STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transcendent Healthcare of Boonville - North	305 E North St Boonville, IN 47601

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on observation, interview and record review, the facility failed to have physician orders for the resident's immediate care for 1 of 1 resident admitted on hospice. One resident failed to have orders for hospice and oxygen. (Resident 204) Finding includes: On 11/12/24 at 9:41 A.M., Resident 204 was observed lying on a mattress on floor with a brief on and covered with sheet with O2 (oxygen) on at 2 lpm (liters per minute) per nasal cannula. On 11/12/24 at 10:26 A.M., Resident 204's clinical records were reviewed. Resident 204 was admitted on [DATE]. Diagnosis included, but were not limited to liver cell carcinoma, abdominal pain, chronic obstructive pulmonary disease, and hypertension. The Admission MDS (Minimum Data Set) assessment was still in progress. Physician orders included, but were not limited to, the following: haloperidol lactate Concentrate 2 MG/ML (milligram/milliliter) (anxiety medication) Give 2 mg by mouth every 4 hours for Restlessness, dated 11/10/2024 lorazepam Oral Tablet (anxiety medication) 1 MG Give 1 tablet by mouth every 2 hours as needed for Anxiety/Restlessness, dated 11/06/2024 lorazepam Oral Tablet 1 MG Give 1 tablet by mouth three times a day for Anxiety/Restlessness, dated 11/06/2024 Morphine Sulfate (Concentrate) Oral Solution (pain medication) 100 MG (milligram)/5ML (milliliter) Give 0.5 ml by mouth every 30 minutes as needed for pain or SOB (shortness of breath), dated 11/03/2024 oxycodone HCl (hydrochloride) (pain medication) Oral Tablet 30 MG Give 1 tablet by mouth every 6 hours for end of life comfort related to liver cell carcinoma, dated 11/05/2024 Physician orders lacked an order for hospice and oxygen. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current Care Plans include, but not limited to, the following: Resident is currently on hospice care and exhibits restlessness, agitation, and chronic confusion, alongside short-term memory loss and disorientation. Due to cognitive and physical limitations, resident requires 1:1 supervision and frequent cues at this time. Resident is experiencing ongoing pain, which exacerbates agitation and restlessness. Staff will focus on providing calming sensory activities, supportive interactions, and gentle reorientation to create a safe, low-stimulation environment that reduces agitation and promotes comfort, dated 11/6/2024. Admission Progress Note from 10/30/24 indicated O2 98.0 % - 10/30/2024 8:58 A.M. Method: Oxygen via Nasal Cannula .Respiratory: No signs of difficulty breathing. Shortness of breath noted. Resident reported Shortness of breath (upon exertion). Nurse observed Shortness of breath (upon exertion). Lung issue #001: New Location: Right: Anterior Upper Lobe Rhonchi on auscultation. Lung sounds present on exhalation. Lung sounds present on inhalation.#002: New Location: Left: Anterior Upper Lobe Wheezes on auscultation. Diminished on auscultation. Lung sounds present on exhalation.#003: New Location: Left: Posterior Upper Lobe Wheezes on auscultation. Diminished on auscultation. Lung sounds present on exhalation.#004: New Location: Right: Posterior Upper Lobe Rhonchi on auscultation. Lung sounds present on exhalation. Lung sounds present on inhalation.#005: New Location: Right: Anterior Middle Lobe Wheezes on auscultation. Diminished on auscultation. Lung sounds present on exhalation. Lung sounds present on inhalation.#006: New Location: Left: Anterior Lower Lobe Diminished on auscultation. Lung sounds present on inhalation. Lung sounds present on exhalation.#007: New Location: Left: Posterior Lower Lobe Diminished on auscultation.#008: New Location: Right: Posterior Middle Lobe Diminished on auscultation. #009: New Location: Right: Anterior Lower Lobe Diminished on auscultation.#010: New Location: Right: Posterior Lower Lobe Diminished on auscultation. Humidification: Yes. Oxygen via nasal cannula. Cough present. Moist/loose non-productive cough noted. Cough with effective airway: Yes.Cough with retained secretions: Yes. Pain related to coughing: No .Comfort concerns - note: on hospice pain management not controlled yet . During an interview on 11/13/24 at 10:29 A.M., the MDS (Minimum Data Set) Coordinator indicated Resident 204 should have physician orders for hospice and oxygen. On 11/14/24 at 10:43 A.M., the MDS Coordinator provided an undated Physician Services policy which indicated .2. Once a resident is admitted , orders for the resident's immediate care and needs can be provided by a physician . 3.1-30(a)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46882 Based on record review and interview, the facility failed to ensure the comprehensive assessment was completed within 14 days after admission for 1 of 5 residents reviewed that were admitted in the last 30 days. A resident admitted on [DATE] did not have a comprehensive assessment completed within 14 days of admission. (Resident 205) Finding includes: On 11/12/24 at 3:14 P.M., Resident 205's clinical records were reviewed. Resident 205 was admitted on [DATE]. Diagnosis included, but were not limited to, unspecified dementia, aphasia, depression, and gastrostomy status. The admission MDS (Minimum Data Set) assessment, dated 10/24/24, was still in progress. The admission MDS assessment should have been completed on 11/7/24. During an interview on 11/13/24 at 10:29 A.M., the MDS Coordinator indicated she had two weeks to complete the admission MDS assessment. On 11/14/24 at 10:44 A.M., the MDS Coordinator provided an undated MDS Completion and Submission Timeframes Policy, which indicated 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' (Centers for Medicare and Medicaid Services) QIES (Quality Improvement and Evaluation System) Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . 3.1-31(d)(1)

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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** 39130 Based on observation, interview, and record review, the facility failed to ensure a resident specific plan of care was developed for 2 of 14 resident care plans reviewed. A dependent resident was not care planned for ADL's (Activities of Daily Living) and a resident at nutritional risk was not care planned timely following an unplanned significant weight loss. (Resident 25, Resident 44) Findings include: 1. During record review on 11/8/24 at 2:00 P.M., Resident 25 diagnoses included, but was not limited to, bi-polar disorder, anxiety, and major depression. Resident 25's most recent Quarterly MDS (Minimum Data Set) assessment, dated 10/12/24, indicated that the resident had a weight loss while not on a prescribed weight loss regimen. A nutritional assessment dated [DATE] indicated the resident was high risk. Resident 25's documented monthly weights indicated the resident experienced a significant weight loss of greater than 10 % from 3/7/24 weighing 170.9 pounds (lbs) to 146.2 lbs on 3/27/24. Resident 25's care plan included, but was not limited to, resident has potential for nutritional problem, initiated 8/30/24. No other nutritional care plans were created following the nutritional assessment on 10/19/23 or following the significant weight loss on 3/27/24. 2. During an observation on 11/7/24 at 9:21 A.M., Resident 44 was lying in bed. The resident had a trapeze bar hanging over the bed for positioning and the resident appeared to be a bilateral lower leg amputee. During record review on 11/12/24 at 11:39 A.M., Resident 44's diagnoses included but were not limited to, muscle wasting and atrophy, acquired absence of left leg above knee, pain in right shoulder, impingement syndrome in right shoulder, and obesity. Resident 44's most recent Quarterly MDS assessment, dated 9/13/24, indicated the resident had 1 sided lower extremity impairment, used a wheelchair for mobility, required substantial assistance from staff for toileting and rolling side to side, and was totally dependent on staff for toileting, bathing, changing position from lying to sitting, and for all transfers. Resident 44's care plan included, but was not limited to, resident has an amputation of left above the knee and right below the knee due to diabetes. Interventions included, change position frequently and physical therapy and occupational therapy to evaluate and treat as ordered. No other care plans addressed the resident's need for assistance to complete ADL's. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 2:20 P.M., the MDS nurse indicated that a resident with significant weight loss should have a care plan developed addressing the weight loss, and that a resident who is dependent on staff for completing ADL's should have a care plan addressing the need for assistance for those ADL's. On 11/14/24 at 10:44 A.M., the MDS nurse provided an undated facility policy titled, Care Plans, Comprehensive Person-Centered. The policy indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change . 3.1-35(a) 3.1-35(b)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39130 Based on observation, interview, and record review, the facility failed to ensure a new diagnosis of schizophrenia followed the professionally accepted diagnostic process for 1 of 5 residents reviewed for unnecessary medications. A resident received a diagnosis of schizophrenia without documented screening/testing or symptoms. (Resident 25) Finding includes: During an observation and interview on 11/6/24 at 9:50 A.M., Resident 25 was sitting on the bed in her room. Resident 25 was dressed, well groomed, appeared alert and oriented, and answered interview questions appropriately. During a record review on 11/8/24 at 2:00 P.M., Resident 25's diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, post-traumatic stress disorder, major depressive disorder and schizophrenia (added 12/5/23). Resident 25's most recent Quarterly Minimum Data Set (MDS) assessment, dated 10/12/24, indicated the resident was over the age of 65 and the resident's admission/re-entry date was 1/1/23, the resident was cognitively intact, presented no behaviors, no hallucinations, and no delusions, and had a diagnosis of schizophrenia. Resident 25's care plan included, but was not limited to, resident has a mood problem due to anxiety and schizophrenia (revised 2/12/24). A nurse practitioner encounter for evaluation and management, dated 12/26/23, indicated Resident 25 was receiving medication Latuda 60 mg (milligrams) for schizophrenia with a start date of 9/28/23. The encounter notes included the resident's appearance as, GENERAL: Well-nourished, well-developed, elderly . female, alert, cooperative and conversant, in no acute distress . PSYCHIATRIC: Alert and pleasant. at baseline. Resident 25's record contained no diagnostic examination regarding a diagnosis of schizophrenia. A psychology progress note, dated 11/6/24, included Resident 25's medication order of, Latuda 60 mg oral tablet, give 1 tablet by mouth one time a day for schizophrenia (start date: 9/28/23). During an interview on 11/13/24 at 1:40 P.M., the Assistant Director of Nursing (ADON) indicated that a nurse practitioner (NP) and physician who were no longer affiliated with the facility had given an inappropriate diagnosis of schizophrenia to Resident 25. The ADON indicated the facility tried to inform the NP and physician that a new diagnosis of schizophrenia cannot by given to a resident without meeting diagnostic criteria, however, the diagnosis was still added. The ADON thought the diagnosis of schizophrenia had been removed from the resident's diagnoses and indicated that it would be removed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Retrieved from: https://www.mayoclinic.org/diseases-conditions/schizophrenia/diagnosis-treatment/drc Diagnosis of schizophrenia involves ruling out other mental health conditions and making sure that symptoms aren't due to substance misuse, medicine or a medical condition. Finding a diagnosis of schizophrenia may include: Physical exam. This may be done to rule out other problems that could cause similar symptoms and check for any related complications. Tests and screenings. These may include tests that help rule out conditions with similar symptoms and screening for alcohol and drug use. A healthcare professional also may request imaging studies, such as an MRI [Magnetic resonance imaging - a noninvasive medical imaging technique] or a CT [computed tomography-medical imaging procedure] scan. Mental health evaluation. A healthcare professional or mental health professional checks mental status by noting how a person looks and behaves, and asking about thoughts, moods, delusions, hallucinations, substance use, and potential for violence or suicide. This evaluation includes family and personal history . Review of the Diagnostic Criteria for schizophreniform disorder (295.40 - F20.81) in the DSM-V provided the following information regarding the professionally accepted diagnostic process and criteria required for the diagnosis of schizophreniform disorder: A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated. At least one of these must be (1), (2), or (3). 1. Delusions. 2. Hallucinations. 3. Disorganized speech (e.g. frequent derailment or incoherence). 4. Grossly disorganized or catatonic behaviors. 5. negative symptoms (i.e. diminished emotional expression or avolition). B. An episode of the disorder lasts at least 1 month but less than 6 months, When the diagnosis must be made without waiting for recovery, it should be qualified as provisional. C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. The disturbance is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication or another medical condition. Specify if: With good prognostic features: This specifier requires the presence of at least two of the following features: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; confusion or perplexity, good premorbid social and occupational functioning; and absence of blunted or flat affect. Without good prognostic features: This specifier is applied if two or more of the above features have not been present. Diagnostic features: The characteristic symptoms of schizophreniform disorder are identical to those of schizophrenia (Criterion A). Schizophreniform disorder is distinguished by its difference in duration; the total duration of the illness, including prodromal, active, and residual phases is at least 1 month but less than 6 months. (Criterion B) The diagnosis of schizophreniform disorder is made under two conditions: 1) when an episode of illness lasts between 1 and 6 months and the individual has already recovered, and 2) when an individual is symptomatic for less than the 6 months duration required for the diagnosis of schizophrenia but has not yet recovered. In this case, the diagnosis should be noted as schizophreniform disorder (provisional) because it is uncertain if the individual will recover from the disturbance within the 6-month period. If the disturbance persists beyond 6 months, the diagnosis should be changed to schizophrenia. On 11/14/24 at 10:43 A.M., the MDS nurse supplied an undated facility policy titled, Physician Services. The policy included, .9. The medical director identifies attending physician qualifications and responsibilities, based on clinical and regulatory requirements and the recommendations of relevant professional associations. 3.1-35(g)(1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39130 Based on observation, interview, and record review, the facility failed to ensure a resident without pressure-related skin impairment did not develop a pressure injury for 1 of 2 residents reviewed for pressure injuries. Following the development of a pressure ulcer, no initial assessment was documented, and no documented treatment was given for 4 days and interventions were not routinely documented as completed by the plan of care. This deficient practice resulted in Resident 12 developing a facility acquired stage III pressure ulcer (Full-thickness skin loss with damage to subcutaneous tissue. The ulcer may extend into the subcutaneous tissue layer. Granulation tissue and epibole [rolled wound edges] are often present. No exposure of bone, tendon, or muscle. The sore looks like a crater and may be foul-smelling on the coccyx that led to a colonization of MRSA (Methicillin-resistant Staphylococcus aureus) in the wound. (Resident 12) Finding includes: During an observation and interview on 11/7/24 at 12:20 P.M., Resident 12 was lying in bed on a pressure reducing air mattress. The resident indicated she had a wound on her coccyx that developed in the facility. During record review on 11/8/24 at 1:40 P.M., Resident 12's diagnoses included, but were not limited to, chronic kidney disease, vitamin deficiency, atrial fibrillation, and chronic obstructive pulmonary disease. A Braden scale, completed on 3/18/23, indicated Resident 12 was at risk for pressure. Resident 12's most recent Quarterly Minimum Data Set (MDS) assessment, dated 9/7/24, indicated the resident had moderate cognitive impairment, used a wheelchair for mobility, required partial to moderate assistance with rolling side to side, moving from lying to sitting position, and moving from sitting to standing position. The resident was occasionally incontinent of bladder and frequently incontinent of bowel, was at risk for the development of pressure injuries, had no unhealed pressure injuries, and was on a turning and repositioning program. Resident 12's current physician orders included, but were not limited to, Candida Auris swab of wound on buttocks. One time only for testing (11/8/24), dressing change to coccyx: cleanse with wound cleanser, pat dry. Pack with 1/4 packing strip moistened with NaCl (sodium chloride), cover with bordered gauze dressing. Initial and date, every day shift for wound care, and as needed for soiled or dislodged dressing (started 11/1/24), and barrier cream, apply to buttock/coccyx topically as needed for wound prevention, incontinent episodes, and Incontinent care every shift per protocol (started 11/23/28). An Activity Participation Note, dated 9/9/24 at 4:20 P.M., indicated the resident had a recent decline in group activity participation. Resident 12 bases active participation in activities on mental mindset and physical ability each day. Resident 12 still wishes to participate in activities but struggles to attend some days due to increasing physical limitations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 12's care plan included, but was not limited to, resident has potential for skin breakdown such as pressure ulcers due to decreased mobility, variable need for assistance with Activities of Daily Living (ADLs), occasional incontinence of bladder (revised 9/10/24). Interventions included, but were not limited to, offer/assist with toileting as needed, observe for decline in continence status and notify the physician as needed. Resident is occasionally incontinent of bladder due to variable need for assistance with ADLs, diagnoses of stress incontinence (revised 9/10/24). Interventions included, check routinely for incontinence, and provide incontinent care as needed, observe skin condition during toileting and incontinent care. Notify the nurse of any abnormal findings. A Nurse's Note, dated 9/16/24 at 8:25 A.M., indicated staff reported Resident 12 was needing assistance with meals and experienced increased incontinence. The resident had an area on her coccyx. Staff will attempt to get the resident to the dining room for meals. The resident's decline was reported to the physician and Nurse Practitioner (NP). The note did not include an assessment or further information regarding the area on the coccyx. No documentation of the area on the coccyx was found in the resident's record prior to 9/16/24. Resident 12's care plan was updated to include: resident has Stage III pressure ulcer to coccyx due to immobility (initiated 9/17/24). Interventions included but were not limited to, the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. A Physician's Visit Note, dated 9/18/24 at 1:05 P.M., indicated the physician was in to see Resident 12 and the resident had experienced a noted decline. Resident 12 voiced no complaints. An increase in incontinence and generalized weakness as well as a decline of ADL's was reported to the physician. No new orders were given by the physician. A Weekly Skin Assessment Note, dated 9/18/24 at 3:49 P.M., indicated a recent wound to coccyx was evaluated by RN 11 and treatment orders were received. A review of Resident 12's Medication Administration Record/ Treatment Administration Record (MAR/TAR) for the month of September 2024 included a wound treatment order of, dressing change to coccyx: Lift dressing daily to assess and apply Medihoney (wound dressing containing Leptospermum honey). If the dressing comes dislodged prior to dressing change, use triad paste (wound dressing) until next scheduled dressing application, every day shift for wound care (started 9/18/24). No other wound treatments were ordered or documented as completed prior to 9/18/24. An as needed (PRN) order for barrier cream to buttocks/coccyx topically as needed for wound prevention/ incontinent episodes was not documented as administered during the month of September 2024. A Weekly Wound Assessment, dated 9/17/24 at 11:38 A.M., indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 4 cm (centimeters) L (length) x 5.5 cm W (width) x 0.1 cm D (depth) and was acquired on 9/14/24. The assessment indicated the wound bed contained 25% epithelial tissue, 25% granulation tissue, 25% slough, and 25% necrotic tissue with minimal serous drainage and that an odor was present. This was documented as the first observation from the wound nurse, and included a new treatment order, a request for an air mattress, and indicated the resident was on a turning and repositioning routine. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Assessment, dated 9/24/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 4 cm L x 4 cm W x 0.1 cm D. The assessment indicated the wound bed contained 25% epithelial tissue, 25% granulation tissue, 25% slough, and 25% necrotic tissue with moderate serous drainage, and an odor was present. A Wound Assessment, dated 10/1/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 1cm L x 2 cm W x 0.2 cm D and described tunneling or undermining of 0.8 cm at 12 o'clock. The assessment indicated the wound bed contained 25% epithelial tissue, 10% granulation tissue, 65% slough with moderate serous drainage and that an odor was present. A Wound Assessment, dated 10/8/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 0.8 cm L x 1.5 cm W x 0.3 cm D and described tunneling or undermining of 0.4 cm at 12 o'clock. The assessment indicated the wound bed contained 25% epithelial tissue, 10% granulation tissue, 65% slough with moderate serous drainage and that an odor was present. A Wound Assessment, dated 10/15/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 1 cm L x 1.8 cm W x 0.1 cm D and described tunneling or undermining of 0.8 cm at 12 o'clock. The assessment indicated the wound bed contained 25% epithelial tissue, 25% granulation tissue, 50% slough with minimal drainage and that an odor was present. No changes to the plan of treatment. A Wound Assessment, dated 10/22/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 2 cm L x 1.5 cm W x 0.8 cm D and described tunneling or undermining of 1.2 cm at 12 o'clock and that the wound was worsening. The assessment indicated the wound bed contained 25% epithelial tissue, 50% granulation tissue, 25% slough with minimal drainage. A Wound Assessment, dated 11/5/24, indicated a facility-acquired stage III pressure ulcer on Resident 12's coccyx measured 1 cm L x 1.2 cm W x 0.1 cm D and described tunneling or undermining of 0.4 cm at 12 o'clock. The assessment indicated the wound bed contained 25% epithelial tissue, 75% granulation tissue with minimal drainage. A review of Resident 12's documented tasks for Turn and Reposition Every 2 Hours & PRN from 10/10/24 to 11/7/24 included that no documentation of turning and repositing had occurred on 10/11/24, 10/14/24, 10/17/24, and 10/26/24. A Lab Results Report, dated 11/12/24 at 8:18 A.M., included results for Resident 12's wound culture that indicated the wound was positive for MRSA. During an observation and interview on 11/12/24 at 11:40 A.M., RN 11 provided Resident 12's wound treatment and completed a weekly wound assessment. A sign indicated that the resident was on enhanced barrier precautions and a bin of personal protective equipment was located outside the resident's room. RN 11 indicated that Resident 12's wound has recently been cultured and tested positive for MRSA. RN 11 indicated that the wound was healing well and was going to complete the treatment order as it was ordered at the time by packing the wound, however felt wound packing was no longer needed due to healing and nearly no depth to the wound. The wound measured 1.2 cm L x 1 cm W x 0.1 cm D and with 0.2 cm tunneling at 12 o'clock. RN 11 indicated at the time the wound developed, Resident 12 was experiencing a decline in abilities and was having significant loose stools with an increase in incontinence. Resident 12 had a history of bouts of loose stools due to a prior diagnosis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transcendent Healthcare of Boonville - North	305 E North St Boonville, IN 47601

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/13/24 at 1:00 P.M., LPN 9 indicated Resident 12 had a decline in September but had bounced back well. During that time, she required more assistance and did not want to get out of bed. During an interview on 11/13/24 at 1:40 P.M., the ADON (Assistant Director of Nursing) indicated that the resident was having increased incontinence of bowels due to loose stools and developed a small area on coccyx on 9/14/24. The ADON indicated the wound developed during the weekend and could not explain why no documentation of the wound was made from 9/14/24 through 9/16/24 or why no documented treatment was completed before 9/18/24. The ADON indicated that if a new area is observed by staff, the charge nurse on duty should be notified and administer a temporary treatment until new orders are received by either the physician or wound nurse. According to the National Library of Medicine (ncbi.nlm.nih.gov), clinical signs that a pressure ulcer may be infected include, malodorous, purulent exudate, excessive draining, bleeding in the ulcer, and pain. On 11/14/24 at 10:46 A.M., the MDS nurse provided an undated facility policy, titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol. The policy indicated, Assessments and Recognition .the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue . Treatment/Management 1. The physician will order pertinent wound treatments . 3.1-40(a)(1) 3.1-40(a)(2) 3.1-40(a)(3)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130 Based on observation, interview, and record review, the facility failed to ensure adequate nutrition was maintained for 1 of 2 residents reviewed for nutrition. The registered dietitian did not document a review of a resident's significant weight loss and no plan of care was created following a nutritional assessment that indicated the resident was at risk, and no plan of care was created immediately following a significant weight loss. (Resident 25) Finding includes: During an observation and interview on 11/6/24 at 9:53 A.M., Resident 25 was sitting on the edge of her bed. Resident indicated that she had lost weight and was not on a prescribed weight loss regimen. During record review on 11/8/24 at 2:00 P.M., Resident 25 diagnoses included, but was not limited to, bi-polar disorder, anxiety, and major depression. Resident 25's most recent MDS (Minimum Data Set) dated 10/12/24, indicated that the resident has a weight loss while not on a prescribed weight loss regimen. A nutritional assessment dated [DATE] indicated the resident was at high risk. Resident 25's physician orders included, but were not limited to, regular diet, regular texture, regular consistency, coffee in morning; sweet tea for lunch and dinner for (initiated 1/1/23), weight weekly one time a day every Wednesday for weight loss monitoring (ordered 5/23/24), and house supplement with meals with meals for weight loss (discontinued - started on 05/30/24). Resident 25's care plan included, but was not limited to, resident has potential for nutritional problem, initiated 8/30/24. No other nutritional care plans were created following the nutritional assessment on 10/19/23 or following a significant weight loss on 3/27/24. Resident 25's documented weights from March 2024 through July 2024 indicated the following: 3/7/24 - 170.9 lbs (pounds) 3/27/24 -146.2 lbs 4/11/24 - 141.6 lbs 5/10/24 - 139.2 lbs 5/29/24 - 130.8 lbs 6/5/24 - 129.6 lbs 6/12/24 - 130.6 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/24 - 127.0 lbs 7/3/24 - 127.4 lbs 7/10/24 - 127.2 lbs 7/17/24 - 128.0 lbs 7/24/24 - 126.6 lbs Resident 25's nurse's progress notes included the following: 3/8/24 at 3:22 P.M. - resident complains of weakness and she also voices the lack of desire to eat, will continue to monitor, no weight loss noted at this time. 3/22/24 at 2:09 P.M. - resident not eating well if at all. Taking few fluids. Obsessed with bowels and cold pack for vaginal itch. Speech slurred, weak and some confusion. Trying to encourage resident to eat. Updated physician. 3/26/24 at 5:09 P.M. - (Nurse Practitioner) NP note - Following issues were addressed: unintentional weight loss, lower abdominal pain, and constipation. New order to give Miralax 1 capful daily for bowel regimen. 3/29/24 at 5:11 P.M. - Pharmacy Review/Documentation - Reviewed pharmacy recommendations and gave order to decrease Remeron to 7.5 mg (milligrams). Aware of weight loss and benefits of decreasing dose should also improve appetite. 3/27/24 at 10:14 A.M. - resident weighed that[; day. Resident has dramatic weight loss recently. Resident saw gastroenterologist yesterday and will have scopes done soon. 3/28/24 at 1:52 P.M. - Aware of weight loss. Resident has not been eating well due to stress of vaginal itching and discomfort. Will reweigh and physician is aware. Supplements offered. Dietitian updated as well for recommendations. 5/16/24 at 2:07 P.M. - Weight Change Note - Resident mental status has declined and treated for Helicobacter pylori which has been completed and resident will be retested . BMI (Body Mass Index) is 23.9. Diet - Regular-nibbles. States she eats meals but staff finds them in trash. Resident refuses supplements but will eat some ice cream at times. Skin issues followed by wound nurse. Physician aware of weight change. Will continue to monitor weight weekly. Registered dietitian available as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/30/24 at 2:05 P.M. - Nutrition/Dietary Note - Met with ADON (Assistant Director of Nursing) - Resident mental status is improving with the decrease in Xanax. Diet Regular- Knows she needs to eat but continues to be sneaky and disposing food in the trash or sharing. Down 8 lbs since last review. Skin issues followed by wound nurse. MD aware of weight change. Will add house supplement 120 ml (milliliters) every meal. Resident would not take Prostat (supplement) for wound healing. Does have new order for Zinc and Vitamin C for 14 days. Will continue to monitor weight weekly. Registered dietitian available as needed. During an interview on 11/13/24 at 2:20 P.M., the MDS nurse indicated that a care plan should be developed following a nutritional assessment that indicated a resident is at risk. The plan of care should also be updated following a significant weight loss. The MDS nurse indicated the RD (Registered Dietitian) would review the resident's weight loss and have input into new interventions for the plan of care. During an interview on 11/14/24 at 9:30 A.M., the ADON indicated that she had discussed Resident 25's weight loss with the RD and that the RD forgot to document a review regarding the resident's weight loss initially, however the RD felt the facility was addressing the weight loss with adjustments to medications and offering supplements. On 11/14/24 at 10:45 A.M., the MDS Coordinator provided an undated facility policy titled Weight Assessment and Intervention. The policy indicated, Weight Assessment . 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing . Evaluation 1. Undesirable weight change is evaluated by the treatment team . Care Planning 1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate . 3.1-46(a)(1)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 46882 Based on interview and record review, the facility failed to ensure staff were certified as CNAs (Certified Nurse Aides) within 120 days of hire date for 3 of 10 CNAs reviewed for certification. Findings include: On 11/08/24 at 9:42 A.M., Employee Records were reviewed for licenses or certification. The following were listed as CNAs on the Employee Record form. CNA 14 hire date of 4/14/23 worked in dietary until 7/3/24 when she started working as a CNA-not certified CNA 16 hire date of 7/3/24-not certified CNA 18 hire date of 10/5/23-certified in Illinois but not certified in Indiana During an interview on 11/13/24 at 3:18 P.M., the DON (Director of Nursing) indicated that CNAs have 120 days after their hire date to become certified. On 11/14/24 at 10:43 A.M., the MDS (Minimum Data Set) Coordinator indicated they did not have a policy on CNA certification. We follow the state guidelines. 3.1-14(b)

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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. 46416 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored under proper temperature controls for 1 of 1 medication storage rooms reviewed. Finding includes: On 11/13/24 at 10:40 A.M., the refrigerator in the storage room was observed. The log indicated the last temperature was taken on 5/28/24. The freezer area was covered in ice. Medications in the refrigerator included, but was not limited to, insulin pens. During an interview on 11/13/24 at 10:48 A.M., the Director of Nursing (DON) indicated the nursing staff should be reading the temperature of the refrigerator at least once a day and documenting it in the log. She was unaware of any reason that it wasn't being done. At that time, the refrigerator temperature was observed to be 46 degrees Fahrenheit. The range on the log sheet indicated a temperature of 33-41 degrees Fahrenheit was acceptable. On 11/14/24 at 10:44 A.M., a current non dated Medication Labeling and Storage Policy was provided by the MDS (Minimum Data Set) Coordinator and indicated The facility stores all medications and biologicals in locked compartments under proper temperature . The nursing staff is responsible for maintaining medication storage . Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station . 3.1-25(m)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents observed during medication pass and 4 of 4 residents reviewed for use of Enhanced Barrier Precautions (EBP). A pill was dropped on the medication cart, touched with a bare hand, and administered to the resident. Residents with indwelling catheters and open wounds were not placed on precautions as indicated. (Resident 12, Resident 44, Resident 54, Resident 205, Resident 2) Findings include: 1. During an observation and interview on 11/7/24 at 12:20 P.M., Resident 12 was lying in bed on a pressure reducing air mattress. The resident indicated they had a wound on her coccyx that developed in the facility. No signage was present indicating the resident was on EBP and no personal protective equipment (PPE) was observed inside or outside the resident's room. Resident 12's physician orders included but were not limited to, dressing change to coccyx: cleanse with wound cleanser, pat dry. Pack with 1/4 packing strip moistened with NaCl (sodium chloride), cover with bordered gauze dressing. Initial and date, every day shift for wound care, and as needed for soiled or dislodged dressing (started 11/1/24). No orders for EBP were found in the resident's record. A lab results report dated 11/12/24 at 8:18 A.M. included results for Resident 12's wound culture that indicated the wound was positive for MRSA (Methicillin-resistant Staphylcoccus aureus bacteria). During an observation and interview 11/12/24 at 11:40 A.M., RN 11 was providing Resident 12's wound treatment and completing a weekly wound assessment. A sign indicated that the resident was on enhanced barrier precautions and a bin of PPE was located outside the resident's room. RN 11 indicated that Resident 12's wound has recently been cultured and tested positive for MRSA. 2. During an observation on 11/7/24 at 9:21 A.M., Resident 44 was lying in bed. The resident had a trapeze bar hanging over the bed for positioning and the resident appeared to be a bilateral lower leg amputee. The resident had no signage that indicated the resident was on EBP and no PPE was located inside or outside the resident's room. Resident 44's physician orders included, but were not limited to, dressing change - Right above knee amputation site: Leave steri-strips in place, allow to fall off naturally. Cleanse with wound cleanser, pat dry. Cover with 4x10 bordered gauze dressing. Initial and date every day shift every other day for surgical incision AND as needed for soiled or dislodged dressing (started 11/12/24), change tunneling dual lumen PICC (peripherally inserted central catheter dressing on right chest weekly (started 11/10/24), Vancomycin HCl (hydrochloric acid) Intravenous Solution 1000 MG (milligrams)/10 ML (milliliters) (Vancomycin HCl). Use 1 gram intravenously one time a day for infection with the incision (started 11/4/24). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's progress note dated 11/11/24 at 2:41 A.M., indicated, Infection Note - Resident continues on Vancomycin and Cefepime for infection. Tolerates well without adverse reactions. Resident is afebrile and taking probiotic as ordered. No signs or symptoms of infection to incisions and no drainage or issues with right hip at this time. Right Subclavian continue to flush in both ports without resistance and remains patent. Dressing change to Subclavian site done as ordered and per protocol and resident tolerated well. No redness or drainage or issues. 46416 3. On 11/13/24 7:48 A.M., Qualified Medication Aide (QMA) 10 was observed preparing medications for Resident 54. When she was dumping the pills into the medication cup from the packet containing multiple medications, the Ezetimebe 10 mg (Milligram) tablet fell on to the medication cart. QMA 10 picked up the pill with her bare hand and placed it into the medication cup with the other pills and then administered them to the resident. 4. On 11/12/24 at 10:35 A.M., the completed Facility Matrix was reviewed and indicated Resident 205 had a gastrostomy tube (gtube-a small, flexible tube surgically inserted through the abdomen and into the stomach used to provide nutrition). On 11/13/24 at 10:46 A.M., Licensed Practical Nurse (LPN) 9 was observed changing the dressing of Resident 205's gtube wearing gloves but not a gown. There was no signage for EBP in Resident 205's room. On 11/12/24 at 3:14 P.M. , Resident 205's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and gastrostomy placement. Resident 205 was admitted (with the gtube) to the facility on [DATE]. The Admission MDS (Minimum Data Set) assessment was still in progress. Resident 205's clinical record lacked a Physician's Order and Care Plan for the resident to be on EBP. 5. On 11/12/24 at 10:35 A.M., the completed Facility Matrix was reviewed and indicated Resident 2 had an indwelling urinary catheter and an unstageable pressure ulcer. On 11/08/24 at 1:20 P.M., Resident 2 was observed sitting up in a wheelchair in his room eating lunch, Foley covered hanging on wheelchair. There was no signage for EBP in Resident 2's room. On 11/8/24 at 2:19 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur and neuromuscular dysfunction of bladder. Resident 2 was readmitted from the hospital on 10/31/24 after fracturing his left femur and returned with the Foley. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 10/10/24 indicated Resident 2 had moderate cognitive impairment, was independent in bed mobility, partial/moderate assistance for toilet use and supervision for transfers, had no skin issues and no Foley catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's clinical record lacked a Physician's Order and Care Plan for the resident to be on EBP. During an interview on 11/13/24 at 11:18 A.M., LPN 9 indicated she was not aware of EBP and nursing staff would only wear gloves while changing dressings or providing care for urinary catheters. At that time, she indicated she was the nurse for all residents and she did not have any residents on EBP currently. During an interview on 11/14/24 at 8:55 A.M., the Infection Preventionist (IP) indicated the facility was not aware of EBP needed to be in place for providing high contact care to residents with open wounds and indwelling devices. At that time, she indicated staff was not in serviced on EBP prior to the survey. If staff passing medications would drop a medication on the medication cart,. she would expect the medication to be discarded and replaced. Staff should not touch medications with bare hands. On 11/14/24 at 10:44 A.M., a current non dated Administering Medications Policy was provided by the MDS Coordinator and indicated . Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications . On 11/14/25 at 10:44 A.M., a current non dated Enhanced Barrier Precautions Policy was provided by the MDS Coordinator and indicated Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms to residents . EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc) and wound care (any skin opening requiring a dressing) . 3.1-18(b)(2)