STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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 ensure the plan of care was implemented for 1 of 3 residents reviewed for wandering and/or elopement. A care plan intervention to indicate which residents were at risk for elopement was not in place for a resident who had demonstrated increased exit seeking behaviors. (Resident F)Finding includes: Record review on 6/1/26 at 10:20 A.M., diagnoses included but were not limited to neurocognitive disorder, unspecified psychosis, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/20/26 indicated the resident had severe cognitive impairment, utilized a walker and required supervision during mobility. An elopement assessment dated [DATE] indicated the resident was at high risk for elopement. The care plan included but was not limited to resident is at risk for elopement (initiated 6/24/25). An intervention included resident will wear a white band on his wrist to identify to staff that he is high risk for elopement (initiated 1/15/26).Nurse's notes included but were not limited to:5/27/2026 at 2:21 P.M. - Resident is more restless today. Noted increased confusion and wondering more. Becomes easily upset with staff reminding to use walker. Resident seems more restless. Will continue to monitor.5/31/2026 3:43 A.M. - Resident has been up pacing this nightshift. Has been redirected numerous time but continues to come out and pace in sitting area. Have given drinks and snacks but is still hard to redirect. Unable to get resident to use his walker when walking. Observation on 6/1/26 at 10:50 A.M., Resident F was sitting in a wheelchair in the dining room. The resident was not wearing a white band on either wrist. Observation on 6/1/26 at at 12:00 P.M., Resident F was wheeling self in a wheelchair near the front hall nurse's station. The resident had no white band on either wrist. Interview on 6/1/26 at 1:00 P.M. QMA 4 indicated Resident F did wander and, at times, was exit seeking. QMA 4 indicated staff could request a list of residents who are at risk for elopement if they wanted to know who is at risk. Interview on 6/1/26 at 2:15 P.M., the MDS nurse and Social Service Director nurse indicated the resident had been recently been demonstrating exit seeking behaviors and that the Social Service Direct came in on 5/27/26 to assist with Resident F's increased behavior. The MDS nurse indicated residents who were assessed to be a high risk for elopement should be wearing a white bracelet. Interview on 6/2/26 at 10:35 A.M., the Director of Nursing (DON) indicated Resident F's white bracelet had been removed about a week prior to his increased wandering and exit seeking behaviors due to a skin condition. The DON indicated there was no documentation made of when the wrist band was removed or how staff monitor the placement of the white wrist band for at risk residents. On 6/2/26 at 11:52 A.M., the Facility Administrator supplied a facility policy titled Wandering/Unsafe Resident, dated 11/2010. The policy included, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement . The residents care plan will indicate the resident is at risk for elopement or other safety issues . Interventions to try to maintain safety will be included in the resident's care plan .This citation relates to intake 3028911.410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with food safety standards to maintain a sanitary environment and prevent foodborne illness during 2 of 2 kitchen observations. Food preparation areas contained a buildup of dust, the walk-in freezer contained a build-up of ice, milk cartons were stored in crates resting on the floor, and the dry food storage room contained canned goods on the floor and a buildup of dust and debris under storage shelving. Finding includes: Kitchen observation on 6/1/26 at 10:20 A.M., the walk in refrigerator contained three milk crates with milk cartons resting directly on the refrigerator floor. The walk-in freezer unit at the back of the freezer had a buildup of ice hanging from under the fans/unit. A buildup of ice had formed on two bread boxes stored under the freezer fans/unit. The dry food storage room contained a buildup of dust and debris under the storage shelving. Two cans of soup were on their sides on the floor under the shelving. The ceiling and smoke detector above a food preparation table contained a buildup of dust. Kitchen observation on 6/2/26 at 9:22 A.M., the walk-in freezer unit at the back of the freezer had a buildup of ice hanging from under the fans/unit. A buildup of ice had formed on two bread boxes stored under the freezer fans/unit. The dry food storage room contained a buildup of dust and debris under the storage shelving. Two cans of soup and a can of dumplings were on the floor under the shelving. The ceiling and smoke detector above a food preparation table contained a buildup of dust. Interview on 6/2/26 at 9:45 A.M., the Dietary Manager (DM) indicated the kitchen will clean the ceiling and overhead vents if they notice they need cleaned but that was not part of their routine cleaning schedule. The milk delivery truck came on Thursdays, and the last milk delivery was the previous Thursday (5/28/26). Crates of milk should not be stored directly on the refrigerator floor. The DM indicated the bread boxes would be moved from under the walk-in freezer unit. Staff cleaned the dry food storage room routinely.Review of the daily and nightly kitchen cleaning task schedule on 6/2/26 at 10:20 A.M., the morning cook task for Mondays included, Organize freezer and remove any ice buildup . The night cook cleaning checklist included sweep/mop all kitchen areas including dry stock and under all equipment and shelves. This citation relates to intake 3016372. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)