

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 12/11/2025
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)
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. (continued on next page)

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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 2 of 3 resident halls observed. Resident areas contained uneven floors, the main dining room contained an odor of cigarette smoke, resident rooms and restrooms were unkept, hall closet doorknobs were missing or were in disrepair, and duct tape was used to repair coved base and door trim. (East Hall, [NAME] Hall, room [ROOM NUMBER], Resident B, Resident C, Resident D, Resident F, and Resident G) Findings include: 1. During an observation on 12/9/25 at 10:30 A.M., Resident B was standing at the foot of the bed in room [ROOM NUMBER]. Resident B leaned over onto a bedside table and the table slid out from under him and caused the resident to lose his balance. A soft spot on the floor was observed at the foot of the bed which caused the floor to be uneven. During an observation on 12/9/25 at 10:40 A.M., a dip in the [NAME] Hall floor outside of room [ROOM NUMBER] caused the floor to be uneven. During an observation on 12/9/25 at 12:34 P.M. a dip in the East Hall floor outside of rooms [ROOM NUMBERS] caused the floor to be uneven. room [ROOM NUMBER] appeared to have a hump and then a dip in floor near the room door which caused the flooring to be coming up. room [ROOM NUMBER] contained an uneven floor with visible indentions in the floor where the floor was uneven. room [ROOM NUMBER] contained a dip in the flooring near the room door that caused the floor to be uneven. 2. During an observation on 12/9/25 at 12:30 P.M., multiple residents were smoking in a designated area just outside a set of double-doors that exited the main dining room. Light could be seen between and under the double-doors due to a gap and lack of weather stripping. The main dining area smelled strongly of cigarette smoke. During an observation on 12/11/25 at 11:10 A.M., Residents were smoking in the designated area just outside a set of double-doors that exited the main dining room. Light could be seen between and under the double-doors due to a gap and lack of weather stripping. The main dining area smelled of cigarette smoke. During an interview on 12/11/25 at 10:55 A.M., Resident C indicated the main dining room smells of cigarette smoke when the smokers are out smoking. 3. During an observation and interview on 12/9/25 at 2:00 P.M., Resident D was lying in bed in room [ROOM NUMBER]. A cup and lid were on next to the bed on the floor with a dark orange colored food or drink that had dried. Resident D indicated the spill was from her breakfast that morning and that staff had come into her room to remove her food tray but did not clean the spill. Resident D's shared restroom contained an uncovered specimen collection hat that was resting on the floor adjacent to the commode. During an interview on 12/10/25 at 12:10 P.M., Resident F indicated the shared restroom in room [ROOM NUMBER] was not cleaned well. During an interview on 12/11/25 at 9:50 A.M., Resident G indicated the resident restrooms are not cleaned well. 4. During an observation on 12/10/25 at 1:00 P.M. the [NAME] Hall linen closets near the far end of the hall was missing a doorknob that appeared to have been broken off. The [NAME] Hall activity closet door handle was bent downward and was in disrepair. The [NAME] Hall linen closet door near the nurse's station contained a doorknob that was loose and hanging away from the door. 5. During an observation on 12/11/25 at 9:20 A.M., room [ROOM NUMBER] on the [NAME] Hall had a small hole on the outside of the shared restroom. Two overhead lights contained a build-up of debris and dead insects trapped in the light cover. 6. During an observation and interview on 12/11/25 at 10:30 A.M., the coved base behind the room refrigerator in room [ROOM NUMBER] was duct taped to the wall. Resident H indicated there was a hole behind the cove base and mice were coming into the room over this past summer. Duct tape was then placed over the coved base to keep it sealed. During an observation on 12/11/25 at 10:45 A.M., the door trim around the restroom door was loose toward the base of the trim. A piece of duct tape was holding the base of the trim to the wall and was taped the door jamb. During an interview on 12/11/25 at 12:20 P.M., the Maintenance and Housekeeping Director indicated cove base for resident rooms had been ordered and that an outside source would be working on the uneven flooring. A resident had been known to break into the linen closets on the [NAME] Hall to retrieve towels but was no longer in the facility. During an interview on 12/11/25 at 12:40 P.M., the Facility Administrator indicated not having a policy related to the physical environment. A record review on 12/11/25 at 1:00 P.M. included an order update and shipping confirmation dated 12/20/25 indicated coved base was ordered on 12/9/25. This citation relates to intakes 2613157 2615101 and 2627530 3 1-19(a)(4)(3 1-19(f)(5)</p>		