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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 proper sanitation to prevent foodborne illness during during 2 of 2 observations of the kitchen. The high temperature dishwasher did not reach a rinse temperature of 180 degrees Fahrenheit, hands were washed with seven and ten second lather, and a suction cup was placed on the cart and then on clean plates used to serve food to the residents. (Kitchen)Finding includes:1. On 3/9/26 at 6:30 A.M., the dishwasher was observed to run. Of three consecutive runs, the dishwasher did not reach a final rinse temperature of greater than 73 degrees Fahrenheit. On 3/12/26 at 10:25 A.M., the Kitchen Manager indicated the dishwasher had not gotten above 180 degrees Fahrenheit during the first observation because the staff had just gotten there that morning. She indicated maintenance had looked at it and said it was working fine, but that the heating element may be going out. He indicated if the red light on the machine was on, to flip the switch off and back on. At that time, the dishwasher was observed to run and the rinse temperature was 169 degrees Fahrenheit. After resetting the red light that was observed to be on, the dishwasher was ran again with a rinse temperature of 171 degrees Fahrenheit. The dishwasher was then ran a third time with a rinse temperature of 169 degrees Fahrenheit. The Kitchen Manager indicated she had spoken with the kitchen staff about the importance of watching for the dishwasher temperature to rise up to the appropriate temperature before washing the dishes. She indicated the staff were not watching the temperature and just documenting a temperature so she was unsure how long it had not been up to the correct rinsing temperature. 2. During an observation on 3/12/26 at 11:29 A.M., the following was observed: Cook 2 performed handwashing with a 10 second lather. Dietary Manager performed handwashing with a 7 second lather. Dietary Manager used a suction cup to pick up clean plates and set them on the bottom plate warmer. After the plate was placed on the plate warmer, she placed the suction cup (part that touched clean plates down) on the plate holder cart rather than on the next clean plate. Food was served on these plates. During an interview on 3/12/26 at 1:14 P.M., the Infection Preventionist indicated staff should lather (rubbing hands together) their hands for at least 20 seconds during handwashing. During an interview on 3/12/26 at 1:29 P.M., the Dietary Manager indicated the bottom of the suction cup used for picking up clean plates should go on the next clean plate instead of on the cart. (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/26 at 9:20 A.M., a current non dated Prevent Foodborne Illness Policy was provided by the Administrator and indicated, Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness . On 3/13/26 at 12:51 P.M., the Administrator provided a current non-dated dishwasher users manual that indicated a minimum and recommended rinse temperature of 180 degrees Fahrenheit. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(2) 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe and secure storage of medications for 8 residents during a random observation of the medication carts. Medications, including narcotics, had been pre-prepared and held in medication cups in the medication cart prior to administration. Loose pills were observed in the medication cart. (Resident 40, Resident 43, Resident 2, Resident 3, Resident 10, Resident 30, Resident 54, Resident 47)Findings include:1. On 3/9/26 at 6:10 A.M., the medication cart for [NAME] Hall was observed. Registered Nurse (RN) 7 opened the top drawer and multiple medication cups were observed with pills in them. At that time, RN 7 indicated he had the medication cups set up for his 6:00 A.M. medication pass. The cups had the resident's first names on them and included the following:- Resident 40's cup contained the following narcotic- Buprenorphine HCl (a medication used to treat opiod use disorder) Sublingual Tablet 8 mg (milligrams) - Resident 43 contained the following narcotic- Norco (opioid pain medication) 5 mg-325 mg - Resident 2 contained the following narcotics- clonazepam (anti-anxiety) 0.5 mg, Norco 7.5 mg-325 mg - Resident 3 contained the following narcotic- Norco 5 mg-325 mg - Resident 10 contained the following narcotic- Oxycodone (opioid pain medication) 7.5 mg-325 mg - Resident 30 contained the following narcotic- Norco 7.5 mg-325 mg - Resident 54 contained the following narcotics- Norco 5 mg-325 mg, Lorazepam (anti-anxiety medication) 1 mg - Resident 47 contained the following narcotic- Lorazepam 0.5 mg 2. Three loose pills were observed in the [NAME] Hall medication cart. The pills were as follows:Amlodipine/olmesartan (blood pressure medication) 10mg-40mg Risperidone (anti-psychotic medication) 0.25 mgRisperidone 2 mg During an interview on 3/12/26 at 10:41 A.M., the Director of Nursing (DON) indicated narcotics had to be double locked in the locked narcotic box until given. During an interview on 3/13/26 at 8:27 A.M., Licensed Practical Nurse (LPN) 9 indicated loose pills should not be in the medication carts. If loose pills were found, they should be destroyed in drug buster liquid. On 3/13/26 at 9:20 A.M., the Administrator provided a non-dated Medication Labeling and Storage policy which indicated, Policy Interpretation and Implementation Medication Storage 1. Medication and biologicals are stored in packaging, containers or other dispensing systems in which they are received. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.7. Controlled substances (listed as Schedule II-V of the Comprehensive Dug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(m)410 IAC 16.2-3.1-25(n)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure care and services were provided to a resident at risk to prevent pressure ulcers and promote the healing of existing pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. Skin assessments were not completed as ordered, specific care plans were not developed for pressure ulcers, and pressure ulcer healing interventions were not in place. (Resident 4)Findings include:On 3/11/26 at 8:36 A.M., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, debility and heart failure. The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/27/26, indicated no cognitive impairment, partial to moderate assistance (staff performs less than half the effort) needed for bed mobility, and was totally dependent on staff with toileting, showering, and transfers. The MDS assessment indicated three facility acquired stage 2 pressure ulcers. A current pressure ulcer care plan indicated:I have pressure ulcers to bilateral heels and potential for further pressure ulcer development, last revised 2/23/26. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, and follow facility policies/protocols for the prevention/treatment of skin breakdown. Current physician orders included, but were not limited to: Right Heel: Paint with betadine. Float every day shift for wound care, dated 3/4/26. Left heel: Paint with betadine. Float every shift for prevention, dated 2/12/26. Weekly skin assessment every night shift every Monday, dated 8/4/25. The following Braden scale for predicting pressure ulcer risk evaluations were completed from 3/19/25 through 2/27/26 which indicate the resident was at high risk for pressure ulcers. Resident 4's Medication Administration Record (MAR) indicated, but was not limited to, the following weekly skin assessments: 8/18/25 existing area, intact (at that time, there were no documented skin areas and no dressings) 8/25/25 existing area, intact (at that time, there were no documented skin areas and no dressings) 9/15/25 not intact, new area (at that time, there was no documentation of a new skin area, but the resident did have a dressing to an area) 9/22/25 not intact (at that time, the resident did have a dressing to an area) 10/27/25 no weekly skin assessment completed 11/3/25 existing area (at that time, there were no documented skin areas) 11/10/25 no weekly skin assessment completed 11/17/25 existing area (at that time, there were no documented skin areas) 12/8/25 no existing area, intact (at that time, the resident had an unstageable pressure ulcer to the left heel with a dressing) 12/15/25 not intact (at that time, the resident did have a dressing to an area) 12/22/25 not intact (at that time, the resident did have a dressing to an area) 12/29/25 no weekly skin assessment completed 1/5/26 no existing area, intact (at that time, the resident had an unstageable pressure ulcer to the left heel with a dressing) 1/19/26 not intact (at that time, the resident did have a dressing to an area) 1/26/26 not intact (at that time, the resident did have a dressing to an area) 2/2/26 not intact (at that time, the resident did have a dressing to an area) 2/9/26 not intact (at that time, the resident did have a dressing to an area) 2/16/26 not intact (at that time, the resident did have a dressing to an area) 2/23/26 not intact, new area (at that time, the resident did have a dressing to an area, but no documentation of a new skin area) 3/2/26 not intact (at that time, the resident did have a dressing to an area) 3/9/26 not intact (at that time, the resident did have a dressing to an area) Pressure wound assessments included, but were not limited to, the following pressure ulcers: #1 Right HeelA right heel stage 2 pressure ulcer was identified on 8/29/25. A care plan for the right heel pressure ulcer was not developed. The area was healed on 9/30/25. The stage 2 right heel pressure ulcer developed again on 1/14/26. A care plan for bilateral heel pressure ulcers was developed on 1/15/26. A specific care plan for the right heel was not developed. The right heel had not been healed and was current. #2 Left HeelA left unstageable pressure ulcer was identified on 9/24/25 and healed on 9/30/25. A care plan for the left heel was not developed at that time. The unstageable left heel pressure ulcer developed again on 12/3/25. A care plan was developed for the left heel on 12/10/25. The area was healed on 2/3/26. The left heel pressure ulcer was developed again on 2/12/26, but no assessment on the area was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed until 2/18/26 and it was identified as a stage 2 pressure ulcer. The area was documented as not healed and current. On 3/11/26 at 10:04 A.M., Licensed Practical Nurse (LPN) 9 indicated Resident 4's left heel pressure ulcer had been healed the previous night, but not documented yet. At that time, Resident 4 was observed lying on his back in bed with a pillow under his calves with both heels hanging off of the pillow resting on the bed. The right heel pressure ulcer was observed to be open to air and was scabbed with surrounding redness, measuring 1cm (centimeter) x 0.8cm. There was no drainage. After observing the area, LPN 9 replaced the right heel on the mattress and did not adjust the pillow. At that time, LPN 9 indicated all nurses were responsible for doing the weekly skin assessments. She indicated there were three questions on each skin assessment that included existing, intact, and new. Existing was to be marked yes if there were any current skin areas including pressure ulcers, skin tears, bruising, etc. Intact was referring to any current dressings, and new would be marked yes if the nurse identified any new skin areas not previously identified. On 3/11/26 at 12:35 P.M., Resident 4 was observed lying in bed with a pillow under his right calf. The right heel was hanging off of the pillow and resting on the bed. At that time, LPN 9 lifted the right foot and then placed it back resting on the bed. The left leg was not elevated with leg and heel resting on the bed. On 3/12/26 at 1:59 P.M., the Director of Nursing (DON) indicated there was some confusion among staff as to what the intact meant on the resident MARs for the weekly skin assessments. Some thought it was referencing skin intact, and others were documenting if the dressing was intact. She also indicated that pressure ulcers in the same areas were placed on the same care plan, for example left and right heels, and was unaware that each area would need its own care plan. On 3/13/26 at 9:20 A.M., the Administrator provided a current non-dated Prevention of Pressure Injuries policy that indicated Monitor regularly for comfort and signs of pressure-related injury . Review the interventions and strategies for effectiveness on an ongoing basis On 3/13/26 at 9:20 A.M., the Administrator provided a current non-dated Pressure Ulcers/Skin Breakdown policy that indicated The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used proper hand hygiene and wound care to help prevent the development and transmission of communicable diseases and infections for 1 of 2 observations of wound care and 1 of 1 observations of incontinence care. While packing a wound, the packing touched the incontinence pad under the resident. During hand washing, the lather time was 5-12 seconds. (Resident 30, Resident 5, CNA 2, LPN 3)Findings include:1. On 3/12/26 at 9:44 A.M., incontinence care performed by CNA 2 (assisted by CNA 16) was observed on Resident 5. CNA 2 washed her hands with a ten second lather and put on gloves. The resident had a bowel movement. She removed her soiled gloves and washed her hands with a seven second lather and put gloves on. She proceeded to perform care on the resident's buttocks. She removed her soiled gloves and washed her hands with a 12 second lather. She put gloves on and put a clean brief on the resident. CNA 2 removed her gloves after care was completed and washed her hands with a six second lather. 2. On 3/11/26 at 1:56 P.M., Licensed Practical Nurse (LPN) 3 changed the dressing on Resident 30's coccyx. LPN 3 knocked on Resident 30's door. Upon entering, she put on a gown and gloves and placed a clean trash bag on the bed. She had requested supplies from another staff member. She removed her gown and gloves to go get the supplies when the staff member knocked on the door with the supplies. She washed her hands and put on a clean gown and gloves. She placed a towel on the bedside table and placed supplies on the towel. The dressing had fallen off the wound. LPN 3 cleaned the area with wound cleaner and patted dry. She cut packing and placed it in a medicine cup. While using a cotton tipped swab to place the packing inside the wound, the end of the packing was touching the clean blue incontinence pad under the resident. After the packing was in the wound, the area was covered with a Telfa island dressing. LPN 3 removed the gown and gloves, removed the trash bag from the bed and tied it shut. She went into the bathroom to wash her hands and only lathered with soap for 5 seconds. During an interview on 3/12/26 at 2:14 P.M., the Infection Preventionist (IP) indicated staff should lather (rub hands together) for at least 20 seconds during handwashing and wound packing should not touch the bedding prior to being put into a wound. On 3/13/26 at 9:30 A.M., the Administrator provided an undated Handwashing/Hand Hygiene policy which indicated, Washing Hands .2. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. 410 IAC 16.2-3.1-18(b)(1) 410 IAC 16.2-3.1-18(l)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing forms were posted daily with the actual working hours of nursing staff during the survey for 5 of 5 days reviewed during the survey. The posted nurse staffing form was not updated over the weekend and the actual working hours of staff was not included on the form. (3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26) Finding includes:On 3/9/26 at 5:45 A.M., the posted nurse staffing form was observed at the nurse's station dated 3/7/26 and lacked the actual working hours of the nursing staff. During an interview on 3/13/26 at 9:42 A.M., the Scheduler indicated the posted nurse staffing should be put up by the nursing staff on the weekends, and they should do it around midnight for the day. She was not aware the actual working hours for nursing staff should be included on the posted nurse staffing form.On 3/13/26 at 11:42 A.M., the Administrator provided the posted nurse staffing forms for 3/9/26 through 3/13/26. At that time, the forms were reviewed and lacked the actual working hours of the nursing staff.On 3/13/26 at 10:42 A.M., a current non dated Posting Direct Care Daily Staffing Policy was provided by the Administrator and indicated, . Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location . The information recorded on the form shall include the following: g. The actual time worked during that shift for each category and type of nursing staff .