l f		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155508	B. WIN	B. WING 02/12/2025			2025	
	PROVIDER OR SUPPLIE	R CARE OF BOONVILLE		725 S S	DDRESS, CITY, STATE, ZIP COD ECOND ST ILLE, IN 47601			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DECLIDED OF A LIVER CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	, L	DATE	
E 0000								
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/12/25 Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 At this Emergency Preparedness survey, Transcendent Healthcare of Boonville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 60.		E 000	E 0000 By submitting the enclosed materials, we are not admitted truth or accuracy of any specifindings or allegations. We reserve the right to contest findings or allegations as parany proceedings and submited responses pursuant to our regulatory obligations. The requests the plan of correct considered our allegation of compliance effective March 2025 to the state findings of Life Safety Code Recertification and Emergency Preparednets Survey conducted on Februa 2025.		cice cof nese cility be l, le on		
K 0000								
Bldg. 01	Licensure Survey v Department of Hea 483.90(a). Survey Date: 02/1: Facility Number: (Provider Number: AIM Number: 100	000451 155508	K 000	00	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The face requests the plan of correction considered our allegation of compliance effective March 14	ic e of nese cility		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Robin L McCarty **Executive Director** 03/02/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/12/2025		
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S	STREET ADDRESS, CITY, STATE, ZIP COD 725 S SECOND ST BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	Healthcare of Boon compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (I. Health Care Occupated This one story facilidetermined to be of was fully sprinklere system with hard we corridors and space battery operated sm sleeping rooms. The and had a census of All areas where resistence were sprinklered, and services were sprinklered and lawnmower stored the services were sprinklere	ville was found not in equirements for Participation in 4, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. At with a basement was a try by (000) construction and red. The facility has a fire alarm irred smoke detectors in the sopen to the corridors, plus oke alarms in all resident refacility has a capacity of 102 foo at the time of this survey. Addents have customary access and all areas providing facility stered, except two detached g of a garage used as a not maintenance storage, and a shed used for facility storage rage.		2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on Februar 2025.	on S	
K 0222 SS=E	Quality Review con NFPA 101 Egress Doors	npleted on 02/18/25				
Bldg. 01	Based on observation failed to ensure the 11 locked exit doors accessible for resident deficient practice of as well as staff and Findings include:	on and interview, the facility means of egress through 1 of s was readily and easily ents, staff, and visitors. This buld affect up to 10 residents, visitors.	K 0222	K 222 The corrective action taken fo those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, ten residen staff and visitors have the pote to be affected by this deficient practice. The northwest corrie	ied ts, ential	

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p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Cassistant, the northwest corridor exit door to the outside required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force, especially at the bottom, to open. Based on interview at the time of observation, the Maintenance Director, and comment of the facility during the exit conference. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b) Tag exit door has now been adjusted by the maintenance staff and opens smoothing upon the entering of the code to the keypad. The corrective action taken for the other residents that have the potential to be affected by the same deficient practice. A housewide inspection of all corridor exit doors has now been completed and all doors open smoothly upon entering the code to the keypad. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all maintenance staff was also re-educated on their responsibility to check the proper functioning of all corridor exit doors a part of their preventative maintenance program and to document their findings. The corrective action taken to mornitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/12/2025	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION p.m. and 5:45 pm. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the northwest corridor exit door to the outside required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force, especially at the bottom, to open. Based on interview at the time of observation, the Maintenance Director acknowledged the exit door required heavy force at the bottom to open. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b) The measures that have the potential to be affected by this deficient practice A housewide inspection of all corridor exit doors has now been completed and all doors open smoothly upon entering the code to the keypad. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all maintenance staff was also re-educated on their responsibility to check the proper functioning of all corridor exit doors function properly and that egress can be smoothly obtained after entering the code to the keypad. The maintenance staff was also re-educated on their responsibility to check the proper functioning of all corridor exit doors function properly and that egress can be smoothly obtained after entering the code to the keypad. The maintenance program and to document their findings. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been				725 S S	SECOND ST	
the Maintenance Director and Maintenance Assistant, the northwest corridor exit door to the outside required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force, especially at the bottom, to open. Based on interview at the time of observation, the Maintenance Director arknowledged the exit door required heavy force at the bottom to open. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b) The corrective action taken for the other residents, staff and opens smoothly upon the entering of the code to the keypad. The orserctive action taken for the other residents that have the potential to be affected by this deficient practice. A housewide inspection of all orridor exit doors has now been completed and all doors open smoothly upon entering the code to the keypad. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all maintenance staff on their responsibility to ensure that all corridor exit doors function properly and that egress can be smoothly obtained after entering the code to the keypad. The maintenance staff was also re-educated on their responsibility to check the proper functioning of all corridor exit doors as part of their preventative maintenance program and to document their findings. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been	PREFIX	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
ensure that corridor door inspections are being conducted	TAG	p.m. and 5:45 p.m. of the Maintenance Di Assistant, the northy outside required headoor code was push magnetic locks did entered, however, the especially at the bot interview at the time Maintenance Direct required heavy force. This finding was remaintenance Direct during the exit confidence of the Maintenance Direct during the exit confidence of t	during a tour of the facility with rector and Maintenance west corridor exit door to the avy force to open when the ed on the keypad. The release when the code was ne door took heavy force, stom, to open. Based on e of observation, the for acknowledged the exit door e at the bottom to open.	TAG	exit door has now been adjust by the maintenance staff and opens smoothing upon the entering of the code to the keypad. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. A housew inspection of all corridor exit to has now been completed and doors open smoothly upon entering the code to the keyp. The measures that have been into place to ensure that the deficient practice does not reat that a mandatory in-service had been provided for all maintens staff on their responsibility to ensure that all corridor exit do function properly and that egrean be smoothly obtained after entering the code to the keyp. The maintenance staff was all re-educated on their responsition check the proper functioninall corridor exit doors as part their preventative maintenance program and to document the findings. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented the ensure that corridor door	or the at all ave this ide doors all ad. a put cur is as ance oors ess er ad. so bility g of of ee cir

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 02/12/2025	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S	T ADDRESS, CITY, STATE, ZIP COD S SECOND ST NVILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
K 0291 SS=F Bldg. 01	interview; the facili documentation for the backup lights that was minuted during the plights would provid power outages. LSG lighting shall be prosection 7.9. Section functional testing should be with a minimum of weeks between tests seconds, (3) Function conducted annually if the emergency light powered and (5) Was inspections and test for inspection by the jurisdiction. This design is a second of the factor of the f	iew, observation, and by failed to ensure there was the testing of 5 of 5 battery tere tested annually for 90 to the state of the state	K 0291	as part of the facility prevental maintenance program. The twill monitor to ensure that eac corridor door is functioning properly and egress is obtained smoothly upon entering the key pad code. This tool will be completed by the Maintenance Supervisor and/or their design weekly for four weeks, then monthly for three quarters. To outcome of this tool will be submitted to the Executive Director to determine if any additional action is warranted. K 291 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors have the potto be affected by this deficient practice. All five battery back lights have now been testing minutes. This testing has been documented and meets the regulatory requirement. The annual 90-minute testing has documented in the facility's preventative maintenance may for inspection by the authoritie Annual 90-minute testing of the battery backup lights will contributed in the facility's preventative maintenance may for inspection by the authoritie Annual 90-minute testing of the battery backup lights will contributed in the facility's preventative maintenance may for inspection by the authoritie Annual 90-minute testing of the battery backup lights will contributed.	ool oh ed ey ee nee then The O3/14/2025 ied s, ential t up for 90 en	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155508	B. W	ING		02/12/2	2025
			<u>. </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE	BOONVILLE, IN 47601				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility.				to be conducted in accordance	е	
					with the regulations and the		
	Findings include:				findings of these testing's		
					recorded in the preventative		
		view on 02/12/25 between 10:15			maintenance manual.		
	_	with the Maintenance Director			The corrective action taken for	r the	
		ssistant present, the facility			other residents that have the		
	_	tive maintenance (PM) report			potential to be affected by the	1	
		powered emergency lights			same deficient practice is that		
	-	ity were tested monthly for 30			residents, staff and visitors ha		
		past 12 month period.			the potential to be affected by	I	
	· · · · · · · · · · · · · · · · · · ·	s no documentation available			deficient practice. All five batte	ery	
		tery powered emergency			backup lights have now been		
	-	nnually for 90 minutes during			testing for 90 minutes. This		
		period. The most recent 90			testing has been documented		
		was dated 10/15/23. Based on			meets the regulatory requirem		
		time of record review, this was			The annual 90-minute testing		
	_	laintenance Director. During a			been documented in the facilit	-	
		with the Maintenance Director			preventative maintenance ma	I	
		ssistant between 2:30 p.m. and			for inspection by the authoritie		
	-	ty was equipped with five			Annual 90-minute testing of th		
		powered light units located			battery backup lights will conti	I	
	throughout the facil	ııy.			to be conducted in accordance	е	
	This finding	viewed with the Administration			with the regulations and the		
	~	viewed with the Administrator, for, and owner of the facility			findings of these testing's		
	during the exit conf	•			recorded in the preventative maintenance manual.		
	during the exit coll	CICIEC.			The measures that have been	nut	
	3.1-19(b)					ραι	
	J.1-17(0)				into place to ensure that the deficient practice does not rec	ur is	
					that a mandatory in-service ha	1	
					been provided for all maintena	I	
					staff on the regulation related		
					the annual required testing of		
					battery backup lights. The sta	1	
					was re-educated on their		
					responsibility to ensure that		
					testing of all battery backup lig	ahts	
					has been conducted and the	,	
					findings documented at least		
			1		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S	SADDRESS, CITY, STATE, ZIP COD SECOND ST IVILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				annually in accordance with the regulation. The corrective action taken to monitor to ensure the deficient practice will not recur is that the documentation of the annual 90-minutes testing of all batter backup lights will now be submitted to the Executive Director annually to ensure the testing has been conduct and to determine if any additional action is warranted.	ont nt the ery nat ed
K 0321 SS=E Bldg. 01	failed to ensure 2 of such as a Medical S emergency supply s provided with a self was smoke resistant at least 20 residents Findings include: Based on observation p.m. and 5:45 p.m. of the Maintenance Di Assistant, the follow a. The Medical Surdoor was locked, howith a self closing of square feet in size a boxes full of supplic other combustible it and cardboard boxe b. The 7 Day Emergence of the supplication of the supp	on and interview, the facility Fover 10 hazardous area doors, upply storage room door or torage room door, was Folosing device, or a door that This deficient practice could and staff. ons on 02/12/25 between 2:30 during a tour of the facility with rector and Maintenance ving was noted: only storage room corridor ovever, it was not provided device. The room was over 50 and stored over 30 cardboard and several shelves with ems, such as paper, plastic,	K 0321	K 321 a.) The corrective action take those residents found to have been affected by the deficien practice is that although no specific residents were identiduring the survey, 20 residen and staff have the potential to affected by this deficient pract A self-closing device has now been placed on the medical supply storage room door for automatic closure and is functioning properly. b.) The corrective action take those residents found to have been affected by the deficien practice is that although no specific residents were identiduring the survey, 20 resident and staff have the potential to affected by this deficient practice to the 7 days the corridor door to the 7 days the series of the resident practice is that although no specific residents were identicated by this deficient practice to the resident of the resident practice to the	fied ts be tice. In for et t fied ts be tice.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
1AG	however, there was of the door which man resistant. This room size and stored over food supplies, and sucception combustible items, and sucception containers. Based on interview observation, the Man Maintenance Assist a self closing device door and the one had Day Emergency Supplies.	a one half inch gap at the top hade this door not smoke have over 50 square feet in 20 cardboard boxes full of everal shelves with other such as paper and plastic at the time of each intenance Director and ant acknowledged the lack of e on the Medical Supply room lf inch gap at the top of the 7 pply Room door. viewed with the Administrator, or, and owner of the facility	TAG	emergency supply room has repeated by the maintenstaff and there is no longer and gap of the door into the door frame. The door fits securely the door frame with no gaps to ensure smoke resistance. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. A housewing inspection has now been completed of all 10 hazardous area doors. All doors are equipped with an automatic closure which functions proper and all doors fit securely in the door frames with no gaps to ensure that they are smoke resistant. The measures that have been into place to ensure that the deficient practice does not received that a mandatory in-service had been provided for all maintens staff on the regulation related hazardous area closures. The staff has been re-educated or responsibility to ensure that the doors remain smoke resistant gaps) and contain the proper functioning automatic door closures. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been provided has been provided has been practice will not recur is that a Quality Assurance tool has been practice to the practice to the practice to the practice to the practice tool has been practice to the practice to the practice tool has been practice.	into or the fall ve this de s fry e their eese (no esure

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Facility ID: 000451

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155508		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/12/2025	
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and C Based on observation review; the facility as an interior finish had a flame spread at LSC 101 10.2.3.4 st tested in accordance Method of Test of S	Ceiling Finish on, interview and record failed to ensure materials used in 1 of 9 smoke compartments rating of Class A or Class B. tates products required to be the with NFPA 255, Standard	K 0331	developed and implemented to monitor the condition and functioning of all hazardous a doors. This tool will monitor to ensure that the doors close securely into the door frames no gaps and that they contain automatic door closure device is functioning properly. This to will be completed by the Maintenance Supervisor and/their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome this tool will be submitted to the Executive Director to determinanty additional action is warrant of those residents found to have been affected by the deficient practice is that although no specific residents were identified uring the survey, 20 residents and staff have the potential to	rea o with an e that ool for of ne ne if nted. 03/14/2025
	grouped in the follo with their flame spr (a) Class A Interior spread 0-25; smoke any material classif spread test scale and scale. Any element not continue to prop (b) Class B Interior	wing classes in accordance ead and smoke development. Wall and Ceiling Finish. Flame development 0-450. Includes ied at 25 or less on the flame d 450 or less on the smoke test thereof, when so tested, shall		affected by this deficient prace. The 2 foot by 2 foot plywood access panel in the ceiling of maintenance work space, while located in a small room in the northwest corridor and opens the corridor now has an interifinish with a material that has flame spread rating of Class A. Class B.	tice. attic the ich is into or a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155508	B. W	ING		02/12	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
IIIAIIOU	EIADEIAI HEVETTI	O, ILL OI DOONVILLE		BOOM	, ILLE, IIV 77001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ied at more than 25 but not			The corrective action taken for	r the	
		e flame spread test scale and			other residents that have the		
	450 or less on the s				potential to be affected by the		
	* *	Wall and Ceiling Finish. Flame			same deficient practice is that		
	-	ske development 0-450.			residents, staff and visitors ha		
	-	al classified at more than 75			the potential to be affected by		
		00 on the flame spread test			deficient practice. A housewid		
		ss on the smoke test scale.			inspection of all interior finishe		
	-	ice could affect up to 20			all nine smoke compartments		
	residents and staff.				been conducted to ensure tha		
					interior finishes are covered w	ith a	
	Findings include:				flame spread rating of Class A	or	
					Class B. No other areas of		
		ons on 02/12/25 between 2:30			concern were identified.		
		during a tour of the facility with			The measures that have been	put	
		rector and Maintenance			into place to ensure that the		
		s a two foot by two foot			deficient practice does not rec	ur is	
		s panel in the ceiling of the			that a mandatory in-service ha	as	
		Space area, which was a small			been provided for all maintena	ance	
		est corridor and open to the			staff on the regulation related	to	
	corridor. This was	acknowledged by the			interior wall and ceiling finishe	s.	
		tor and Maintenance Assistant			The staff was re-educated on	the	
		vation, furthermore, the			requirement that all interior wa	all	
		tor indicated the plywood attic			and ceiling surface finishes m	ust	
	•	t have a flame spread rating as			be covered with a material tha	ıt	
	far as she knew.				has a flame spread rating of C	lass	
					A or Class B.		
	This finding was re	viewed with the Administrator,			The corrective action taken to		
	Maintenance Direct	tor, and owner of the facility			monitor to ensure the deficient	t	
	during the exit conf	Perence.			practice will not recur is that the	ne	
					maintenance supervisor will no	OW	
	3.1-19(b)				submit a copy of the flame spr	ead	
					rating documentation of all inte	erior	
					finish materials utilized in any		
					the nine smoke compartments	of	
					the facility to the Executive		
					Director for review. The Exec	utive	
					Director will review the		
					documentation to ensure that	the	
			1		required Class A or Class B fla	amo	I

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/12/2025	
	ROVIDER OR SUPPLIEF	CARE OF BOONVILLE	725 S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
				spread rating is being utilized in the facility's smoke compartments.	
K 0374 SS=E Bldg. 01	Barrie	ilding Spaces - Smoke			
	failed to ensure 1 o would close and lat barrier. LSC, Section in smoke barriers sl 8.5.4. LSC, Section barriers to close the minimum clearance which is defined as movement of smok affect at least 20 revisitors. Findings include: Based on observation p.m. and 5:45 p.m. the Maintenance Di Assistant, the set of doors leading into the close completely artimes. These doors hardware. There resulting between the doors with the maintenance of the close completely artimes. These doors hardware. There resulting the complete the doors with the control of the complete the control of the control of the complete the control of the control	on and interview, the facility of 6 sets of smoke barrier doors ch to form a smoke resistant on 19.3.7.8 requires that doors hall comply with LSC, Section of 8.5.4.1 requires doors in smoke opening leaving only the encessary for proper operation 1/8 inch to restrict the e. This deficient practice could sidents, as well as staff and ons on 02/12/25 between 2:30 during a tour of the facility with firector and Maintenance of smoke barrier/fire barrier the southwest corridor did not ad latch when tested several were equipped with latching mained a one half inch gap when closed to their fullest. diged by the Maintenance enance Assistant at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors at the time of faintenance Assistant worked before doors for your doors for the facility	K 0374	The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, at least 20 residents, staff and visitors have the potential to be affected by this deficient practice. The smoke barrier/fire barrier door located or the southwest corridor has now been adjusted by the maintenanc staff. The door now closes and latches completely when tested. The smoke barrier/fire barrier doors will continue to be checked by the maintenance staff to ensure their continued proper closure and functioning. The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affected by this deficient practice. All smoke barrier/fire barrier doors have now been inspected by the maintenance staff. All smoke barrier/fire barrier doors are now closing and latching completely when released.	n re d e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A PUBLISHED OF COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155508	A. BUILDING <u>01</u> B. WING			COMPLETED 02/12/2025	
		133300	b. wii			02/12/	2023
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD ECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE			ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	F	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG	during the exit conf	R LSC IDENTIFYING INFORMATION		TAG	The measures that have been	nut	DATE
	during the exit com	erence.			into place to ensure that the	ραι	
	3.1-19(b)				deficient practice does not rec	ur is	
					that a mandatory in-service ha		
					been provided for all maintena		
					staff on their responsibility to		
					ensue that all smoke barrier/fil	е	
					barrier doors are checked for		
					proper functioning in accordar		
					with the regulation. The staff v		
					re-educated on their responsit to document these door	Jilly	
					inspections as part of the facil	itv's	
					preventative maintenance pro		
					and in accordance with the	5	
					regulation.		
					The corrective action taken to		
					monitor to ensure the deficien		
					practice will not recur is that a		
					Quality Assurance tool has be		
					developed and implemented to		
					monitor the proper functioning smoke barrier/fire barrier door		
					This tool will monitor to ensure		
					that the doors close securely a		
					latch completely upon release		
					This tool will be completed by		
					Maintenance Supervisor and/o	or	
					their designee weekly for four		
					weeks, then monthly for three		
					months and then quarterly for		
					three quarters. The outcome		
				this tool will be submitted to the Executive Director to determine			
					any additional action is warrar		
					, manual design is walled		
K 0741	NFPA 101						
SS=E Bldg. 01	Smoking Regulati	ons					
Diag. 01	Based on observation	on and interview, the facility	K 07	41	K 741		03/14/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155508	B. W	ING		02/12/	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8					
TDANGO					SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOOM	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	failed to ensure ciga	arette butts were properly			The corrective action taken for	r	
	_	l areas where cigarettes were			those residents found to have		
	-	ed by residents and staff. This			been affected by the deficient		
		ould affect up to 20 residents			practice is that although no		
	and staff.	1			specific residents were identifi	ed	
					during the survey, approximat		
	Findings include:				twenty residents and staff hav	-	
					potential to be affected by this		
	Based on observation	ons on 02/12/25 between 2:30			deficient practice. A deep	•	
		during a tour of the facility with			cleaning of the smoking area l	has	
		rector and Maintenance			now been conducted. All ciga		
		yard outside the main dining			butts have now been placed in		
		designated smoking area, had			appropriate fire-retardant cont		
		te butts scattered on the			and there are no cigarette but		
	_	two small metal cans and one			the ground or floor surface. T		
	-	table, full of cigarette butts.			smoking area will continue to		
		were several eigarette butts in			supervised by facility staff who		
		bag along with paper trash			ensure that all cigarette butts		
		te or a bird's nest. Based on			properly disposed of in the pro		
		e of observation, the			designated containers.	рсі	
		for and Maintenance Assistant			The corrective action taken for	r the	
		ssues with the cigarette butts			other residents that have the	ilic	
	-	d smoking area, and further			potential to be affected by the		
		t 20 residents who use the			same deficient practice is that		
	Courtyard to smoke				residents who smoke and all s		
	Courtyard to smoke	·•			have the potential to be affect		
	This finding was re	viewed with the Administrator,			by this deficient practice. All	cu	
		for, and owner of the facility			cigarette butts have now been	,	
	during the exit conf				_	l	
	during the exit coll	crence.			placed in the appropriate fire-retardant container and the	oro	
	2.1.10/%					ere	
	3.1-19(b)				are no cigarette butts on the		
					ground or floor surface. The	L _	
					smoking area will continue to		
					supervised by facility staff who		
					ensure that all cigarette butts		
					properly disposed of in the pro	pper	
					designated containers.	,	
					The measures that have been	put	
					into place to ensure that the		
					deficient practice does not rec	ur is	

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	OF CORRECTION	IDENTIFICATION NUMBER 155508	A. BUILDING B. WING	01	COMPLETED 02/12/2025
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0921	NFPA 101			that a mandatory in-service had been conducted for all staff on facility smoking policy and the responsibilities to ensure that smoking area is kept clean and that all cigarette butts are to be discarded in the appropriate fire-retardant containers. The was also reminded of their responsibility to supervisor all resident smokers and to remine the smokers of the proper mandato dispose of their cigarette but the corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has be developed and implemented to monitor the condition of the smoking area to ensure it remore clean and that all cigarette but are disposed of in the fire-reta containers. This tool will be completed by Social Services and/or their designee weekly four weeks, then monthly for the months and then quarterly for three quarters. The outcome this tool will be submitted to the Executive Director to determinant and additional action is warrant.	a the ir the dee staff and noner atts. If en columns ains ats rdant architects architects architects architects are if
SS=F Bldg. 01	Electrical Equipme Maintenanc Based on record rev interview; the facili required maintenand documentation of in	riew, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care equipment (PCREE). NFPA 99	K 0921	K 921 The corrective action taken for those residents found to have been affected by the deficient practice is that although no	03/14/2025

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SU COMPLET 02/12/20	TED	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 725 S SECOND ST BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE (PROPRIATE	(X5) COMPLETION DATE	
	physical integrity, r touch current tests f is performed as requare established with PCREE used in path accordance with 10 into service and afte Any system consist appliances demonst 99 as a complete sy instructions, and promanufacturer included 10.5.3.1.1 and are coff a program for electrical equipmer manuals are readily and condensed oper appliance are legible equipment tests, repmaintained for a percompliance in according policy. Personnel remaintenance and us receive continuous practice could affect Findings include: Based on record revalum. and 2:30 p.m. and Maintenance A documentation for the electric beds, nebulipumps for air mattroother electrical medianterview at the tim Maintenance Direct tested and document tested and	ins 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE dired in 10.3. Testing intervals policies and protocols. All ent care rooms is tested in 3.5.4 or 10.3.6 before being put er any repair or modification. In the information as required by considered in the development extrical equipment maintenance available, and safety labels eating instructions and maintenance available, and safety labels eating instructions on the endance with the facility's responsible for the testing, endered appliances training. This deficient it all residents. The won 02/12/25 between 10:15 with the Maintenance Director esistant present, there was not the testing of PCREE, such as itzers, oxygen concentrators, air resses, vital sign monitors, and ical equipment. Based on the of record review, the or said the facility has not ted the PCREE items as of yet. On between 2:30 p.m. to 5:45		specific residents were in during the survey, all residents and staff that utilizes or oportable patient care related electrical equipment have potential to be affected by deficient practice. All net recently repaired portably care related electrical edis now being inspected by maintenance staff to ensure sident safety prior to be into service. A record of inspections will be docur the facility's preventative maintenance manual. The anon-going process. The corrective action take other residents that have potential to be affected by same deficient practice is residents and staff that a coperate any portable pateriated electrical equipment the potential to be affected deficient practice. All net recently repaired portably care related electrical equipment is now being inspected by maintenance staff to ensure staff to ensure staff to ensure staff to ensure that safety prior to be into service. A record of inspections will be docur the facility's preventative maintenance manual. The measures that have into place to ensure that deficient practice does in that a mandatory in-service.	idents operate ated e the oy this w and or e patient unipment oy the sure eing place these mented in this will be ten for the e the oy the sure eint care ent have ed by this w and or e patient unipment oy the sure eint care ent have ed by this w and or e patient unipment oy the sure eing place these mented in this will be been put the ot recur is		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/12/2025		
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 725 S SECOND ST BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	DEFICIENCY)		(X5) COMPLETION DATE	
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)			CROSS-REFERENCED TO THE APPROPRIATE			

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