STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	X2) MULTIPLE CONSTRUCTION X3		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155508	B. WI			03/27/	
		10000		_	_	00/21/	2020
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	no viden on borrein.				SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOON\	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for t	he Investigation of Complaint	F 00	000	By submitting the enclosed		
	IN00456171.	8 1	1	,00	materials, we are not admitting	a the	
					truth or accuracy of any specif	-	
	Complaint IN0045	6171: Federal/state deficiencies			findings or allegations. We		
	_	ation(s) are cited at F689, F842,			reserve the right to contest the	د	
	and F9999.				findings or allegations as part		
	unu 1 ////.				any proceedings and submit the		
	Survey dates: Marc	sh 26 & 27 2025			responses pursuant to our	1636	
	Survey dates. Mare	Sii 20 & 27, 2023			regulatory obligations. The fa	oility	
	Facility number: 00	00451			requests the plan of correction	-	
	Provider number: 1					ı be	
	AIM number: 1002				considered our allegation of		
	Anvi number: 1002	200240			compliance effective April 18,	. .	
	C DIT				2025, to the state findings of the		
	Census Bed Type:				Complaint Survey conducted	on	
	SNF/NF: 58				March 27, 2025.		
	Total: 58						
	Census Payor Type	»:					
	Medicare: 4						
	Medicaid: 52						
	Other: 2						
	Total: 58						
	These deficiencies	reflects State Findings cited in					
	accordance with 41						
	0.11	1 . 1					
	Quality review con	npleted on April 3, 2025.					
F 0689	483.25(d)(1)(2)						
SS=G	Free of Accident						
Bldg. 00	Hazards/Supervis	sion/Devices					
	•	on, interview, and record	F 06	589	F - 689		04/18/2025
		failed to ensure adequate		, 5 ,	The corrective action taken for	r	0 11 10/2025
		secure environment was			those residents found to have		
		t a resident with dementia from			been affected by the deficient		
		and leaving the property for 1			practice is that the resident		
		wed for elopement risk. This			identified as resident C is now	,	
l l		1	- 1		1		I

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

TITLE

(X6) DATE 04/14/2025

Any definecystatement 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 disclodays 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.

Robin L McCarty

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Executive Director

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155508	B. W	ING		03/27	/2025
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			SECOND ST		
TDANSC	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
TRANSC	LINDENI NEALIN	CANE OF BOONVILLE		BOONV	TILLE, IIN 47001		
(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	ļ	TAG	DEFICIENCY)		DATE
	-	esulted in an elopement that			being provided the necessary		
	_	early morning hours on			supervision and a secure		
	_	last seen by facility staff at			environment to prevent the		
	approximately 2:00 A.M. A resident exited the facility through an unsecured window and was				resident from leaving the facili	ty	
					unattended. The appropriate		
		nissing until approximately 5:00			interventions have been put in	1	
		was located by local law			place to ensure the resident's		
	* *	roximately 6:00 A.M. in a field			safety and to reduce the risks	of	
		t and shivering and required			elopement.		
	hospitalization. (Re	sident C)			The corrective action taken for	r the	
					other residents that have the		
	Finding includes:				potential to be affected by the		
					same deficient practice is that		
	-	ew on 3/26/25 at 9:10 A.M.,			housewide audit of all residen		
		oses included, but were not			who have been identified as b	-	
	limited to dementia	-			an elopement risk have now b		
	schizoaffective disc	order, and heart failure.			reviewed by the interdisciplina	-	
					team. The team has reviewed		
		ecent quarterly MDS			residents' elopement risks and	t	
	· ·	t) assessment, dated 1/17/25,			have added the appropriate		
		nt had severe cognitive			interventions to their respectiv		
	-	walk 10 feet with partial to			care plans in an attempt to pre	event	
		e, and could walk 50 feet with			an elopement. No additional		
	substantial to maxii	nal assistance.			episodes of elopement have		
					occurred since the survey.		
	*	nt assessment, completed			The measures that have been	put	
	_	Resident C was not at risk for			into place to ensure that the		
	elopement.				deficient practice does not rec		
					that a mandatory in-service ha		
	•	lan included but was not			been provided for all staff on t		
		had late loss Activity of Daily			facility's policies and procedur	es	
	- '	care performance deficit due to			related to providing a safe		
	· ·	10/17/24) with an intervention			environment for all residents.		
	-	assistance with bed mobility.			in-service included a review of		
	Resident C had imp				facility's policies on elopemen	t	
		ocesses related to dementia			risk assessments,		
		with an intervention of cue,			incident/accident investigation	S	
	-	vise as needed. Resident at risk			and reporting of		
	for elopement (initi	ated 3/24/25).			incidents/accidents in accorda	ince	
1	i		1		with the State and Federal		ı

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155508	B. WI	ING		03/27/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
	Г				,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(>	(5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPL	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DA	ΙΈ
		ian orders included, but were			regulations. All staff members	•	
	· ·	and reposition every two hours			were instructed on their		
	for prevention every	y shift (started 10/10/24).			responsibilities to ensure resid	lent	
	D 11 C				safety at all times, including		
		ss notes included, but were			providing adequate supervisio		
	not limited to:	1-4-12/12/25			those residents identified at ris	SK	
	` *	as dated 3/12/25 with no other			for elopement.		
		le prior to the note on 3/15/25			The corrective action taken to	,	
	at 6:36 A.M. in the				monitor to ensure the deficien	·	
		I Resident sent out to			practice will not recur is that a		
	hospital for evaluati	M Resident admitted to the			Quality Assurance tool has be		
	hospital with altered				developed and implemented to		
	*	I Resident was admitted to			monitor the resident's safety.	ine	
		5) with altered mental status			tool includes ensuring that		
		fection (UTI). Facility to pick			accurate assessments have b		
	up from hospital are				completed to identify any pote		
	up from nospital are	Sund 4.00 F.M.			safety risks of the resident as		
	During on observati	ion on 3/26/25 at 9:30 A.M.,			as ensuring that the appropria plan of care has been develop		
	_	ing on the couch in a common			and implemented for the resid		
		nall nurse's station watching			This tool will be completed by		
	television.	ian nuise's station watering			Director of Nursing and/or the		
	television.				designee weekly for four week		
	During an interview	on 3/26/25 at 9:40 A.M., CNA			then monthly for three months		
	1	t C could walk without			then quarterly for three quarte		
		not always steady. Resident C			The outcome of this tool will b		
		If and had not displayed any			reviewed at the Quality Assura		
		ring or exit seeking that she			meetings to determine if any		
	was aware of.	6 5			additional action is warranted.		
	During an interview	on 3/26/25 at 9:55 A.M.,					
		ndicated that Resident C had					
	_	uring the morning hours of					
	3/15/25. Resident C	had apparently slipped out of					
		cility, crossed a ditch on the					
		d then fell and was found by					
	police lying on the	ground near a neighboring					
	middle school, in th						
	During an interview	on 3/26/25 at 10:10 A.M., LPN					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155508	B. WING		03/27/2025
NAME OF D	DOMDED OD CHIDDI IEL		STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF P	PROVIDER OR SUPPLIEF			SECOND ST	
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE	BOOM	IVILLE, IN 47601	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION worked the morning of 3/15/25	TAG	DEFICIENCIT	DATE
		g to work due to the bad			
		morning hours of 3/15/25. LPN			
		had received a report from			
		shift nurse and was told the			
	resident had been so	ent to the hospital for altered			
		6 indicated she was not aware			
		that occurred during the			
		hours of 3/15/25 and that			
		have any history of exit			
	seeking or elopeme	nts.			
	During an interview	on 3/26/25 at 10:25 A.M.,			
	-	ndicated that Emergency			
	_	EMS) was called to the scene			
	the morning of 3/15	5/25, after Resident C was			
	located in the rain,	shivering.			
	A local police repor	rt, dated 3/15/25 at 5:57 A.M.,			
		was dispatched in reference to			
	a person "down in t	he grass." An officer arrived			
	at the scene to find	Resident C with his clothes			
		e facility called and indicated			
		s a resident at the facility. EMS			
		e unknown timeframe of which			
		tside, cold and wet. The			
		ed that Resident C was last A.M. bed check. Staff then			
	-	was missing around 5:00			
		alled for police on a missing			
		eather search indicated, at 3:00			
	-	ived heavy rain and wind gusts			
	from 14 to 23 miles	per hour.			
	During an interview	on 3/26/25 at 10:55 A.M., the			
	-	tor indicated that she was			
	-	t shift nurse on 3/15/25 that			
		sing and then had been found			
		ide of the facility. The Facility			
	Administrator indic	ated that Resident C was			

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Event ID:

8RUK11 Facility ID: 000451

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155508		UILDING	instruction 00	(X3) DATE COMPL 03/27/	ETED	
	OF PROVIDER OR SUPPLIE SCENDENT HEALTH	CARE OF BOONVILLE	725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	had called the local unable to locate the facility. Resident C for a change in men been able to slip our construction crews secured the window facility to vent the state of the window facility of the window facility of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility on the morn by local police. Restate of the window facility o	resident in or around the was then sent to the hospital atal status. The resident had at of a bedroom window after had removed the screws that was while doing repairs in the facility during the construction. The facility during the construction at the bedroom window was a rain. Resident C's Emergency all Doctor (MD) exam, dated for an example of the facility and was found lying in a rain. For on 3/27/25 at 8:25 A.M., RN esident C had eloped from the sident C was last seen by staff during a bed check. RN 10 could time but being notified that the his room, a search was outside of the facility. RN 10 and Administrator and was told to be department. RN 10 indicated to report the missing resident, at the facility shortly after to resident was found outside of the facility shortly after to resident was found the facility shortly after to				

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Event ID:

8RUK11 Facility ID: 000451

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER 155508	JILDING	00	COMPL 03/27/	ETED
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S S	DDRESS, CITY, STATE, ZIP COD ECOND ST ILLE, 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)	ATE	(X5) COMPLETION DATE
F 0842	around 5:00 A.M., Or C's room had been to was not in his room the room was opened open and it was not resident may have go immediately notified checking all rooms then searched in and until the local policity resident had been for the searched in an autil the local policity and interview Facility Administer RN 10 at 5:46 A.M. was missing. The Far RN 10 to call the localled to notify the Resident C had been to alled to notify the Resident C had been wandering and Elogonia. If a resident is elopement/missing and initiate a search premises; and c. If the notify the administration nursing services, the representative, the allength of the services of the representative of the allength of the search premises and c. If the notify the administration in the residual relation relates and the search premise and the residual relation relates and the search premise and the	CNA 8 observed that Resident rearranged, and the resident. CNA 8 indicated a window in ed, but was not completely obvious at the time that the gone out the window. CNA 8 dd the nurse, and staff began and closets on the unit. Staff d around the entire building enotified them that the bund. For on 3/27/25 at 9:30 A.M., the indicated she was called by and notified that Resident C acility Administrator instructed cal police. At 6:12 A.M., RN 10 Facility Administrator that in located by the local police. P.M., the Facility Administrator I facility policy titled pements. The policy included, missing, initiate the resident emergency procedure: in of the building(s) and the resident is not located, attor and the director of the resident's legal intending physician, law ls f. document relevant esident's medical record." to complaint IN00456171.				
SS=D Bldg. 00	483.20(f)(5), 483.7 Resident Records	/0(ı)(1)-(5) - Identifiable Information				

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLET	ΓED
		155508	B. WI	NG		03/27/2	025
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TDANCC	PENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		ВООИ	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and record review, the facility	F 08	342	F - 842		04/18/2025
		ident records were complete			1.) The corrective action taker	n for	
		of 3 residents reviewed for			those residents found to have		
	_	esident records contained no			been affected by the deficient		
		n elopement event, and the			practice is that a new elopeme	ent	
		istration Records (MAR) was			risk assessment has now bee	n	
	documented inaccu	rately. (Resident C)			completed for the resident		
					identified as resident C which		
	Findings includes:				accurately reflects the residen	ťs	
					elopement risks. In addition,		
	_	view on 3/26/25 at 9:10 A.M.,			resident's C care plan has bee	en	
	I	oses included, but were not			updated to reflect the interven	tions	
	limited to dementia				that have been put in place in	an	
	schizoaffective disc	order, and heart failure.			effort to keep the resident safe	€.	
					The facility has also transcribe	ed a	
		ecent quarterly MDS			complete and accurate record	of	
	1	t) assessment, dated 1/17/25,			the resident's elopement even	it in	
	indicated the reside	nt had severe cognitive			detail including all notifications	3	
	impairment, could	walk 10 feet with partial to			that were made.		
	moderate assistance	e, and could walk 50 feet with			2.) The corrective action taker	n for	
	substantial to maxing	mal assistance.			those residents found to have		
					been affected by the deficient		
		nt assessment completed			practice is that the medication		
	1/15/25 indicated R	tesident C was not at risk for			administration record of the		
	elopement.				resident identified as resident	C	
					has now been corrected by the	e	
	•	lan included but was not			nurse which indicates that the		
	limited to, resident	at risk for elopement (initiated			resident did not receive their 7	' AM	
	3/24/25).				medications as scheduled on		
					03-15-25. All medication and		
	Resident C's progre	ess notes included, but were			treatment documentation is no	w	
	not limited to:				complete and accurate.		
		as dated 3/12/25 with no other			The corrective action taken for	r the	
		le prior to the note on 3/15/25			other residents that have the		
	at 6:36 A.M. in the	resident's record.)			potential to be affected by the		
		1 Resident sent out to			same deficient practice is that	all	
	hospital for evaluat	ion and treatment.			residents have the potential to	be	
					affected by this deficient pract	ice.	
	During an interview	v on 3/26/25 at 10:55 A.M., the			A housewide review of all clini	cal	
	Facility Administra	tor indicated that she was			record documentation comple	ted	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155508	B. W	ING		03/27/	/2025
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	l	
NAME OF F	PROVIDER OR SUPPLIEF	8					
TDANGO	ENDENT HEALTH	CARE OF BOON /!! ! F			SECOND ST		
IKANSU	ENDENI MEALIM	CARE OF BOONVILLE		BOONV	/ILLE, 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	notified by the nigh	t shift nurse on 3/15/25 that			within the past thirty days has		
	Resident C was mis	ssing and then had been found			now been made to ensure the		
	by local police outs	ide of the facility. The Facility			accuracy and thoroughness of	f the	
	Administrator indic	ated that Resident C was			documentation to include all		
	found on facility pr	operty and that the night nurse			pertinent events that have		
		police department after being			occurred for each resident.		
	unable to locate the	resident in or around the			The measures that have been	put	
	1	was then sent to the hospital			into place to ensure that the		
	for a change in mer	ntal status.			deficient practice does not rec	ur is	
					that a mandatory in-service ha	as	
	During an interview	v on 3/27/25 at 8:25 A.M., RN			been provided for all nursing s	staff	
	10 indicated that Re	esident C had eloped from the			on their individual responsibilit	ties	
	facility on the morn	ning of 3/15/25 and was found			to ensure that all pertinent		
	by local police. Res	sident C was last seen by staff			information is complete and		
	around 2:00 A.M. d	luring a bed check. RN 10 could			accurately recorded in the clin	ical	
	not recall the exact	time but being notified that the			records in accordance with fac	cility	
	resident was not in	his room, a search was			policies and procedures.		
	initiated inside and	out of the facility. RN 10			The corrective action taken to		
	notified the Facility	Administrator and was told to			monitor to ensure the deficient	t	
	call the local police	department. RN 10 indicated			practice will not recur is that a		
	he called the police	to report the missing resident,			Quality Assurance tool has be	en	
	and the police calle	d the facility shortly after to			developed and implemented to	0	
	alert them that the r	resident was found outside of			monitor the accuracy and		
		indicated no documentation			completeness of the clinical		
	was made in the rec	cord regarding the elopement or			record. The tool will monitor to	0	
	notification to the p	olice department.			ensure that all medications,		
					treatments, changes in conditi	on,	
	On 3/26/25 at 2:05	P.M., the Facility Administrator			special events, notifications, e	tc.	
		l facility policy titled			are accurately documented in	the	
	_	pements. The policy included,			clinical record. This tool will b	е	
		missing, initiate the			completed by the Director of		
	elopement/missing	resident emergency procedure:			Nursing and/or their designee		
		ant information in the			weekly for four weeks, then		
	resident's medical r	ecord."			monthly for three months and	then	
					quarterly for three quarters. T	he	
	2. During an intervi	iew on 3/26/25 at 11:15 A.M.,			outcome of this tool will be		
	QMA 14 indicated	she had worked the day of			reviewed at the Quality Assura	ance	
	3/15/25 and had rec	eived a report from RN 10 that			meetings to determine if any		
	Resident C had bee	n sent out to the hospital			additional action is warranted.		
	during the night shi		1				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	_	SURVEY LETED 7/2025
	PROVIDER OR SUPPLIER	CARE OF BOONVILLE	725 S S	ADDRESS, CITY, STATE, ZIP CO SECOND ST VILLE, IN 47601	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Resident C's Medic (MAR) for the mondocumentation indithe following medication pass, signification as a medication and a medication and a medication and be a medication and be a medication and be a medication as a medication and be a medication and be a medication and be a medication and the medi	cated that Resident C received cations during the 7:00 A.M., gned by QMA 14: ms (mg) (started 10/11/24) sinistered on 3/15/25 at 7:00 125 mg (started 10/10/24) sinistered on 3/15/25 at 7:00 (started 10/11/24) documented 3/15/25 at 7:00 A.M. der 17 grams (started 2/10/25) sinistered on 3/15/25 at 7:00 te extended release 25 mg documented as administered on 4. e 125 mg (started 2/19/25) sinistered on 3/15/25 at 7:00 Itium 8.6-50 mg (started ted as administered on 3/15/25 at 7:00 Itium 8.6-50 mg (started 2/20/25) documented as 3/15/25 at 7:00 A.M. or on 3/27/25 at 11:35 A.M., that Resident C was not in the at 7:00 A.M., and that the en documented as or. QMA 10 indicated she ecord to show the resident was				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPL	ETED
		155508	B. W	NG		03/27/	/2025
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
TDANCO		ICARE OF BOONIVILLE			SECOND ST		
TRANSC	ENDENT HEALTH	ICARE OF BOONVILLE		BOON	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-50(a)(1)						
	3.1-50(a)(2)						
F 9999							
Bldg. 00							
			F 99	999	9999		04/18/2025
		tion and Management			The corrective action taken for	r	
		tor is responsible for the overall			those residents found to have		
	_	e facility but shall not function			been affected by the deficient		
		supervisor, for example, director			practice is that the State agen	-	
	-	service supervisor, during the			is now aware of the elopemen	t	
		esponsibilities of the			event of resident C. Failure to)	
		include, but are not limited to,			notify the State agency by		
	the following:				administration was an oversig	ht	
		forming the division by			and has now been addressed	with	
	-	d by written notice within			the Executive Director.		
		ours, of unusual occurrences			The corrective action taken for	r the	
	-	en the welfare, safety, or health			other residents that have the		
	of the resident or re	esidents.			potential to be affected by the		
					same deficient practice is that		
	This state rule was	not met as evidenced by:			residents have the potential to		
					affected by this deficient pract		
		and record review, the facility			No other reportable events ha		
		stigate and report to the state			occurred at this time. All futur		
		occurrence of resident			reportable events will be prom		
		1 resident elopements			reported to the State agency i		
		e agency was not notified when			accordance with the regulation		
		e facility through a bedroom			The measures that have been	put	
		ound by the local police			into place to ensure that the		
	department off the	facility's property. (Resident C)			deficient practice does not rec		
					that a mandatory in-service ha		
	Finding includes:				been provided for the Executiv	/e	
					Director and the facility's		
	-	ew on 3/26/25 at 9:10 A.M.,			management team on the Sta	te	
		oses included, but were not			regulation related to unusual		
	limited to dementia				occurrences, with a focus on t	heir	
	schizoaffective dis	order, and heart failure.			responsibility to ensure that		
					thorough investigations are		
	Resident C's most	recent quarterly MDS			conducted on each event and		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155508	B. W			03/27/	
					_		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					SECOND ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOON	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	(Minimum Data Se	t) assessment, dated 1/17/25,			promptly reported to the		
	indicated the reside	ent had severe cognitive			appropriate State agency.		
		walk 10 feet with partial to			The corrective action taken to		
	_	e, and could walk 50 feet with			monitor to ensure the deficient	•	
	substantial to maxing				practice will not recur is that a		
					Quality Assurance tool has be	en	
	Resident C's care p	lan included but was not			developed and implemented to		
		t at risk for elopement (initiated			monitor for compliance with th		
	3/24/25).	. av 11011 101 010p 01110111 (1111111110			investigating and reporting of		
	3/2 1/23).				unusual occurrences. This too	-	
	Resident C's progre	ess notes included, but were			will monitor the facility's)i	
	not limited to:	ass notes meraded, out were			documentation to determine if	anv	
		A Resident sent out to			unusual occurrence has occur	•	
	hospital for evaluat				and if there is supportive	ieu	
	_	M Resident admitted to the			documentation to ensure that	tho	
						ırıe	
	hospital with altere				appropriate State agency has		
		1 Resident was admitted to			been notified and that a thorou	_	
		5) with altered mental status			investigation of the event has	been	
	I -	fection (UTI). Facility to pick			documented. The tool will be		
	up from hospital are	ound 4:00 P.M.			completed by the Vice Preside		
	D	2/26/25 (10.55 1.35 (1			of Clinical Operations weekly t		
	_	v on 3/26/25 at 10:55 A.M., the			four weeks, then monthly for the	rree	
	1	tor indicated that she was			months and then quarterly for		
		at shift nurse on 3/15/25 that			three quarters. The outcome		
		ssing and then had been found			this tool will be reviewed at the		
	-	side of the facility. The facility			Quality Assurance meetings to		
		cated that the incident was not			determine if any additional act	ion	
	reported to the state	e agency.			is warranted.		
	0 2/26/25 : 11.04						
	On 3/26/25 at 11:00	-					
		lied a timeline of events for the					
		. The Facility Administrator					
		n statements were obtained					
		ocumentation of staff					
	ınterviews regardin	g the incident were available.					
	On 3/26/25 at 3.25	P.M., the Facility Administrator					
		d facility policy titled, Unusual]
		ing. The policy included, "As					
	_	or state regulations, our					
	1 required by rederal	or state regulations, our					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 03/27/2025	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE				725 S S	ADDRESS, CITY, STATE, ZIP COD SECOND ST VILLE, 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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reportable events w or welfare of our re- occurrences shall be appropriate agencie state regulations"	sual occurrences or other hich affect the health, safety, sidents 2. Unusual ereported via telephone to s as required by federal and to complaint IN00456171.					

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