assistance.</p> <p>A risk for elopement assessment completed 1/15/25 indicated Resident C was not at risk for elopement.</p> <p>Resident C's care plan included but was not limited to, resident at risk for elopement (initiated 3/24/25).</p> <p>Resident C's progress notes included, but were not limited to:</p> <p>(A previous note was dated 3/12/25 with no other documentation made prior to the note on 3/15/25 at 6:36 A. M. in the resident's record.)</p> <p>3/15/25 at 6:36 A.M. - Resident sent out to hospital for evaluation and treatment.</p> <p>During an interview on 3/26/25 at 10:55 A.M., the Facility Administrator indicated that she was notified by the night shift nurse on 3/15/25 that Resident C was missing and then had been found by local police outside of the facility. The Facility Administrator indicated that Resident C was found on facility property and that the night nurse had called the local police department after being unable to locate the resident in or around the facility. Resident C was then sent to the hospital for a change in mental status.</p> <p>During an interview on 3/27/25 at 8:25 A.M., RN 10 indicated that Resident C had eloped from the facility on the morning of 3/15/25 and was found by local police. Resident C was last seen by staff around 2:00 A.M. during a bed check. RN 10 could not recall the exact time but being notified that the resident was not in his room, a search was initiated inside and out of the facility. RN 10 notified the Facility Administrator and was told to call the local police department. RN 10 indicated he called the police to report the missing resident, and the police called the facility shortly after to alert them that the resident was found outside of the building. RN 10 indicated no documentation was made in the record regarding the elopement or notification to the police department.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/25 at 2:05 P.M., the Facility Administrator supplied an undated facility policy titled Wandering and Elopements. The policy included, .3. If a resident is missing, initiate the elopement/missing resident emergency procedure: .f. document relevant information in the resident's medical record.</p> <p>2. During an interview on 3/26/25 at 11:15 A.M., QMA 14 indicated she had worked the day of 3/15/25 and had received a report from RN 10 that Resident C had been sent out to the hospital during the night shift.</p> <p>During record review on 3/26/25 at 2:30 P.M., Resident C's Medication Administration Record (MAR) for the month of March, 2025, documentation indicated that Resident C received the following medications during the 7:00 A.M., medication pass, signed by QMA 14:</p> <p>Aspirin 81 milligrams (mg) (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Depakote Sprinkles 125 mg (started 10/10/24) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Famotidine 20 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>GlycoLax oral powder 17 grams (started 2/10/25) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Metoprolol succinate extended release 25 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Quetiapine fumarate 125 mg (started 2/19/25) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Senna-docusate sodium 8.6-50 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>Seroquel 25 mg (started 2/20/25) documented as administered on 3/15/25 at 7:00 A.M.</p> <p>During an interview on 3/27/25 at 11:35 A.M., QMA 10 indicated that Resident C was not in the building on 3/15/25 at 7:00 A.M., and that the medications had been documented as administered in error. QMA 10 indicated she would correct the record to show the resident was in the hospital at that time.</p> <p>This citation relates to complaint IN00456171.</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p>		