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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish a facility-wide system to prevent, identify, report, investigate, and control infections for 4 of 5 residents reviewed for hospitalizations (Resident 27, Resident 19, Resident 1, and Resident 48). Residents who experienced upper respiratory symptoms were not tested or treated for influenza. The facility did not investigate the cause of or track residents' signs and symptoms. This deficient practice resulted in Resident 27, Resident 1, and Resident 48 being hospitalized . Residents tested positive for influenza A upon arriving at the hospital. Resident 19 was ordered to be sent to the hospital, but expired before she could get there. Resident 27 and Resident 1 expired while in the hospital from complications from influenza A.This Immediate Jeopardy began on [DATE], when residents complained of upper respiratory symptoms. The facility failed to test residents for influenza A and track signs and symptoms in order to prevent the spread of contagion. The Administrator was notified of the Immediate Jeopardy on February 13, 2026, at 3:34 P.M. The Immediate Jeopardy was removed on February 16, 2026, but noncompliance remained at the lower scope and severity level of pattern, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On [DATE] at 12:33 P.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, acute kidney failure, and influenza A. The most current full admission Minimum Data Set (MDS) Assessment, dated [DATE], indicated that Resident 27 had severe cognitive impairment and did not have a respiratory diagnosis or infection. The most current Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], indicated that Resident 27 had severe cognitive impairment and did not have a respiratory diagnosis or infection. An Informed Consent and Authorization for Immunizations document, dated [DATE], indicated Resident 27 declined to receive the influenza vaccine. Physician orders included, but were not limited to:kidneys, ureter, and bladder x-ray (KUB) and chest x-ray (CXR) STAT (immediately) for monitoring, dated [DATE] guaifenesin liquid (cough suppressant) 100 milligrams (mg) per 5 milliliters (mL) – Give 20 mL by mouth every four hours as needed (PRN) for cough, dated [DATE] benzonatate (cough suppressant) 100 mg capsule - Give one capsule by mouth three times a day for excessive mucus for six administrations, dated [DATE] May apply oxygen 2 to 4 liters (L) via nasal cannula to maintain oxygen saturation greater than 90%, dated [DATE] (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	azithromycin (an antibiotic) 250 mg tablet – Give two tablets by mouth at bedtime for upper respiratory infection and give one tablet by mouth at bedtime for upper respiratory infection until [DATE], dated [DATE] The clinical record lacked a care plan to indicate Resident 27 experienced, or was being treated for, an upper respiratory illness or signs and symptoms of flu-like illness. A nursing alert note, dated [DATE] at 9:10 P.M., indicated that a chest x-ray was obtained. A radiology results report, dated [DATE] at 10:52 P.M., indicated that there was no acute focal consolidation (solid/fluid material inside the lungs) or effusion (solid/fluid material outside the lungs in the pleural space). A provider progress note, dated [DATE] at 11:59 P.M., indicated that Resident 27 was seen by the Nurse Practitioner (NP). The NP documented that Resident 27 was not feeling well, as evidenced by groaning and agitation. She had a frequent, dry cough on assessment, and lungs were diminished. Staff reported that the resident had a cough for the past three days, and she did not eat breakfast that morning. A complete blood count (CBC), complete metabolic panel (CMP), and stat (immediate) (CXR were ordered. On [DATE] at 10:00 A.M., PRN guaifenesin was administered. A communication with family note, dated [DATE] at 12:06 P.M., indicated There have been positive cases of flu within our building. At this time, appropriate infection control precautions have been implemented to help prevent further spread and to protect the health and safety of our residents and staff. Visitors are encouraged to perform frequent hand hygiene before, during, and after visits and to utilize available hand sanitizer stations throughout the facility. Mask use is recommended to prevent any further spread. We will continue to monitor closely and provide updates as necessary. Please contact the facility with any questions or concerns. Thank you for your understanding and continued support. A nursing alert note, dated [DATE] at 2:25 P.M., indicated that Resident 27 complained of generalized body pain and had a persistent cough. The nurse on duty was notified, and guaifenesin was administered. On [DATE] at 2:17 P.M., PRN guaifenesin was administered. On [DATE] at 7:18 A.M., PRN guaifenesin was administered. A communication with a physician note, dated [DATE] at 8:07 A.M., indicated Resident 27 was seen by the Nurse Practitioner (NP). New orders were received for benzonatate (non-narcotic medication used to relieve cough) 100 mg and DuoNeb via nebulizer every four hours for wheezing (a high-pitched whistling sound caused by narrowed or inflamed airways). The clinical record lacked documentation to indicate that the order for DuoNeb was placed in the clinical record or was administered to the resident. An order note, dated [DATE] at 11:35 A.M., indicated that Resident 27 was seen by the NP. New orders were received for azithromycin (antibiotic) for an upper respiratory infection and oxygen via nasal cannula to maintain oxygen saturation levels above 90%. It was noted that a chest x-ray had (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	been completed five days prior and was negative; however, there was still copious amounts of mucus drainage. A nursing alert note, dated [DATE] at 1:30 A.M., indicated that Resident 27 would not keep her oxygen on. Resident 27's power of attorney (POA) was notified and did not wish to send Resident 27 to the hospital at that time. Resident 27 told the nurse, I'm sick. A provider note, dated [DATE] at 11:11 A.M., indicated that Resident 27 was seen by the Medical Director (MD). Resident 27 was assessed with rhonchi (low-pitched, rattling, or snoring-like lung sounds caused by airway obstruction from mucus or secretions in the large airways) present bilaterally in the lungs, and hoarseness and acute bronchitis were present. An order was given to send Resident 27 to the emergency room (ER) for further evaluation. A transfer/discharge note, dated [DATE] at 12:47 P.M., indicated Resident 27 was sent to the hospital room for respiratory distress and increased shortness of breath. The clinical record lacked documentation to indicate that Resident 27 was tested for influenza following identification of upper respiratory signs and symptoms on [DATE] at 9:10 A.M. and before leaving for the hospital on [DATE] at 12:47 P.M. The clinical record lacked documentation to indicate that the Infection Preventionist (IP) was notified that Resident 27 experienced signs and symptoms of upper respiratory and flu-like illness or that those signs and symptoms were tracked following identification of upper respiratory signs and symptoms on [DATE] at 9:10 A.M. and before leaving for the hospital on [DATE] at 12:47 P.M. An Emergency Department note, dated [DATE] at 1:13 P.M., indicated Resident 27 arrived at the ER with a wet cough and shortness of breath. A chest x-ray was concerning for developing pneumonia in the right midlung and right lower lobe. A respiratory panel was positive for influenza A. A urinalysis was positive for a urinary tract infection. The resident was admitted to the hospital for treatment of influenza A, acute renal failure secondary to dehydration, and a urinary tract infection. Hospitalist notes, dated [DATE] at 11:27 A.M., indicated Resident 27's blood culture grew MSSA (methicillin-susceptible Staphylococcus aureus) and her intravenous (IV) antibiotics were changed. A hospital Discharge summary, dated [DATE], indicated that Resident 27 expired in the hospital with influenza A as the presumptive cause of death. A nursing alert noted, dated [DATE] at 7:20 P.M., indicated the facility received a phone call from the hospital informing them that Resident 27 died at 4:06 P.M. while a patient in the Intensive Care Unit (ICU). During an interview on [DATE] at 11:50 A.M., the [NAME] County Health Department Clerk indicated that Influenza A was listed as a cause of death on Resident 27's death certificate. 2. On [DATE] at 9:26 A.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dementia, and acute respiratory failure with hypoxia. The most recent full Annual Minimum Data Set (MDS) Assessment, dated [DATE], indicated that (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 19 was cognitively intact, had diagnoses of COPD and respiratory failure, and did not have a respiratory infection. The most recent Quarterly MDS Assessment, dated [DATE], indicated that Resident 19 was cognitively intact, had diagnoses of COPD and respiratory failure, and did not have a respiratory infection. Physician orders included, but were not limited to:budesonide-formoterol fumarate (an inhalant used to help control the symptoms of asthma and improve lung function) 80-4.5 micrograms per actuation (mcg/act) - Two puffs inhale orally two times a day related to COPD and acute respiratory failure with hypoxia, dated [DATE] Continuous oxygen: Apply four Liters (L) via nasal cannula every shift related to COPD and acute respiratory failure with hypoxia, dated [DATE] Chest x-ray (CXR) immediately (STAT) for monitoring, dated [DATE] Guaifenesin (cough suppressant) liquid 100 milligrams (mg) per 5 milliliters (mL) - Give ten mL by mouth every four hours as needed (PRN) for cough, dated [DATE] Levaquin (an antibiotic) 750 mg tablet - Give 750 mg by mouth one time a day for pneumonia until [DATE], dated [DATE] Albuterol sulfate (a bronchodilator) nebulization solution (2.5 mg/3mL) 0.083% one vial - Inhale orally via nebulizer every four hours as needed for shortness of breath and wheezing, dated [DATE] Comprehensive Metabolic Panel (CMP) one time only for monitoring, dated [DATE] Complete Blood Count (CBC) and CMP one time only for monitoring, dated [DATE] Resident 19 received the influenza vaccination on [DATE]. A nursing alert note, dated [DATE] at 1:57 P.M., indicated that Resident 19 had an increased productive cough. The resident's vital signs were within normal limits. A COVID swab was ordered. The clinical record lacked documentation to indicate details of the completion of the COVID swab and the results. A nursing alert note, dated [DATE] at 9:10 P.M., indicated a chest x-ray was obtained. A Radiology Results Report, dated [DATE], indicated increased interstitial markings that may represent interstitial edema, a viral pneumonitis, or atypical pneumonia. A provider note, dated [DATE] at 11:59 P.M., indicated that Resident 19 was seen by the Nurse Practitioner (NP) for a cough. The resident complained of a frequent cough since yesterday. She was coughing up phlegm at that time. A stat chest x-ray and guaifenesin ten mL every four hours as needed was ordered. Staff were instructed to monitor for increased shortness of breath. The clinical record lacked documentation to indicate that PRN guaifenesin was administered for cough. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A provider note, dated [DATE] at 11:59 P.M., indicated the NP saw Resident 19 for a follow-up to the chest x-ray. The resident indicated she was feeling better and was receiving oxygen at 3 L via nasal cannula. Levaquin (antibiotic) 750 mg daily for seven days was ordered. A respiratory infection care plan was initiated on [DATE]. A communication with family note, dated [DATE] at 12:06 P.M., indicated There have been positive cases of flu within our building. At this time, appropriate infection control precautions have been implemented to help prevent further spread and to protect the health and safety of our residents and staff. Visitors are encouraged to perform frequent hand hygiene before, during, and after visits and to utilize available hand sanitizer stations throughout the facility. Mask use is recommended to prevent any further spread. We will continue to monitor closely and provide updates as necessary. Please contact the facility with any questions or concerns. Thank you for your understanding and continued support. An infection noted, dated [DATE] at 6:18 P.M., indicated that wheezing (a high-pitched whistling sound caused by narrowed or inflamed airways) was noted upon exhalation in bilateral lung fields. Resident 19 complained of generalized achiness. The NP was notified, and a new order was received to start albuterol nebulizer treatment every four hours as needed for shortness of breath and wheezing. An infection note, dated [DATE] at 10:56 A.M., indicated that wheezing was noted upon exhalation in bilateral lung fields. An albuterol nebulizer treatment was administered. Resident 19 complained of generalized achiness. An infection note, dated [DATE] at 2:09 A.M., indicated that Resident 19 was on Levaquin for an upper respiratory infection and viral pneumonia. Lung sounds were diminished, and coarseness was noted upon auscultation. An infection note, dated [DATE] at 2:51 A.M., indicated that Resident 19 continued to have a productive cough. The clinical record lacked documentation to indicate that PRN guaifenesin was administered for cough. A doctor visit note, dated [DATE] at 9:46 A.M., indicated Resident 19 was seen by the Medical Director (MD). The resident complained of feeling weak and having increased sweating. A new order was given for a CMP. An infection note, dated [DATE] at 3:03 A.M., indicated that Resident 19 completed the course of antibiotics. The resident had a runny nose with clear, thin drainage. A Lab Results Report, collected and reported on [DATE], indicated the following lab results contained abnormal values:BUN (blood urea nitrogen) (nitrogen in the blood that comes from the waste product urea) – 45 mg/deciliter (dL) (normal 8-23) Creatinine (a waste product from normal muscle metabolism) – 2.8 mg/dL (normal 0.4 – 1.1) Potassium (used to diagnose, monitor, or manage kidney disease, as damaged kidneys cannot properly remove excess potassium from the blood) – 5.5 millimole (mmol)/L (normal 3.5 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	– 5.4) Alkaline Phosphatase (ALK PHOS) (measures the level of the ALP enzyme in the blood, primarily used to detect liver disease or bone disorders) – 172 units (u)/L (normal 25-130) Alanine aminotransferase (ALT) (measures the level of the ALT enzyme in the blood to detect liver damage or disease) – 6 u/L (normal 7-35) Estimated Glomerular Filtration Rate (EST GFR) (measures how well kidneys filter blood) – 15 mL/minute (min)/1.73 meters squared (sq.m) (normal >90) The clinical record lacked documentation to indicate why the CMP lab ordered on [DATE] was not collected until [DATE]. On [DATE] at 3:44 P.M., an albuterol nebulizer treatment was administered. An order note, dated [DATE] at 3:22 P.M., indicated that the NP assessed Resident 19 due to increased weakness, fatigue, decreased appetite, and complaints of moderate pain. Pain medication was adjusted at that time, and fluids were encouraged. A communication with family note, dated [DATE] at 8:32 A.M., indicated Resident 19 felt lethargic and weak and was unable to get out of bed and into her wheelchair. A nursing alert note, dated [DATE] at 11:43 A.M., indicated that results from the chest x-ray were received. Findings indicated increased interstitial markings that may represent interstitial edema (abnormal accumulation of fluid within the tissue spaces surrounding cells), a viral pneumonitis (common, often contagious lung infection caused by viruses like influenza, RSV, or COVID-19, leading to air sac inflammation, fluid buildup, fever, and coughing), or atypical pneumonia (a mild infection of the lungs). The NP was notified. No new orders were received. The clinical record lacked an order for the chest x-ray that was performed on [DATE]. The clinical record lacked documentation to indicate why a chest X-ray was ordered on [DATE]. On [DATE] at 2:27 P.M., Resident 19's oxygen saturation was 86% (normal for a person with a COPD diagnosis 90% - 92%) and blood pressure was 96/60 (normal 120/80). A nursing alert note, dated [DATE] at 6:25 P.M., indicated Resident 19 had increased sleepiness and decreased appetite. The resident was seen by the NP. The resident refused to be sent out for further evaluation. Lab results were pending. Blood pressure and oxygen saturations were trending downwards (blood pressure 88/40 and oxygen saturation 84%). The resident's Power of Attorney (POA) was notified and requested that the resident to be sent to the emergency room (ER) to be evaluated. The NP was notified, and an order was received to send the resident to the ER. A Death Packet progress note draft, dated [DATE] at 10:48 P.M., indicated Resident 19 died at 7:20 P.M in the facility. Paramedics were present and confirmed the death. The physician and family were notified. A Lab Results Report, collected and reported on [DATE], indicated the following lab results contained (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	abnormal results:White Blood Count (WBC) (measures the total number of leukocytes in your blood, acting as a crucial indicator of your immune system's response to infections, inflammation, or diseases) – 28.0 thousand/uL (thousands of cells per microliter of blood) (normal 4.0 – 10.4) Mean Corpuscular Volume (MCV) (measures the average size of your red blood cells) - 102.2 femtoliters (fL) (normal 81.0 - 98.0) Mean Corpuscular Hemoglobin Concentration (MCHC) (measures the average concentration of hemoglobin (the oxygen-carrying protein) inside a specific volume of red blood cells) - 29.3 grams (g)/dL (normal 33.0 - 37.0) Red Cell Distribution Width – Coefficient of Variation) RDWCV (measures the variation in size and volume of red blood cells) - 15.3% (normal 11.5 - 14.5) Red Cell Distribution Width – Standard Deviation) RDW-SD (measures the variation in volume and size of red blood cells) - 57.7 fL (normal 35.0 - 42.0) Platelet (PLT) (measures the number, size, and function of platelets, tiny blood cells in bone marrow that help blood clot) - 450 thousand/uL (normal 130 – 400) Neutrophils (NEUT) (measures the body's immediate immune response to infection, inflammation, and injury) - 88.6% (normal 42.2 - 75.2) Lymphocytes (LYMPH) (measures the number of specialized white blood cells in the blood to assess immune system function, typically indicating how the body is fighting infections) - 7.0% (normal 20.5 - 51.1) Eosinophil (EO) (measures the number of specialized white blood cells in the blood to assess immune system function) - 0.0% (normal 1.0 - 3.0) Immature Granulocytes (IMMATURE GRAN) (measures the presence of young while blood cells and used to diagnose and monitor severe infections) - 0.8% (normal 0.0 - 0.4) Absolute Neutrophil Count (ABS NEUT) (measures the exact number of neutrophils, the primary infection-fighting white blood cells) - 24.8 thousand/uL (normal 1.7 - 8.3) Absolute Immature Granulocytes (ABS IMM GRAN) (measures the concentration of precursor white blood cells circulating in the peripheral blood, indicating early bone marrow release and often signaling severe infection) - 0.21 thousand/uL (normal 0.00 - 0.04) Glucose (measures the concentration of sugar in the blood to evaluate how well the body manages energy usage) - 282 mg/dL (normal 70 – 99) BUN - 67 mg/dL (normal 8 – 23) Creatinine - 2.7 mg/dL (normal 0.4 - 1.1) Potassium - 5.6 mmol/L (normal 3.5 - 5.4) (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Total Bilirubin (a waste product from the breakdown of red blood cells) - 0.2 mg/dL (normal 0.3 - 1.2) EST GFR - 16 mL/min/1.73 m² (normal >90) An Interdisciplinary Team (IDT) note, dated [DATE] at 9:45 A.M., indicated that on [DATE], Resident 19 was noted to be lethargic. Vitals were trending down. Labs were pending. The resident did not want to go to the hospital. The NP was aware. At 6:25 P.M. that day, the resident's vitals continued to trend downwards, and the resident was unable to make any decisions. The POA was notified and requested to have the resident sent to the ER for evaluation. Emergency Medical Services (EMS) was called and arrived at the facility. The resident expired at the facility. A late charted nursing alert note, dated [DATE] at 9:51 A.M., indicated that on [DATE] at 5:00 P.M., Resident 19 was alert and oriented, and at 6:25 P.M., Resident 19 was noncoherent. The clinical record lacked documentation to indicate that Resident 19 was tested for influenza following identification of upper respiratory signs and symptoms on [DATE] at 1:57 P.M. and prior to expiring on [DATE] at 7:20 P.M. The clinical record lacked documentation to indicate that the Infection Preventionist (IP) was notified that Resident 19 experienced signs and symptoms of upper respiratory and flu-like illness or that those signs and symptoms were tracked following identification of upper respiratory signs and symptoms on [DATE] at 1:57 P.M. and prior to expiring on [DATE] at 7:20 P.M. 3. On [DATE] at 9:47 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic cough, and influenza A. The most recent full Annual Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident 1 had moderate cognitive impairment, had a diagnosis of COPD, and had pneumonia. The most recent Quarterly MDS Assessment, dated [DATE], indicated Resident 1 had severe cognitive impairment, had a diagnosis of COPD, and did not have any respiratory infections. Physician orders included, but were not limited to:Robafen DM (Dextromethorphan-Guaifenesin) Cough (a cough reduction medication) oral liquid 10-100 milligrams (mg)/5 milliliters (mL) - Give ten mL by mouth every six hours as needed (PRN) for cough related to chronic cough and give ten mL by mouth at bedtime for chronic cough related to chronic cough and give ten mL by mouth one time a day for cough for five days, dated [DATE] Benzonatate (a cough suppressant medication) Capsule 200 mg - Give one capsule by mouth as needed for cough related to chronic cough twice a day, dated [DATE] Ipratropium-albuterol (a bronchodilator) solution 0.5- 2.5 (3) mg/3mL - inhale every four hours for upper respiratory symptoms for seven days while awake, dated [DATE] Levaquin (an antibiotic) oral tablet 750 mg - Give 750 mg by mouth one time a day for upper respiratory symptoms, dated [DATE] Resident 1 received the influenza vaccination on [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 8:28 A.M., PRN benzonatate was administered. The clinical record lacked documentation to indicate why the benzonatate was administered. On [DATE] at 8:30 A.M., PRN Robafen was administered. The clinical record lacked documentation to indicate why the Robafen was administered. On [DATE] at 3:36 P.M., Resident 1 had a temperature 99.5 Fahrenheit (F). A warning of high of 99.0 was exceeded was indicated. A communication with family note, dated [DATE] at 3:56 P.M., indicated Resident 1 was dealing with upper respiratory symptoms. The Nurse Practitioner (NP) was notified. New orders for Levaquin750 mg daily and ipratropium-albuterol every four hours were received. The clinical record lacked documentation to indicate what upper respiratory symptoms the resident experienced and if Resident 1 was seen by the NP. A respiratory infection care plan was initiated on [DATE]. On [DATE] at 6:44 P.M., PRN benzonatate was administered. An infection note, dated [DATE] at 2:08 A.M., indicated Resident 1 took Levaquin 750 mg as ordered for an upper respiratory infection. It was tolerated well without adverse reaction. Oxygen saturations were within normal limits. A coarse and congested cough was noted, but no sputum was noted, and the resident was afebrile. The [DATE] electronic Medication Administration Record (eMAR) indicated Resident 1 did not receive Levaquin 750 mg due to being hospitalized . A nurse's note, dated [DATE] at 4:12 A.M., indicated the Registered Nurse (RN) entered the resident's room to give him the scheduled nebulizer treatment, and the resident was warm to the touch. The RN assessed the resident and noted an elevated temperature of 100.4 Fahrenheit (F). Resident 1 responded to painful stimuli but otherwise was not responsive and had diaphragmatic breathing. The RN auscultated the resident's lungs and found them to be wet with a coarse rub noted and an occasional cough. The RN applied the nebulizer treatment and again assessed overall status and vital signs (all vital signs except for temperature were within normal limits). Resident 1 never became very arousable. The NP was notified, and orders were received to send the resident to the emergency room (ER) for evaluation. The clinical record lacked documentation to indicate that Resident 1 was tested for influenza following identification of upper respiratory signs and symptoms on [DATE] at 8:28 A.M. and prior to leaving for the ER on [DATE] at 4:12 A.M.The clinical record lacked documentation to indicate that the Infection Preventionist (IP) was notified that Resident 1 experienced signs and symptoms of upper respiratory and flu-like illness or that those signs and symptoms were tracked following identification of upper respiratory signs and symptoms on [DATE] at 8:28 A.M. and prior to leaving for the ER on [DATE] at 4:12 A.M. A hospital history and physical note, dated [DATE] at 6:42 A.M., indicated that upon arrival in the ER, the resident was still unresponsive and had a Glasgow Coma Scale score (GCS) of 5 (a severe brain injury or deep comatose state) and was intubated upon arrival. Resident 1 had a temperature of 102 F, (continued on next page)

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	02/17/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a respiratory rate of 26 (elevated), and he was tachycardic (increased heart rate) with heart rates between 108 and 117. ABG (arterial blood gas) showed a pH of 7.3, pCO2 was 32, and pO2 was 428 (indicating respiratory acidosis). Resident 1 had an elevated lactic of 2.6 (indicative of sepsis). A respiratory panel indicated Resident 1 was positive for influenza A. A computed tomography scan (CT scan) (a noninvasive imaging test used to diagnose injuries, tumors, infections, and internal bleeding) of the head was concerning for severe sinusitis. A chest x-ray showed patchy bilateral lung opacities suspicious for pneumonia. Resident 1's admitting diagnoses included, but was not limited to, severe sepsis (sepsis with associated acute organ dysfunction) secondary to influenza A, possible bilateral pneumonia, metabolic encephalopathy (a broad term for brain dysfunction caused by non-structural issues like metabolic, toxic, or organ-related imbalances), acute hypoxic respiratory failure with mechanical ventilation, and severe sinusitis (inflammation of the sinus lining). A nursing alert note, dated [DATE] at 1:03 A.M., indicated the facility received a call from the hospital that Resident 1 expired at the hospital on [DATE] at 10:00 P.M. During an interview on [DATE] at 11:50 A.M., the [NAME] County Health Department Clerk indicated that influenza A, acute hypoxia due to respiratory failure requiring intubation, and sepsis secondary to bilateral pneumonia was listed as causes of death on Resident 1's death certificate. 4. On [DATE] at 12:13 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia and influenza A. The most current full admission Minimum Data Set (MDS) Assessment, dated [DATE], indicated that Resident 48 had moderate cognitive impairment and did not have a respiratory diagnosis or infection. The most current Quarterly MDS Assessment, dated [DATE], indicated that Resident 48 had moderate cognitive impairment and did not have a respiratory diagnosis or infection. Physician orders included, but were not limited to:May have immunizations as required, including, but not limited to, influenza, pneumonia, and TB (1st and second step) and annual TB, dated [DATE] acetaminophen (a fever reducer) 325 milligrams (mg) tablet – Give two tablets via percutaneous endoscopic gastrostomy (PEG) tube (a medical device inserted directly into the stomach through the abdominal wall to provide long-term nutrition, fluids, and medication for individuals unable to meet their needs orally) every four hours as needed for temperature of 100 Fahrenheit (F) or above, dated [DATE] Send to the emergency room (ER) for peg tube replacement. One time only for evaluation and treatment, dated [DATE] An Informed Consent and Authorization for Immunizations document, dated [DATE], indicated Resident 48 gave consent to receive the influenza vaccine. The clinical record lacked documentation to indicate the influenza vaccination was given to Resident 48. A nursing alert note, dated [DATE] at 2:04 P.M., indicated Resident 48 complained of not feeling well and a low-grade temperature of 100.2 Fahrenheit (F) was noted. The Nurse Practitioner (NP) was notified, and a COVID swab was ordered. Acetaminophen was administered. (continued on next page)

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	02/17/2026

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Transcendent Healthcare of Boonville - North	305 E North St Boonville, IN 47601

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The clinical record lacked documentation to indicate details of the completion of the COVID swab and the results. A skilled nursing evaluation, dated [DATE] at 2:04 P.M., indicated Resident 48 had a cough. On [DATE] at 8:12 A.M., Resident 48 had a temperature of 101.9 F. A warning of high of 99.0 was exceeded was indicated. Acetaminophen was administered. The clinical record lacked documentation to indicate the provider was notified of the elevated temperature. A communication with family note, dated [DATE] at 12:06 P.M., indicated There have been positive cases of flu within our building. At this time, appropriate infection control precautions have been implemented to help prevent further spread and to protect the health and safety of our residents and staff. Visitors are encouraged to perform frequent hand hygiene before, during, and after visits and to utilize available hand sanitizer stations throughout the facility. Mask use is recommended to prevent any further spread. We will continue to monitor closely and provide updates as necessary. Please contact the facility with any questions or concerns. Thank you for your understanding and continued support. On [DATE] at 11:37 A.M., Resident 48 had a temperature of 100.0 F. A warning of high of 99.0 was exceeded was indicated. Acetaminophen was administered. The clinical record lacked documentation to indicate that the provider was notified of the elevated temperature. On [DATE] at 8:13 A.M., Resident 48 had a temperature of 100.1 F. A warning of high of 99.0 was exceeded was indicated. Acetaminophen was administered. A doctor visit note, dated [DATE] at 10:52 A.M., indicated the Medical Director (MD) assessed the resident with no acute or abnormal findings. On [DATE] at 8:47 A.M., Resident 48 had a temperature of 99.1 F. A warning of high of 99.0 was exceeded was indicated. The clinical record lacked documentation to indicate that the provider was notified of the elevated temperature. The clinical record lacked documentation between [DATE] at 8:47 A.M. and [DATE] at 2:30 P.M. to indicate that Resident 48 was assessed for signs and symptoms of infection or the resident's condition was monitored. On [DATE] at 2:30 P.M., Resident 48's vital signs were taken and were within normal limits. A nursing alert note, dated [DATE] at 7:50 A.M., indicated that Resident 48's PEG tube was not functioning properly. The NP was notified and an order was given to send

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	155801	A. Building B. Wing	02/17/2026

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure fall prevention measures were in place for 1 of 2 residents reviewed for falls resulting in major injury. This deficient practice resulted in a fall with a brain bleed. (Resident 5)Finding includes: On 2/11/26 at 9:19 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.A care plan dated 7/23/24 indicated the resident was at risk for falls related to confusion, unaware of safety needs, vision/hearing problems with diagnosis of dementia. Interventions included, but were not limited to:Non-skid strips to shower floor dated 4/28/25Apply Fluorescent tape to armrest for visual guidance dated 8/6/25Dycem (non-slip material to provide grip and stability) in recliner dated 9/2/25Provide spill proof cup for hydration to prevent spills that may cause slipping and falls in room dated 11/21/25Adding non-slip furniture pads under recliner dated 12/18/25.Quarterly Minimum Data Set (MDS) Assessment, dated 10/9/25, indicated Resident 5 was severely cognitively impaired, required supervision for eating, partial assistance (staff do half of the work) for toileting, bathing, upper and lower body dressing and putting on/taking off footwear, and transfers.The record indicated the resident had 44 falls between January 2025 and January 2026.Fall #26, dated 10/24/25 at 8:48 A.M., indicated the care plan intervention was provide the resident with non-slide socks at HS (bedtime).Fall #27, dated 11/2/25 at 3:30 A.M., indicated the care plan intervention was non-skid socks to be in place and remind the resident to use call light and ask for assistance.Fall #44, a fall incident report, dated 1/5/26 at 1:31 A.M., indicated Resident 5 had an unwitnessed fall that resulted in two lacerations to right forehead temple with skull exposed, skin tear to right hand and knuckle, and abrasions to bilateral knees and toes. Resident was found in the bedroom, face down in a puddle of blood. The resident became less responsive while waiting for the ambulance. Staff had assisted Resident 5 to the bathroom [ROOM NUMBER] minutes prior and was checked on by staff five minutes prior. The resident was bare foot and did not have any non-slip socks on at the time of the fall.Resident 5 was sent to the ER. A hospital history and physical note, dated 1/5/26 at 3:07 A.M., indicated Resident 5 had hemorrhaging (bleeding) of the right frontal lobe, and laceration to the right forehead closed by sutures. The resident returned to the facility and the following interventions were implemented.Bed in lowest position, every shift for fall prevention; Start date 1/7/26Full size mattress with fall mat next to bed with sensor pressure to mat will turn call light on, check function every shift for fall prevention; Start date 1/30/2615 minutes safety checks-initiated due to fall risk, every shift for fall prevention; Start date 2/9/26A care plan dated 1/6/26 indicated the resident had a floor alarm with a full-size mattress that will sound and turn on my call light due to my poor safety awareness, history of frequent falls, and occasional difficulty with communication. POA (power of attorney) and hospice both would like this in place as a safety intervention.The most recent Significant Change MDS Assessment, dated 1/9/26, indicated Resident 5 was severely cognitively impaired, required supervision for eating, required partial assistance (staff do more than half of the work) for toileting and transfers, required maximal assistance for bathing, upper and lower body dressing, putting on/taking off footwear, and had one fall with injury since the last MDS assessment.The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/26/26, indicated Resident 5 was severely cognitively impaired, required maximal assistance (staff do more than half of the work) for eating, toileting, bathing, upper and lower body dressing, putting on/taking off footwear, and transfers, and had one fall with major injury since the last MDS assessment. During an observation on 2/12/26 at 1:19 P.M., Resident 5's room did not have a recliner, did not have a drink cup, did not have non-slip pads under any furniture, there was no fluorescent tape to the arm rest of a chair.During an interview on 2/12/26 at 2:49 P.M., the MDS Coordinator indicated she leaves care plan interventions in place even if it is not working or is no longer in use, as reference what has been used (continued on next page)

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	155801	A. Building B. Wing	02/17/2026

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Transcendent Healthcare of Boonville - North	305 E North St Boonville, IN 47601

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F 0689 Level of Harm - Actual harm Residents Affected - Few	as intervention previously, and indicated she did not update the care plan with interventions provided by hospice.During an interview on 2/12/26 at 3:07 P.M., the Administrator indicated Resident 5's recliner was removed after last fall, and care plan interventions should be updated when interventions are no longer in place. During an observation on 2/12/26 at 3:45 P.M., the Director of Nursing reviewed fall interventions in Resident 5's care plan. The DON confirmed Resident 5 did not have a recliner in the room, there were no nonslip pads under furniture, stated she was unsure what fluorescent tape was supposed to be on. Resident 5 does not have shower in his room; the DON reviewed the shower room and confirmed there were no non-slip strips in the shower room.During an interview on 2/13/26 at 8:49 A.M., The DON indicated if a fall care plan intervention says a resident should be wearing non-slip socks, resident should have them on.On 2/17/26 at 12:47 P.M., the Administrator provided an undated policy titled Fall Protocol that indicated Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has resolved by addressing the underlying cause. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions.On 2/17/26 at 12:47 P.M., the Administrator provided an undated policy titled Falls and Fall Risk Managing that indicated If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.3.1-45(a)(2)

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	155801	A. Building B. Wing	02/17/2026

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the kitchen manager met required qualifications for 1 of 1 dietary manager qualifications reviewed. (Food Services Director) Findings include:During an interview on 2/9/26 at 9:30 A.M., the Dietary Manager indicated that she was currently enrolled in the course for dietary manager. She indicated that she missed passing the test by 1 point in 2024 and had to wait to re-enroll and take the course. On 2/9/26 at 2:00 P.M., the manager produced an invoice where she had just registered for the class on [DATE] at 12:00 P.M.On 2/12/26 at 11:00 A.M., the employee record for the Food Service Manager indicated she started her role on 1/2/26.During an interview on 2/13/26 at 8:55 P.M., the Administrator indicated that the dietary manager should be certified and during the survey 2/9/26-2/13/26.On 2/17/26 at 1:55 P.M., the Administrator provided a current, non-dated copy of the [Facility Name] Job Description for the Director of Food Services. The FDS job description . indicated the Food Service Director must be registered as a Food Service Director in this state .Be a graduate of an accredited course in dietetic training approved by the American Dietetic Association .the director was to provide leadership training that includes the administrative and supervisory principles essential of the Food Services Department 3.1-20(g)(2)

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	155801	A. Building B. Wing	02/17/2026

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Transcendent Healthcare of Boonville - North	305 E North St Boonville, IN 47601

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to ensure the required staff were present at the monthly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings related to the Infection Preventionist and Medical Director, or designee, and Director of Nursing not being present. This had the potential to affect all residents in the facility.Finding includes:During an interview on 2/17/26 at 11:31 A.M., the Administrator indicated the QAA/QAPI committee met monthly. Monthly attendance records of meetings were requested. On 2/17/26 at 2:27 P.M., the Administrator provided QAPI committee meeting attendance sheets for the following dates: 2/20/25 (Infection Preventionist and Director of Nursing not present) 3/19/25 (Infection Preventionist and Director of Nursing not present) 4/22/25 (Infection Preventionist and Director of Nursing not present) 7/28/25 (Infection Preventionist and Medical Director not present) 10/16/25 (Infection Preventionist and Medical Director not present) 1/12/26 (Infection Preventionist not present) 1/16/26 (Infection Preventionist not present) During an interview on 2/13/26 at 9:38 A.M., the Infection Preventionist indicated she worked from another building and came to the facility monthly for QAPI meetings and staff in-services related to infection control. During an interview on 2/17/26 at 2:07 P.M., the Administrator indicated there was a QAPI meeting held on 2/6/26 but no attendance was signed during the meeting. On 2/10/26 at 3:36 P.M., the Administrator provided a 2026 QAPI Plan that indicated The Executive Leadership team will assure that time and resources are provided to the designated persons that participate on the QAPI Steering Committee or any other associated work groups. Minutes of meetings will reflect membership and attendance of those participating and will be reported quarterly in the monthly QAPI summary report 3.1-52

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	02/17/2026

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observation, interview, and record review, the facility failed to ensure a designated infection preventionist was onsite to implement programs and activities to prevent and control infections. Finding includes: During the entrance conference on 2/9/26 at 10:27 A.M., the Administrator indicated the facility's Infection Preventionist (IP) worked from another building. On 2/12/26 at 1:59 P.M., the IP's employee file was reviewed. The Infection Control Nurse job description included duties such as: Make rounds to nursing units for the purpose of case findings, review of environmental sanitation procedures, and supervision of isolation precautions/practices. Visit isolated residents as necessary to ensure that established isolation precautions and aseptic technique are followed. Works in office area(s) as well as throughout the facility. During an interview on 2/13/26 at 9:38 A.M., the IP indicated she worked from another building and came to the facility monthly for QAPI meetings and staff in-services related to infection control. On 2/17/26 at 12:47 P.M., the Administrator provided an undated policy titled Infection Preventionist that indicated The infection preventionist is employed on site and at least part time.

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	155801	A. Building B. Wing	02/17/2026

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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. Based on observation, interview and record review, the facility failed to ensure medications were properly secured, failed to keep insulin refrigerated until opened, and to label and date vials of tuberculin solution with open and expiration dates for 2 of 2 medication carts and the [Pharmacy Name] Medication room refrigerator. (West Medication Cart, East Medication Cart, [Pharmacy Name] Medication Room) FIndings include: 1, On 2/9/26 at 2:19 P.M., during random observation of the [NAME] Medication Cart the following was observed:1 unopened Lantus pen for Resident 26 with no open date or expiration date1 open Lispro insulin pen for Resident 4 with no open date or expiration date 2. On 2/9/26 at 2:27 P.M., during a random observation of the East Medication Cart the following was observed:1 large round white pill number N32 During an interview on 2/9/26 at 2:21 P.M., Qualified Medicine Aide (QMA) 4 indicated insulin should be refrigerated if unopened. During an interview on 2/9/26 at 2:45 P.M., QMA 5 indicated there should be no loose pills in the medication carts if there were a loose pills it was to be placed in a drug buster solution and reported to the nurse. 3. On 2/10/26 at 2:19 P.M., during a random observation of the [Pharmacy Name] Room, the following was observed in the medication refrigerator. 2 open bottle of tuberculin testing solution with no open date or expiration date. On 2/10/26 at 2:25 P.M., Licensed Practical Nurse(LPN) 6 indicated the vials should be dated when opened. During an interview on 2/13/26 at 8:45 A.M., the Director of Nursing (DON) indicated that insulin needs to go straight to the refrigerator if not used immediately and needs to be dated with the open date.On 2/17/26 at 1:46 P.M., the Administrator provided a current, undated policy Medication Labelling and Storage The policy indicated .mediations and biologicals are stored in the packaging, containers or other dispensing systems in which they are received .Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly .multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .3.1-25(k)3.1-25(o)

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	155801	A. Building B. Wing	02/17/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that a sink in a therapy restroom was safely secured to the wall and personel belongings in shared restrooms were labeled with resident names in 4 of 4 shared restrooms reviewed.(Sink in therapy area restroom, Shared restrooms between rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], rooms [ROOM NUMBERS], rooms [ROOM NUMBERS])Findings include:1. On 2/12/23 at 9:15 A.M, during random observations of restrooms, the following were observed:In the restroom between rooms [ROOM NUMBERS]:1 bottle of shampoo with no name1 tube of toothpaste with no name2 bottles of lotion with no namesIn the restroom between rooms [ROOM NUMBERS]:1 toothbrush with no name1 tube of toothpaste with no name3 bottles of lotionIn the restroom between rooms [ROOM NUMBERS]:1 bottle of mouthwash with no name1 tube of toothpaste with no name 1 can of shaving cream with no nameIn the restroom between rooms [ROOM NUMBERS]:1 tooth cup with no name1 tube of toothpaste with no name1 toothbrush with no name2 combs with no name2 bottles of lotion with no name2. On 2/12/26 at 2:30 P.M., during a random observation in the therapy restroom the sink was observed to have pulled away from the wall and loose in movement.During an interview on 2/11/26 at 9:45 A.M., Certified Nursing Assistant (CNA) 11 indicated that she knew what most residents were capable of doing for hygiene, but all of resident's personal items needed to be labeled with their names and if the items were not labeled, she would usually through the items away. During an interview on 2/13/26 at 8:40 A.M., the Administrator indicated that the sink should be against the wall and all residents' personal belongings should be labeled with their names.On 2/17/26 at 11:55 A.M., the Administrator provided a current, non-dated policy Homelike Environment. The policy indicated . the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment .On 2/17/26 at 11:55., the Administrator provided a current non-dated policy Personal Property. The policy indicated Resident belongings are treated with respect by facility staff, regardless of perceived value. Personal care items will be properly stored to prevent the spread of infection, such as toothbrushes and hairbrushes/combs will be stored in individual containers, etc . 3.1-19(f)

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	02/17/2026

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 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 interview and record review, the facility failed to develop care plans for 1 of 1 residents reviewed for Urinary Tract Infection (UTI) and 1 of 1 residents reviewed for Respiratory Care. A care plan was not developed for residents for use of antibiotics and oxygen use. (Resident 3, Resident 34) Findings include: 1. On 2/12/2026 at 1:43 P.M., Resident 3's clinical record was reviewed. Diagnoses included but were not limited to Parkinson's Disease without Dyskinesia, unspecified dementia, and Alzheimer's Disease. The current Quarterly Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident 3 was mildly cognitively intact. She needed supervision to eat, but required partial to moderate assistance for toileting, dressing, hygiene, and transferring. Current physician orders included but were limited to:Cipro 500 mg (Milligrams) BID for 7 d for UTI. Dated 2/7/26. A care conference was conducted on 11/5/2025 at 3:15 P.M., with the resident and Power of Attorney present. The care plan was reviewed at that time. The current clinical documentation lacked a care plan for antibiotic use during the time the resident use of one 2/7-2/13/26 During an interview on 2/17/26 at 10:55 A.M., the Minimum Data Set (MDS) Coordinator indicated care plans were initiated with MDS reviews and quarterly. Care plans needed to be updated with new intervention with changes and needed. 2. On 2/11/26 at 11:53 A.M., Resident 34's clinical record was reviewed. Resident 34 was admitted on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent annual Minimum Data Set (MDS) Assessment, dated 1/3/26, indicated Resident 34 was cognitively intact, required maximal assistance (staff do more than half of the work) for toileting, bathing, and transfers, and was using oxygen therapy. Physician orders included, but were not limited to: Oxygen via nasal cannula at two liters two times a day, Start date 2/8/26 Change all oxygen supplies every Sunday every night shift, Start date 2/1/26 The clinical record lacked a care plan related to oxygen use. On 2/17/26 at 12:47 P.M., the Administrator provided an undated policy titled Care Plans, Comprehensive Person-Centered that indicated The comprehensive, person-centered care plan includes: measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change 3.1-35(b)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure interventions were in place for 1 of 2 resident reviewed for falls. An intervention for falls was not implemeted.(Resident 21) Finding includes:During a random observation on 2/12/26 at 9:30 A.M., there were no non-skid stripes observed on the floor of Resident 21's During a random observation on 2/13/26 at 8:37 A.M., Resident 21 was observed lying in bed, and no non-skid strips were observed on the left or right floor of the resident's bed. On 2/11/26 at 1:35 P.M., the clinical record for Resident 21 was reviewed. Diagnoses included, but were not limited to Alzheimer's disease, personality disorder, and fracture of the nasal bones, subsequent encounter for fracture for routine healing. The current Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 21 was cognitively intact. Resident 21 needed supervision with eating, but required partial to moderate assistance with dressing, mobility, and hygiene also had a history of falls. Physician orders included, but were not limited to the following:Send to ER for evaluation and treatment. No directions specified dated 11/22/25.The current care plan had potential for fall-related injury r/t related/to decreased mobility d/t Due/to falls. Psychotropic medication use was revised on 7/24/23. Included interventions related to but not including:Send to the emergency room (ER) for evaluation and treatment dated 11/22/25.Review medications to r/o medications that may be potential ADR's Adverse Drug Reaction (ADR's) causing falls with possible reduction or discontinue (D/C) dated 11/23/25.Non-skid strips on the exit side of the bed on the floor dated 11/25/25. An initial reported fall date 11/22/25 at 9:58 A.M., indicated this was the first unwitnessed fall for the resident. The note indicated that the resident was noted to be ambulating down hallway with blood running down his face. Resident stated, I fell out of bed. Upon assessment, the resident was observed with multiple facial injuries including a laceration to distal mid-forehead, nasal bridge visibly misaligned with swelling, redness and sm abrasion.A post hospital return summary dated 11/22/25 at 6:10 P.M., indicated that resident had an unwitnessed fall that resulted in the resident having a nasal fracture, a maxillary fracture of the left side and facial laceration measuring 1 centimeter x 0.3 centimeters in length sealed with wound glue. Care plan intervention was to be sent to the emergency room (ER). An initial fall report dated 11/23/25 at 4:53 P.M. indicated this was a second unwitnessed fall for this resident. The report indicated the resident was noted sitting on floor with knees bent, blood running down face from laceration on forehead and nares. Hematoma noted above L orbital area. Resident stated, I fell out of bed. The Nurse Practioner was notified and was ordered to send to the ER. An Interdisciplinary (IDT) note dated 11/24/25 at 9:23 A.M., indicated that the team agreed with the intervention for sending to ER and adding an intervention to review the resident's medication to rule out medications that may add risk of falls.An additional IDT note dated 11/24/2025 at 10:05 A.M., add non-skid strips to the floor by bed on the side the resident exits on.A third fall's initial incident report dated 11/25/25 at 3:45 A.M., indicated that the resident had witnessed a fall sliding to floor while getting up from a couch. There were no new injuries. The intervention was to add non-skid strips to the floor was on the care plan dated 11/25/25. During an interview on 2/17/26 at 11:15 A.M. Certified Nursing Assistant 10 indicated that the resident should have non-skid strips on the sides of his bed and he did not. On 2/17 at 1:47 P.M., the Administrator provided a current, non-dated policy Care Plans, Comprehensive Patient Centered. The policy indicated .Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change . 3.1-35(b)(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician documented a clinical contraindication when a gradual dose reduction (GDR) was declined for 3 of 5 residents reviewed for unnecessary medications (Resident 2, Resident 4, and Resident 33).Findings include:1. On 2/12/26 at 8:53 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/16/25, indicated Resident 2 was moderately cognitively impaired, required partial assistance (staff do half of the work) for toileting, bathing, and transfers, and received antipsychotic, antianxiety, antidepressant, and anticonvulsant medication during the seven day lookback period. Physician orders included, but were not limited to: Duloxetine HCl Capsule (Drizalma) Delayed Release Particles 30 MG (milligrams) Give one capsule by mouth two times a day related to depression, Start date 8/31/25 Clonazepam Tablet 0.5 MG Give one tablet by mouth two times a day related to anxiety disorder, Start date 11/6/24 The current care plan included, but was not limited to: I do take antidepressant as ordered. Date Initiated: 3/3/23 I take antianxiety as ordered, and an anticonvulsant for off label use. Date Initiated: 5/28/25 A Pharmacy Physician Recommendations form, dated 9/2/25, indicated the Pharmacy made a recommendation to reduce the Duloxetine 30 MG and Clonazepam 0.5 MG. The Nurse Practitioner indicated no change in doses made, but did not provided a rational for declining the pharmacy recommendations. 2. On 2/11/2026 at 8:35 A.M., Resident 4 clinical record was reviewed. Diagnoses included, but were limited to, major depressive disorder, anxiety disorder, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side. The current Quarterly MDS dated [DATE] indicated Resident 4 was cognitively intact. Resident 4 needs substantial to maximum assistance eating, dressing, and transferring, but partial to moderate assistance with hygiene. She also takes antidepressant medications. Physician orders included, but were not limited to: Trazodone (antidepressant) HCl Oral Tablet 50 MG. Give 1 tablet by mouth at bedtime dated 12/5/25. Desvenlafaxine (antidepressant) ER Oral Tablet Extended Release 24 Hour 100 MG. Give 1 tablet by mouth one time a day dated 6/10/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consultant Pharmacist Recommendation to prescriber for Resident 4 dated 12/18/25 for Divalproex DR (antiseizure medication) 250 Milligrams (mg) 1 po bid initiated on 7/25/25 was reviewed and Nurse Practitioner did not provide rationale for disagreement of the drug dose reduction. Consultant Pharmacist Recommendation to prescriber for Resident 4's dated 1/21/26 for Trazodone (antidepressant) HCl Oral Tablet 50 MG. Give 1 tablet by mouth at bedtime dated 12/5/25 was reviewed and Nurse Practitioner did not provide rationale for disagreement of the drug dose reduction. 3. On 2/11/2026 at 10:15 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were limited to, brief psychotic disorder, anxiety disorder, and unspecified dementia. The current Quarterly MDS assessment dated [DATE] indicated Resident 33 was severely cognitively impaired. Resident 33 needed substantial to maximum assistance eating, dressing toileting, and transferring and taking antianxiety and anticonvulsant medications. Current physician orders included, but were not limited to: Divalproex DR (antiseizure medication) 250 Milligrams (mg) 1 po (by mouth) bid (twice a day) initiated on 7/25/25. Buspirone (anti-anxiety) 7.5 mg 1 po bid initiated on 7/11/25. Consultant Pharmacist Recommendation to prescriber for Resident 33 dated 12/18/25 for Buspirone (anti-anxiety) 7.5 mg 1 po bid initiated on 7/11/25 was reviewed and Nurse Practitioner did not provide rationale for disagreement of the drug dose reduction. Consultant Pharmacist Recommendation to prescriber for Resident 33 dated 1/21/26 for Divalproex DR (antiseizure medication) 250 Milligrams (mg) 1 po bid initiated on 7/25/25 was reviewed and Nurse Practitioner did not provide rationale for disagreement of the drug dose reduction. During an interview on 2/12/26 at 9:15 A.M., the Nurse Practitioner indicated if there is a disagreement on the Gradual Dose Agreement (GDR) there needs to be a reason why there is disagreement. On 2/17/26 at 12:00 P.M., the Administrator provided a current, non-dated policy Psychotropic Medication Use. The policy indicated . If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued, and document the rationale for this decision . 3.1-25(i)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure vaccinations were provided according to residents' informed consent for 2 of 6 residents reviewed for immunizations. A resident who consented to receive the influenza vaccine did not receive it. A resident who declined to receive the influenza vaccine did receive it. (Resident 48 and Resident 33)Findings include:1. On 2/12/26 at 10:44 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on [DATE].The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/13/25, indicated Resident 33 had severe cognitive impairment and received the influenza vaccination on 10/27/25.Physician orders included, but were not limited to:May have immunizations as required including, but not limited to: influenza, pneumonia, and tuberculosis (TB) (first and second step) and annual TB., dated 6/18/25Monitor resident for low grade fever, aches, redness, soreness, itching and swelling at the flu vaccine injection site every shift x 72 hours. Left Deltoid every shift for flu vaccine monitoring for three days. If symptoms arise, notify physician, dated 10/27/25Current care plans included, but were not limited to:Would like to exercise my right to refuse being vaccinated for Flu, Pneumococcal, COVID, or RSV. I and/or my power of attorney (POA) have been educated on benefits and risk and decline the option to receive the vaccine at this time, initiated 2/6/26An Informed Consent and Authorization for Immunizations, dated 6/18/25, indicated the influenza vaccination was declined and was signed by the POA.An Informed Consent and Authorization for Immunizations, dated 1/15/26, indicated the influenza vaccination was declined and was signed by the POA.A nursing alert note, dated 10/27/25 at 3:14 P.M., indicated that Resident 33 received the influenza vaccine in her left deltoid per consent. The clinical record lacked documentation to indicate who gave the consent.On 2/12/26 at 3:16 P.M., the Regional Consultant provided an Informed Consent and Authorization for Immunizations form, dated 10/27/25. The form indicated verbal consent was acquired from the POA on 10/27/25.During an interview on 2/13/26 at 9:13 A.M., the POA indicated she did not give consent for Resident 33 to have the influenza vaccine. She saw it had been given to Resident 33 on the communication application the facility used to communicate to families what care had been given to residents. She indicated that staff called her after the fact and told her that Resident 33 wanted the influenza vaccine, but Resident 33 had severe dementia. She indicated if they would have called her before administering the vaccination, she would have declined it.2. On 2/13/26 at 12:13 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia and influenza A. Resident 48 was admitted to the facility on [DATE].The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/1/25, indicated that Resident 48 had moderate cognitive impairment and did not receive the influenza vaccination because she declined it.An Informed Consent and Authorization for Immunizations, dated 8/27/25, indicated consent to receive the influenza vaccination was given and was signed by the resident's responsible party.The clinical record lacked documentation to indicate the influenza vaccination was given to Resident 48.On 2/14/26 at 12:43 P.M., the MDS Regional Coordinator provided a list of all residents who received the influenza vaccination and the date it was received. Resident 48 received the influenza vaccination on 2/13/26.During an interview on 2/13/26 at 9:38 A.M., the Infection Preventionist (IP) indicated that influenza vaccine consents were obtained on admission and annually thereafter. If a resident had cognitive impairment, the POA or guardian gave consent or declined the vaccination on behalf of the resident. On 12/13/26 at 12:31 P.M., the Administrator provided a current undated Influenza Vaccine policy that indicated All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associate with vaccinations against influenza . Prior to the vaccination, the resident (or resident's legal representative) .will be provided information and education regarding the benefits and potential side effects of the influenza vaccine . A resident's (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record.3.1-13(a)