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	05/21/2025

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 Complaints IN00459395 and IN00458151. Complaint IN00459395: Federal/State deficiencies related to the allegation(s) are cited at F755. Complaint IN00458151: Federal/State deficiencies related to the allegation(s) are cited at F658. Unrelated deficiencies are cited. Survey date: May 21, 2025 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 10 Medicaid: 47 Total: 57 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 23, 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 June 13, 2025, to the state findings of the Complaint Survey conducted on May 21, 2025.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 1 of 1 residents reviewed for	F 0602	F - 602 *The corrective action taken for those residents found to have*	06/13/2025

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

Robin L McCarty | Executive Director | 06/06/2025

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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	misappropriation. A resident's debit card was taken without consent and used by staff to make multiple unauthorized purchases. (Resident D) Finding includes: During a review of facility reported incidents on 5/21/25 at 11:15 A.M., an incident dated 5/2/25, indicated Resident D contacted local police to report a stolen debit card. Resident D identified on a bank statement several unauthorized transactions. The local police reviewed surveillance footage from the locations where the unauthorized purchases were made that showed CNA 13 had been responsible for the transactions. CNA 13 was placed on suspension during an investigation. During a review of the facility's investigation into the incident on 5/21/25 at 11:30 A.M., a facility grievance form, dated 4/30/25, indicated Resident D had a bank statement with unknown charges. Resident D claimed someone used her debit card without her permission. An undated and unsigned, typed, note in the facility investigation indicated on 5/1/25 at approximately 7:00 P.M., Resident D stated she was missing her entire wallet, however a few a items from the wallet were located on her bed. The local police department were called and arrived to the facility. On 5/5/25, a local police detective indicated that CNA 13 was observed on camera with Resident D's debit card. During record review on 5/21/25 at 11:50 A.M., Resident D's diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder.		*been affected by the deficient practice is that* the event that occurred involving the resident identified as resident D and the CNA identified as CNA 13 was thoroughly investigated by the facility and all appropriate agencies (local police and ISDH) were notified in accordance with the regulation. The matter has now been turned over to the local prosecutor for the appropriate legal action. The CNA 13 has been removed from the facility schedule and resident D has had not additional reports of misappropriation of funds. *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 audit of all residents has now been conducted and no other issues related to the misappropriation of funds were identified. *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 conducted for all employees on the facilities resident rights policies and procedures. The staff was re-educated on the fact that only specific key personnel may do shopping business for the residents and only with the resident's direction and approval.	

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	Resident D's most recent quarterly minimum data set (MDS) assessment, dated 4/8/25, indicated the resident had moderate cognitive impairment. During an interview on 5/21/25 at 12:35 P.M., Resident D indicated she had placed her purse at the foot of her bed and fell asleep, when she woke, her wallet and debit card was missing. Resident D indicted she called the local police to report the stolen wallet. She later reviewed a bank statement and noticed several unauthorized purchases made with her debit card. Resident D was unable to determine the total sum of fraudulent purchases, but indicated there were multiple transactions at a local gas station and a paid phone bill that was not hers. During an interview on 5/21/25 at 11:40 A.M., the Facility Administrator indicated the facility did not have a written policy related to shopping or making purchases for residents. The Facility Administrator indicated the CNA's and nursing staff were not permitted to make purchases for residents, and that only department heads or the facility Activity Director could make purchases on a resident's behalf, with the resident's permission. On 5/19/25 at 11:55 A.M., the Facility Administrator supplied an undated facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. The policy included, "All reports of... theft/misappropriation of resident property are reported to local, state and federal agencies..." 3.1-28(a)		Appropriate receipts will be provided to the resident for any purchases that they request. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor this process. The QA tool will monitor to ensure that the resident has in fact requested the specific purchases be made for them and that they have been provided with receipts for each purchase. This tool will be completed by the Social Service Director 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 facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards			

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	Based on interview, and record review, the facility failed to ensure the physicans orders were thoroughly followed and documented when completed for 2 of 3 residents reviewed for nursing services related to wound care. Routine dressing changes and skin assessments were not completed per the physician's orders. (Resident F, Resident G) Findings include: 1. During record review on 5/21/25 at 9:15 A.M., Resident F's diagnoses included, but were not limited to peripheral vascular disease, morbid obesity, and lymphedema. Resident F's most recent admission MDS (Minimum Data Set) dated 3/12/25, indicated the resident had one unhealed venous ulcer. Resident F's physician orders included, but were not limited to, Right dorsal lateral foot: Cleanse with wound cleanser and pat dry, Apply collagen moistened with sodium chloride to wound bed. Cover with bordered foam dressing and apply three layer compression wrap every day shift, Monday, Wednesday, and Friday (started 5/9/25 and discontinued on 5/15/25), Right dorsal lateral foot: Cleanse with wound cleanser. Place collagen dressing as filler to wound bed. cover with alginate dressing. Cover with abdominal pad. Cover with absorbent wound dressing. Wrap with Kerlix (medical gauze). Apply medical tape, then wrap with four layer compression wrap. Wear post-operative shoe for offloading of wound. To bed done three times a week every day shift,	F 0658	F - 658 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F is now receiving their wound care as ordered by their physician. There is documentation in the clinical record on the treatment record indicating that the treatment is being provided as directed by their physician and that the wound is being assessed weekly for any changes. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G no longer has a wound. The area has healed and the treatment order has now been discontinued. *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 currently with any skin wounds has been completed. All residents with any type of skin wound are receiving the necessary wound treatments as ordered by their physician. Weekly skin assessments of all residents are being completed and documented in the clinical records. Any new skin issues will be promptly reported to their physician and appropriate treatment orders	06/13/2025

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	every Monday, Wednesday, and Friday (started 5/15/25), Right medial foot: Cleanse area and peri-wound with wound cleanser, apply alginate border dressing every Monday, Wednesday, and Friday (discontinued 5/15/25), Right dorsal mid-foot: Cleanse area with wound cleanser, cover with Mepilex Transfer (wound dressing), cover with gauze, cover with abdominal pad, wrap with Kerlix and apply medical tape. Wrap with four layer compression wrap. Wound to be offloaded with post operative shoe. Three times a week, every Monday, Wednesday, and Friday (started 5/16/25), and weekly skin assessment every day shift, every Thursday. Resident F's care plan included, but was not limited to, resident has surgical wound on top/dorsal side of foot (initiated 4/19/25) with an intervention of; provide treatment as ordered. Resident F's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2025 lacked documentation indicating the resident received the following orders on the following dates and times: Right dorsal lateral foot: Cleanse with wound cleanser and pat dry, Apply collagen moistened with sodium chloride to wound bed. Cover with bordered foam dressing and apply three layer compression wrap every day shift, Monday, Wednesday, and Friday (started 5/9/25 and discontinued on 5/15/25) - not completed Monday 5/12/25. Right dorsal lateral foot: cleanse with wound cleanser. Place collagen dressing as filler to wound bed. cover with alginate dressing. Cover with abdominal pad. Cover with absorbent wound		obtained and provided in accordance with each individual physician orders. *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 responsibility of monitoring and reporting of the residents' skin condition. The licensed nurses and QMAs were also in-serviced on their responsibility related to skin assessments and providing physician ordered wound treatments in accordance with each resident's individualized plan of care. *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 care and services that are being provided for the resident with a skin condition in accordance with their individualized physician's orders. The tool will monitor to ensure that treatments are being provided as ordered and that weekly skin assessments are 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	

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	dressing. Wrap with Kerlix (medical gauze). Apply medical tape, then wrap with four layer compression wrap. Wear post-operative shoe for offloading of wound. To bed done three times a week every day shift, every Monday, Wednesday, and Friday (started 5/15/25) - not completed Monday 5/19/25. Right medial foot: Cleanse area and peri-wound with wound cleanser, apply alginate border dressing every Monday, Wednesday, and Friday (discontinued 5/15/25) - not completed Friday 5/2/25 and Monday 5/12/25. Right dorsal mid-foot: Cleanse area with wound cleanser, cover with Mepilex Transfer (wound dressing), cover with gauze, cover with abdominal pad, wrap with Kerlix and apply medical tape. Wrap with four layer compression wrap. Wound to be offloaded with post operative shoe. Three times a week, every Monday, Wednesday, and Friday (started 5/16/25) - not completed Monday 5/19/25. Weekly skin assessment every day shift, every Thursday - not completed Thursday 5/8/25. 2. During record review on 5/21/25 at 10:00 A.M., Resident G's diagnoses included, but were not limited to pressure ulcer to right heel, type II diabetes, and edema. Resident G's most recent admission MDS (Minimum Data Set) dated 4/11/25, indicated the resident admitted to the facility with one unhealed stage IV pressure wound. Resident G's physician orders included, but were not limited to; Right Heel: Cleanse with wound cleanser, pat dry. Cover with bordered gauze dressing, initial and date every day shift for wound care (started 4/11/25 and discontinued 4/19/25), Right Heel: Cleanse with wound cleanser,		reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	pat dry. Cover with bordered gauze dressing. Initial and date every day shift for wound care (started 4/20/25 and discontinued 5/20/25), and Check placement of dressing to right heel every shift and replace if not present every shift (started 4/19/25). Resident G's care plan included, but was not limited to; resident has ulcer of the right foot/heel (initiated 4/16/25). Interventions included, but were not limited to, monitor placement of dressing every shift. Replace if soiled/dislodged, and provide treatment as ordered. Resident G's MAR/TAR for April and May 2025 lacked documentation that indicated the resident received the following orders on the following dates: Right Heel: Cleanse with wound cleanser, pat dry. Cover with bordered gauze dressing, initial and date every day shift for wound care (started 4/11/25 and discontinued 4/19/25) - not completed 4/11/25, 4/15/25, and 4/19/25. Right Heel: Cleanse with wound cleanser, pat dry. Cover with bordered gauze dressing. Initial and date every day shift for wound care (started 4/20/25 and discontinued 5/20/25) - not completed 4/20/25, 4/21/25, 4/29/25, 4/30/25, 5/4/25, 5/12/25, and 5/18/25. Check placement of dressing to right heel every shift and replace if not present every shift (started 4/19/25) - 4/20/25 (day shift), 4/21/25 (day shift), 4/29/25 (day shift), 4/30/25 (day shift), 5/4/25 (day shift), 5/12/25 (day shift), 5/14/25 (nightshift), and 5/18/25 (day shift). During an interview on 5/21/25 at 12:30 P.M., the Director of Nursing (DON) indicated some of the uncompleted treatment orders were due to the resident having an order completed by an outside			

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	source, however could not provide a rational for not providing all treatment orders. During an interview on 5/21/25 at 1:20 P.M., LPN 4 indicated a residents routine treatment orders should be documented as completed in the resident's record or if the treatment was not provided, a reason should be documented. On 5/21/25 at 1:25 P.M., the Facility Administrator provided an undated facility policy titled, Medication and Treatment Orders. The policy included, "Orders for medications and treatments will be consistent with principles of safe and effective order writing." This Federal tag relates to complaint IN00458151. 3.1-35(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure adequate pharmaceutical services were available to provide physician prescribed routine treatments for 1 of 3 residents reviewed for pharmaceutical services. A facility did not have a treatment on hand and could not provide proof that the treatment (ointment) had been delivered by the pharmacy. (Resident C) Finding include: During an interview on 5/21/25 at 12:50 P.M., Resident C indicated that he typically received his ordered medications, however he had not been receiving a routine hemorrhoid cream and had asked for multiple times.	F 0755	F - 755 *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 all of their medications and treatments as ordered by their physician. *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. Upon completion of a housewide audit, all currently ordered	06/13/2025

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	During record review, Resident C's diagnoses included, but were not limited to, anxiety, irritable bowel syndrome, and hypertension. Resident C's physician orders included but were not limited to; "2-BAD Cream" Baclofen/Diltiazem/Amitriptyline topical: apply to hemorrhoids twice a day to reduce inflammation/pain related to rectal fissure (started 3/20/25). During an interview on on 5/21/25 at 1:00 P.M., the Assistant Director of Nursing (ADON) indicated Resident C's hemorrhoid cream was not in the medication cart but should be in the treatment cart on the front hall of the building. The ADON indicated that she had not administered the resident's routine dose yet that shift. The ADON then searched the treatment cart and could not locate the resident's hemorrhoid cream. During an interview on 5/21/25 at 1:45 P.M., the Director of Nursing (DON) indicated she was unable to locate a pharmacy delivery receipt for Resident C's ordered hemorrhoid cream. On 5/21//25 at 1:25 P.M., the Facility Administrator supplied an undated facility policy titled, Medication and Treatment Orders. The policy included, "...11. Drugs and biologicals that are required to refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available..." This citation relates to complaint IN00459395. 3.1-25(a)		medications and treatments are now available for each resident in accordance with their individualized physician's orders. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been conducted for all licensed nurses and QMAs on medication/treatment administration. All nurses and QMAs have been re-educated on their responsibility to ensure each resident receives all of their medications/treatments as ordered by their physician. The staff was re-educated on the process that they are to follow if a medication and/or treatment is not readily available at the time of administration. The facility has a backup pharmacy who is available to meet those needs. In addition, the staff was reminded that the physician must be notified if a medication/treatment is not available so that the physician can determine a possible different choice of treatment if needed. This notification will be entered into the resident's clinical record. *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 ensure that each resident is receiving the necessary medications and treatment in	

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			accordance with their current physician's orders and plan of care. 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 facility's Quality Assurance meetings to determine if any additional action is warranted.	