STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00456171. Complaint IN00456171: Federal/state deficiencies related to the allegation(s) are cited at F689, F842, and F9999. Survey dates: March 26 & 27, 2025 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 4 Medicaid: 52 Other: 2 Total: 58 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 2025.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective April 18, 2025, to the state findings of the Complaint Survey conducted on March 27, 2025.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure adequate supervision, and a secure environment was provided to prevent a resident with dementia from exiting the facility and leaving the property for 1 of 3 residents reviewed for elopement risk. This	F 0689	F - 689 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C is now	04/18/2025

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

Robin L McCarty | Executive Director | 04/14/2025

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	deficient practice resulted in an elopement that occurred during the early morning hours on 3/15/25 after being last seen by facility staff at approximately 2:00 A.M. A resident exited the facility through an unsecured window and was not realized to be missing until approximately 5:00 A.M. The resident was located by local law enforcement at approximately 6:00 A.M. in a field near the facility wet and shivering and required hospitalization. (Resident C) Finding includes: During record review on 3/26/25 at 9:10 A.M., Resident C's diagnoses included, but were not limited to dementia, anxiety disorder, schizoaffective disorder, and heart failure. Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/17/25, indicated the resident had severe cognitive impairment, could walk 10 feet with partial to moderate assistance, and could walk 50 feet with substantial to maximal assistance. A risk for elopement assessment, completed 1/15/25, indicated Resident C was not at risk for elopement. Resident C's care plan included but was not limited to, resident had late loss Activity of Daily Living (ADL) self-care performance deficit due to dementia (initiated 10/17/24) with an intervention of resident required assistance with bed mobility. Resident C had impaired cognitive function/thought processes related to dementia (initiated 2/25/25) with an intervention of cue, reorient, and supervise as needed. Resident at risk for elopement (initiated 3/24/25).		being provided the necessary supervision and a secure environment to prevent the resident from leaving the facility unattended. The appropriate interventions have been put in place to ensure the resident's safety and to reduce the risks of elopement. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all residents who have been identified as being an elopement risk have now been reviewed by the interdisciplinary team. The team has reviewed the residents' elopement risks and have added the appropriate interventions to their respective care plans in an attempt to prevent an elopement. No additional episodes of elopement have occurred since the survey. *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 staff on the facility's policies and procedures related to providing a safe environment for all residents. The in-service included a review of the facility's policies on elopement risk assessments, incident/accident investigations and reporting of incidents/accidents in accordance with the State and Federal	

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	Resident C's physician orders included, but were not limited to, turn and reposition every two hours for prevention every shift (started 10/10/24). Resident C's progress notes included, but were not limited to: (A previous note was dated 3/12/25 with no other documentation made prior to the note on 3/15/25 at 6:36 A.M. in the resident's record.) 3/15/25 at 6:36 A.M. - Resident sent out to hospital for evaluation and treatment. 3/15/25 at 11:29 A.M. - Resident admitted to the hospital with altered mental status. 3/21/25 at 3:13 P.M. - Resident was admitted to hospital (on 3/15/25) with altered mental status and urinary tract infection (UTI). Facility to pick up from hospital around 4:00 P.M. During an observation on 3/26/25 at 9:30 A.M., Resident C was sitting on the couch in a common area near the back hall nurse's station watching television. During an interview on 3/26/25 at 9:40 A.M., CNA 2 indicated Resident C could walk without assistance but was not always steady. Resident C often kept to himself and had not displayed any behaviors of wandering or exit seeking that she was aware of. During an interview on 3/26/25 at 9:55 A.M., Police Sergeant 4 indicated that Resident C had exited the facility during the morning hours of 3/15/25. Resident C had apparently slipped out of a window of the facility, crossed a ditch on the facility property and then fell and was found by police lying on the ground near a neighboring middle school, in the rain. During an interview on 3/26/25 at 10:10 A.M., LPN		regulations. All staff members were instructed on their responsibilities to ensure resident safety at all times, including providing adequate supervision for those residents identified at risk for elopement. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's safety. The tool includes ensuring that accurate assessments have been completed to identify any potential safety risks of the resident as well as ensuring that the appropriate plan of care has been developed and implemented for the resident. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted.	

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	6 indicate that she worked the morning of 3/15/25 but was late arriving to work due to the bad weather during the morning hours of 3/15/25. LPN 6 indicated that she had received a report from Resident C's night shift nurse and was told the resident had been sent to the hospital for altered mental status. LPN 6 indicated she was not aware of anything unusual that occurred during the night shift morning hours of 3/15/25 and that Resident C did not have any history of exit seeking or elopements. During an interview on 3/26/25 at 10:25 A.M., Police Sergeant 4 indicated that Emergency Medical Services (EMS) was called to the scene the morning of 3/15/25, after Resident C was located in the rain, shivering. A local police report, dated 3/15/25 at 5:57 A.M., indicated an officer was dispatched in reference to a person "down in the grass." An officer arrived at the scene to find Resident C with his clothes completely wet. The facility called and indicated that Resident C was a resident at the facility. EMS was called due to the unknown timeframe of which the resident was outside, cold and wet. The facility staff indicated that Resident C was last seen during a 2:00 A.M. bed check. Staff then noticed the resident was missing around 5:00 A.M. "Staff never called for police on a missing person." A local weather search indicated, at 3:00 A.M., the area received 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 Facility Administrator indicated that she was notified by the night shift nurse on 3/15/25 that Resident C was missing and then had been found by local police outside of the facility. The Facility Administrator indicated that Resident C was			

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	found on facility property and that the night nurse had called the local police department after being unable to locate the resident in or around the facility. Resident C was then sent to the hospital for a change in mental status. The resident had been able to slip out of a bedroom window after construction crews had removed the screws that secured the windows while doing repairs in the facility to vent the facility during the construction. It was not known that the bedroom window was unsecured. During a review of Resident C's Emergency Department Medical Doctor (MD) exam, dated 3/15/25 at 7:06 A.M., indicated Resident C presented via EMS. Resident C apparently eloped from a nursing facility and was found lying in a football field in the rain. During an interview on 3/27/25 at 8:25 A.M., RN 10 indicated that Resident C had eloped from the facility on the morning of 3/15/25 and was found by local police. Resident C was last seen by staff around 2:00 A.M. during a bed check. RN 10 could not recall the exact time but being notified that the resident was not in his room, a search was initiated inside and outside of the facility. RN 10 notified the Facility Administrator and was told to call the local police department. RN 10 indicated he called the police to report the missing resident, and the police called the facility shortly after to alert them that the resident was found outside of the building. During an interview on 3/27/25 at 8:50 A.M., CNA 8 indicated she was the staff member that realized Resident C was not in his room during the early morning hours of 3/15/25. CNA 8 indicated Resident C was observed in his room during the 2:00 A.M. bed check. During a bed check at			

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	around 5:00 A.M., CNA 8 observed that Resident C's room had been rearranged, and the resident was not in his room. CNA 8 indicated a window in the room was opened, but was not completely open and it was not obvious at the time that the resident may have gone out the window. CNA 8 immediately notified the nurse, and staff began checking all rooms and closets on the unit. Staff then searched in and around the entire building until the local police notified them that the resident had been found. During an interview on 3/27/25 at 9:30 A.M., the Facility Administer indicated she was called by RN 10 at 5:46 A.M. and notified that Resident C was missing. The Facility Administrator instructed RN 10 to call the local police. At 6:12 A.M., RN 10 called to notify the Facility Administrator that Resident C had been located by the local police. On 3/26/25 at 2:05 P.M., the Facility Administrator supplied an undated facility policy titled Wandering and Elopements. The policy included, "...3. If a resident is missing, initiate the elopement/missing resident emergency procedure: ...b. initiate a search of the building(s) and premises; and c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials ... f. document relevant information in the resident's medical record." This citation relates to complaint IN00456171. 3.1-45(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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	Based on interview and record review, the facility failed to ensure resident records were complete and accurate for 1 of 3 residents reviewed for elopement risks. Resident records contained no documentation of an elopement event, and the Medication Administration Records (MAR) was documented inaccurately. (Resident C) Findings includes: 1. During record review on 3/26/25 at 9:10 A.M., Resident C's diagnoses included, but were not limited to dementia, anxiety disorder, schizoaffective disorder, and heart failure. Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/17/25, indicated the resident had severe cognitive impairment, could walk 10 feet with partial to moderate assistance, and could walk 50 feet with substantial to maximal assistance. A risk for elopement assessment completed 1/15/25 indicated Resident C was not at risk for elopement. Resident C's care plan included but was not limited to, resident at risk for elopement (initiated 3/24/25). Resident C's progress notes included, but were not limited to: (A previous note was dated 3/12/25 with no other documentation made prior to the note on 3/15/25 at 6:36 A.M. in the resident's record.) 3/15/25 at 6:36 A.M. - Resident sent out to hospital for evaluation and treatment. During an interview on 3/26/25 at 10:55 A.M., the Facility Administrator indicated that she was	F 0842	F - 842 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a new elopement risk assessment has now been completed for the resident identified as resident C which accurately reflects the resident's elopement risks. In addition, resident's C care plan has been updated to reflect the interventions that have been put in place in an effort to keep the resident safe. The facility has also transcribed a complete and accurate record of the resident's elopement event in detail including all notifications that were made. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the medication administration record of the resident identified as resident C has now been corrected by the nurse which indicates that the resident did not receive their 7 AM medications as scheduled on 03-15-25. All medication and treatment documentation is now complete and accurate. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide review of all clinical record documentation completed	04/18/2025

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	notified by the night shift nurse on 3/15/25 that Resident C was missing and then had been found by local police outside of the facility. The Facility Administrator indicated that Resident C was found on facility property and that the night nurse had called the local police department after being unable to locate the resident in or around the facility. Resident C was then sent to the hospital for a change in mental status. During an interview on 3/27/25 at 8:25 A.M., RN 10 indicated that Resident C had eloped from the facility on the morning of 3/15/25 and was found by local police. Resident C was last seen by staff around 2:00 A.M. during a bed check. RN 10 could not recall the exact time but being notified that the resident was not in his room, a search was initiated inside and out of the facility. RN 10 notified the Facility Administrator and was told to call the local police department. RN 10 indicated he called the police to report the missing resident, and the police called the facility shortly after to alert them that the resident was found outside of the building. RN 10 indicated no documentation was made in the record regarding the elopement or notification to the police department. On 3/26/25 at 2:05 P.M., the Facility Administrator supplied an undated facility policy titled Wandering and Elopements. The policy included, "...3. If a resident is missing, initiate the elopement/missing resident emergency procedure: ...f. document relevant information in the resident's medical record." 2. During an interview on 3/26/25 at 11:15 A.M., QMA 14 indicated she had worked the day of 3/15/25 and had received a report from RN 10 that Resident C had been sent out to the hospital during the night shift.		within the past thirty days has now been made to ensure the accuracy and thoroughness of the documentation to include all pertinent events that have occurred for each resident. *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 nursing staff on their individual responsibilities to ensure that all pertinent information is complete and accurately recorded in the clinical records in accordance with facility policies and procedures. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy and completeness of the clinical record. The tool will monitor to ensure that all medications, treatments, changes in condition, special events, notifications, etc. are accurately documented in the clinical record. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted.	

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	During record review on 3/26/25 at 2:30 P.M., Resident C's Medication Administration Record (MAR) for the month of March, 2025, documentation indicated that Resident C received the following medications during the 7:00 A.M., medication pass, signed by QMA 14: Aspirin 81 milligrams (mg) (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M. Depakote Sprinkles 125 mg (started 10/10/24) documented as administered on 3/15/25 at 7:00 A.M. Famotidine 20 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M. GlycoLax oral powder 17 grams (started 2/10/25) documented as administered on 3/15/25 at 7:00 A.M. Metoprolol succinate extended release 25 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M. Quetiapine fumarate 125 mg (started 2/19/25) documented as administered on 3/15/25 at 7:00 A.M. Senna-docusate sodium 8.6-50 mg (started 10/11/24) documented as administered on 3/15/25 at 7:00 A.M. Seroquel 25 mg (started 2/20/25) documented as administered on 3/15/25 at 7:00 A.M. During an interview on 3/27/25 at 11:35 A.M., QMA 10 indicated that Resident C was not in the building on 3/15/25 at 7:00 A.M., and that the medications had been documented as administered in error. QMA 10 indicated she would correct the record to show the resident was in the hospital at that time. This citation relates to complaint IN00456171.			

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	3.1-50(a)(1) 3.1-50(a)(2)			
F 9999 Bldg. 00	3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to fully investigate and report to the state agency an unusual occurrence of resident elopement for 1 of 1 resident elopements reviewed. The state agency was not notified when a resident exited the facility through a bedroom window and was found by the local police department off the facility's property. (Resident C) Finding includes: During record review on 3/26/25 at 9:10 A.M., Resident C's diagnoses included, but were not limited to dementia, anxiety disorder, schizoaffective disorder, and heart failure. Resident C's most recent quarterly MDS	F 9999	9999 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the State agency is now aware of the elopement event of resident C. Failure to notify the State agency by administration was an oversight and has now been addressed with the Executive Director. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. No other reportable events have occurred at this time. All future reportable events will be promptly reported to the State agency in accordance with the regulation. *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 the Executive Director and the facility's management team on the State regulation related to unusual occurrences, with a focus on their responsibility to ensure that thorough investigations are conducted on each event and	04/18/2025

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	(Minimum Data Set) assessment, dated 1/17/25, indicated the resident had severe cognitive impairment, could walk 10 feet with partial to moderate assistance, and could walk 50 feet with substantial to maximal assistance. Resident C's care plan included but was not limited to, Resident at risk for elopement (initiated 3/24/25). Resident C's progress notes included, but were not limited to: 3/15/25 at 6:36 A.M. - Resident sent out to hospital for evaluation and treatment. 3/15/25 at 11:29 A.M. - Resident admitted to the hospital with altered mental status. 3/21/25 at 3:13 P.M. - Resident was admitted to hospital (on 3/15/25) with altered mental status and urinary tract infection (UTI). Facility to pick up from hospital around 4:00 P.M. During an interview on 3/26/25 at 10:55 A.M., the Facility Administrator indicated that she was notified by the night shift nurse on 3/15/25 that Resident C was missing and then had been found by local police outside of the facility. The facility Administrator indicated that the incident was not reported to the state agency. On 3/26/25 at 11:00 A.M., the Facility Administrator supplied a timeline of events for the incident on 3/15/25. The Facility Administrator indicated no written statements were obtained from staff and no documentation of staff interviews regarding the incident were available. On 3/26/25 at 3:25 P.M., the Facility Administrator supplied an undated facility policy titled, Unusual Occurrence Reporting. The policy included, "As required by federal or state regulations, our		promptly reported to the appropriate State agency. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor for compliance with the investigating and reporting of any unusual occurrences. This tool will monitor the facility's documentation to determine if any unusual occurrence has occurred and if there is supportive documentation to ensure that the appropriate State agency has been notified and that a thorough investigation of the event has been documented. The tool will be completed by the Vice President of Clinical Operations weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents... 2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by federal and state regulations..." This citation relates to complaint IN00456171.			