STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155801	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C **05/15/2023**

NAME OF PROVIDER OR SUPPLIER **TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **305 E NORTH ST** **BOONVILLE, IN 47601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	**INITIAL COMMENTS** Paper compliance to the Investigation of Complaint IN00401287 and the Covid -19 Focused Infection Control Survey completed on April 14, 2023. Review date: May 15, 2023 Facility number: 000450 Provider number: 155801 AIM number: 100273890 Transcendent Healthcare Boonville North was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the paper compliance review to the Investigations of Complaint IN00401287 and Covid-19 Focused Infection Control Survey.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE