

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155801	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2025
NAME OF PROVIDER OR SUPPLIER  Transcendent Healthcare of Boonville - North		STREET ADDRESS, CITY, STATE, ZIP CODE  305 E North 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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent a resident with a history of exit-seeking/elopement behavior from exiting the facility and leaving the property for 1 of 3 residents reviewed for elopement. This deficient practice resulted in an elopement that occurred during the morning hours of September 1, 2025. The resident was located with the assistance of the local police department, approximately 1.2 miles from the nursing facility, near a previous residence. This Immediate Jeopardy began on September 1, 2025, when the facility failed to ensure Resident C did not exit the facility property through a doorway on the [NAME] Hall at approximately 5:30 A.M. Resident C was not realized to be missing until 7:15 A.M. after staff noticed she was not in her room. A search in and around the facility lasted approximately 30 minutes before local law enforcement was notified and arrived to the facility at approximately 7:50 P.M. Resident C was located by local law enforcement and returned to the facility at approximately 8:30 A.M. The Facility Administrator was notified of the Immediate Jeopardy on 9/15/25 at 3:45 P.M. (Resident C) Finding includes: During record review on 9/15/25 at 11:00 A.M., Resident C's diagnoses included, but were not limited to, early onset Alzheimer's disease, unspecified convulsions, anxiety, depression, and chronic obstructive pulmonary disease (COPD). Resident C's most recent admission date was 8/24/25. Resident C had previously been discharged from the facility on 11/30/24. A risk for elopement assessment, dated 8/24/25 indicated Resident C had a history of or attempted elopement at home, had verbally expressed a desire to go home, packed belongings to go home, or stayed near an exit door, and was recently admitted to the facility and was not accepting of the situation. The elopement assessment indicated a score of 3 or at risk for elopement. , The most recent admission MDS (Minimum Data Set) assessment, dated 8/31/25 indicated the resident had no cognitive impairment and the resident required supervision for mobility and transfers. Resident C's care plan included, but was not limited to, Resident has sleep issues and takes medication to help sleep with an intervention that included, monitor for abnormal sleep patterns (initiated 8/25/25). Resident C's nurse's progress notes included, but were not limited to: 8/24/25 at 7:30 A.M. - Resident arrived at facility at 6:30 A.M. from home. 8/26/25 at 9:10 A.M. - Resident ambulated to smoke, staff spoke to her, and she looked at staff in silence then looked away. Staff to monitor for mood. Resident exited building to smoke with the smoking group. 8/30/25 at 5:22 A.M. - Resident up and pacing hallways and asking for a light and wants to smoke. Resident is agitated and upset, short in demeanor. Resident reports that someone has wrecked her room but when nursing observed her room, her bed was made and her belongings were all in place, as were the roommate's belongings. Resident went back to her room. 9/1/25 at 8:55 A.M. - Registered Nurse (RN) entered resident's room at approximately 3:30 A.M. to administer medication to the resident's roommate. Resident C was awake and watching television. RN observed Resident C's Hall (West Hall) at approximately 5:20 A.M. and observed Resident C in her room. During shift change at 7:15 A.M, the oncoming RN indicated being unable to locate Resident C in her room or bathroom. A search in and around building was initiated. The Facility Administrator was notified of an elopement. Law enforcement was notified at 7:45 A.M. after 30 minutes of searching and they arrived at the facility at 7:50 A.M. Camera footage showed Resident C walked into the [NAME] hallway, looked up and down hall, and then walked to the exit doors at the end of the hall where she entered the passcode on the keypad and exited the building around 5:30 A.M. Officers were informed of a previous home address and they located Resident C two houses from that address and brought resident back to facility at 8:30 A.M. Resident was placed on elopement precautions. During an interview on 9/15/25 at 10:30 A.M., the Facility Administrator indicated Resident C was able to open the [NAME] Hall exit doors without staff being made aware and without a door alarm sounding by pushing the correct code into the keypad to unlock the door. The keypad had a label that indicated the keycode was month/year (star). An observation on 9/15/25 at 11:10 A.M., included Resident C's room was near the far end of the [NAME] Hall, two doors down from a locked exterior exit door that the resident used to exit the facility on 9/1/25. A keypad controlled the locking mechanism for the exterior doors and no label that indicated the code was observed. During an interview on 9/15/25 at 11:15 A.M., Resident C's Power of Attorney (POA) indicated Resident C had trouble with her memory and occasionally thought she needed to go home, not realizing that she no longer lived there. Resident C had a residence near where she was found on the morning of 9/1/25 around 20 years prior. Resident C had not had any wandering or exit seeking behavior prior to the elopement on 9/1/25 since</p>		