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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  03/25/2025		
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			305 E	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
Bldg. 00	IN00455471.  Complaint IN0045 are cited at F690 are cited at F690 are Survey dates: Marc Facility number: 002 AIM number: 1002 Census Bed Type: SNF/NF: 49 Total: 49  Census Payor Type Medicare: 10 Medicaid: 37 Other: 2 Total: 49  These deficiencies accordance with 41	ch 24 & 25, 2025  00450 155801 273890  e: reflect State findings cited in	F 0000	O4/14/2025  Suzanne Williams Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204  RE: Transcendent Healthcare Boonville - North Complaint IN00455471 Survey Event ID 016G1:  Dear Ms. Williams;  On March 25, 2025 a Complat Survey was conducted at our facility. By submitting the enclosed material we are not admitting the truth or accuracy any specific findings or allegations. We reserve the ri to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fa requests that the plan of correction be considered our allegation of compliance effect 04/18/2025 to the State finding the Complaint Survey conduct on March 25, 2025.	e of  1  int  y of  ight  cility  tive gs of
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	TITLE	(X6) DATE	

Sarah McKenzie **HFA** 04/14/2025

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

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STATEMENT OF DEFICIENCIES		, ,		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155801	B. WING 03/25			03/25/	2025	
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST /ILLE, IN 47601			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DOLUMNIA NA POSTA SA POSTA		(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	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					We respectfully request a desk review to validate the facility's compliance to the findings of the Complaint Survey of March 25, 2025. Please feel free to contact the facility if any additional information is needed.  Respectfully submitted,			
F 0690	483.25(e)(1)-(3)				Sarah McKenzie, HFA Executive Director Transcendent Healthcare of Boonville - North			
SS=D Bldg. 00		continence, Catheter, UTI						
	review, the facility care for 1 of 1 resid care. Catheter care completed per the p of care. (Resident C Finding includes:  During an observati Resident C was obs wheelchair. Cathete	on, interview, and record failed to implement the plan of ents observed for catheter orders and treatments were not hysician orders and the plan on on 3/24/25 at 12:30 P.M., erved in the dining room in a r tubing connected to a ag was clipped to the side of	F 06	590	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 receiving care and services in accordance with physician's orders and facility policies for care of their urinary catheter. There is documentation to sup that these services are being followed consistently in accordance with the physician orders.  The corrective action taken for other residents that have the	the oport 's	04/18/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/25/2025 155801 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 305 E NORTH ST TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During record review on 3/24/25 at 1:45 P.M., potential to be affected by the Resident C's diagnoses included, but were not same deficient practice is that all limited to, neuromuscular dysfunction of bladder, residents with a urinary catheter prostatic hyperplasia with lower urinary tract have the potential to be affected symptoms, and dementia. by this deficient practice. All residents with urinary catheters Resident C's most recent quarterly MDS are now receiving the necessary (Minimum Data Set) assessment, dated 1/4/25, care and services as ordered by indicated the resident had moderate cognitive their physician and in accordance impairment and had an indwelling catheter. with their individualized plan of Resident C's physician orders included, but were The measures that have been put not limited to, monitor Foley catheter output each into place to ensure that the shift, (ordered 11/18/24), acetic acid irrigation deficient practice does not recur is solution 60 milliliters (ml) via irrigation on time a that a mandatory in-service has day every Friday for catheter maintenance been provided for all nursing staff (ordered 2/25/25), Foley catheter with 60 ml normal on their responsibility in providing saline flush for blockage every shift (ordered the necessary care and services 11/20/24), and change catheter 20 Fr (French) for a urinary catheter in coude (curved tip) one time a day starting on the accordance with each resident's 20th (day of the month) (ordered 3/11/25). physician's orders and their plan of care. The in-service included a Resident C's care plan included, but was not review of the facility's policies and limited to, resident has indwelling Foley catheter procedures related to catheter in place for urinary retention (initiated 11/7/24). care to ensure appropriate Interventions included, catheter care as ordered, infection control practices are intake and output as ordered, empty catheter bag utilized. at least three times daily (initiated 11/7/24). The corrective action taken to monitor to ensure the deficient Resident C's Treatment Administration Record practice will not recur is that a (TAR) for the month of March 2025 indicated the Quality Assurance tool has been following regarding the completion and developed and implemented to documentation of catheter care orders: monitor the care and services Change catheter 20 Fr coude one time a day provided for those residents with a starting on the 20th (ordered 3/11/25) not urinary catheter. The tool will completed 3/20/25. monitor to ensure that the specific Foley catheter with 60 ml normal saline flush for physician's orders are followed as blockage every shift (ordered 11/20/24) not well as to ensure that acceptable completed on day shift of 3/11/25, 3/13/25, 3/14/25, standards of infection control

3/18/25, 3/19/25, and 3/20/25.

practices are demonstrated during

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155801 B. WING 03/25/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 305 E NORTH ST TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Monitor Foley catheter output each shift (ordered catheter care. This tool will be 11/18/24) not completed on day shift 3/11/25, completed by the Infection Control 3/15/25, day and night shift 3/17/25 & 3/18/25, day Preventionist and/or their designee shift 3/20/25, and 3/22/25. weekly for four weeks, then monthly for three months and then During an interview on 3/25/25 at 8:40 A.M., LPN quarterly for three quarters. The 4 indicated being unsure if Resident C had outcome of this tool will be catheter care orders every shift. reviewed at the Quality Assurance meetings to determine if any During an interview on 3/25/25 at 9:55 A.M., CNA additional action is warranted. 6 indicated Resident C's catheter care should be completed every shift and documented. On 3/25/25 at 10:40 A.M., RN 8 supplied a facility policy titled, Catheter Care, Urinary. The policy included, "...Input/Output 1. Observe the THC North QA Tool Completion resident's urine level for noticeable increases or Schedule for the Complaint Survey decreases... 2. Follow the facility procedure for of 03-25-25 measuring and documenting input and output... 5. Alleged Compliance Date of Catheter irrigation may be ordered to prevent 04-18-25 obstruction in residents at risk for obstruction..." This citation relates to complaint IN00455471. 3.1-35(a) 3.1-35(g)(2)F - Tag 690 Weekly Schedule To Be Completed by the Infection Preventionist 04-16-25 04-23-25 04-30-25 05-07-25

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CENTERS FO	OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/25/2025			
NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			305 E	STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST				
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTE	BOON	VILLE, IN 47601	<u> </u>			
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				F – Tag 690 Monthly Schedule To Be Completed by the Infect Preventionist 06-04-25 07-02-25 07-30-25	tion			
				F – Tag 690 Quarterly Schedule To Be Completed by the Infect Preventionist 10-22-25 01-14-26 04-08-26	tion			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/	Wk, Full Time DON						
5	failed to provide Ro of at least 8 hours of did not include at lo occasions.	and record review, the facility egistered Nurse (RN) coverage laily. Weekend RN coverage east eight (8) hours on two	F 0727	The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identificationing the survey, all residents have the potential to be affected by this deficient practice. The facility has now hired additional	ied s ed			

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facility's nursing schedule from 3/10/25 through

3/24/25, eight (8) hours of RN coverage was not

indicated by the schedule on 3/22/25 or 3/23/25.

An RN was scheduled to be in the facility on

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RN staff nurses and updated the

has eight hours of RN coverage

daily as required by the

nursing schedule. The facility now

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155801	B. WING 03/25			/2025	
				CTREET	IDDREGG CITY OT TO COP		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					IORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOOM	/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
	3/22/25 from 12:00	A.M. to 7:00 A.M. and on			regulations.		
	3/23/25 from 6:30 I	P.M. to 12:00 A.M.			The corrective action taken for	r the	
					other residents that have the		
	During an interview	v on 3/25/25 at 10:20 A.M., LPN			potential to be affected by the		
	15 indicated she wo	orked the weekend of 3/22/25			same deficient practice is that	all	
	and 3/23/25 and did	I not recall that the DON was in			residents have the potential to		
	the building. LPN 1	5 indicated the DON was on			affected by this deficient pract		
	call during the weel	kends but did not typically			The facility has now hired		
	come to the facility	to work a full shift.			additional RN staff nurses and	I	
					updated the nursing schedule.		
		A.M, RN 8 provided an			The facility now has eight hou	rs of	
	undated facility pol	icy titled, Staffing, Sufficient			RN coverage daily as required	d by	
	and Competent Nur	sing. The policy included,			the regulations.		
	"A registered nur	se provides services at least			The measures that have been	put	
	eight (8) consecutiv	ve hours every 24 hours, seven			into place to ensure that the		
	(7) days a week"				deficient practice does not rec	ur is	
					that the facility has recently hi	red	
	This citation relates	to complaint IN00455471.			a new Director of Nursing. Th	е	
					new Director of Nursing has b	een	
	3.1-17(b)(3)				educated on the regulatory		
					requirement for at least eight		
					hours of RN coverage daily. I		
					their responsibility to ensure the		
					the nursing schedule reflects t		
					RN coverage in accordance w	vith	
					the 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	0	
					monitor RN coverage for	.,	
					compliance. The tool will mon		
					to ensure that there is at least		
					eight hours of consecutive RN		
					nurse coverage scheduled for		
					day of the week. This tool will	be	
					completed by the Executive		
					Director and/or their designee		
		I		weekly for four weeks, then		I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155801		(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2025				
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD  305 E NORTH ST  BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		DATE		
				quarterly for three quarters. Toutcome of this tool will be reviewed at the Quality Assurameetings to determine if any additional action is warranted.	ance		
				THC North QA Tool Complet Schedule for the Complaint St of 03-25-25 Alleged Compliance Date of 04-18-25			
				F – Tag 690 Weekly Schedule To Be Completed by the Infect Preventionist 04-16-25 04-23-25 04-30-25 05-07-25	tion		
				F – Tag 690 Monthly Schedule To Be Completed by the Infec Preventionist 06-04-25	tion		

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		JLTIPLE CO	ONSTRUCTION	TION (X3) DATE SUR		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED		
		155801	B. WING			03/25/20		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					NORTH ST			
IRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		ROOM/	/ILLE, IN 47601			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		BROWINEBIC BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION			DEFICIENCY)	IE	DATE	
					07-02-25			
					07-30-25			
					F – Tag 690			
					Quarterly Schedule			
					To Be Completed by the Infec	tion		
					Preventionist			
					10-22-25			
					01-14-26			
					04-08-26			
					04 00 20			
					F – Tag 727			
					Weekly Schedule			
					To Be Completed by the Exec	utiva		
					Director	ulive		
					04-16-25			
					04-16-25			
					04-30-25 05-07-25			
					05-07-25			
1					F – Tag 727			

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CENTERSTOR	MEDICARE & MEDIC					_	ID NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED		
15580		155801	B. WING			03/25/	/2025	
100001				_				
NAME OF D	ROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	KOVIDEK OK SUFFLIEI			305 E N	NORTH ST			
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			BOONVILLE, IN 47601					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETIO	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION			DEFICIENCY)	.16	DATE	
					Monthly Schedule			
					To Be Completed by the Exec	utive		
					Director			
					06-04-25			
					07-02-25			
					07-30-25			
					F – Tag 727			
					Quarterly Schedule			
					To Be Completed by the Exec	cutive		
					Director			
					10-22-25			
					01-14-26			
					04-08-26			

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