CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	uilding 00		COMPLETED	
		155508	B. WIN	G		05/21/	2025
	ı	CARE OF BOONVILLE STATEMENT OF DEFICIENCIE		725 S S	DDRESS, CITY, STATE, ZIP COD ECOND ST ILLE, IN 47601 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
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Bldg. 00	IN00459395 and IN Complaint IN00459 related to the allega Complaint IN00458 related to the allega Unrelated deficience Survey date: May 2 Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type Medicare: 10 Medicaid: 47 Total: 57 These deficiencies is accordance with 416 Quality review com	2395: Federal/State deficiencies tion(s) are cited at F755. 8151: Federal/State deficiencies tion(s) are cited at F658. ies are cited. 1, 2025 0451 55508 66240 : reflects State Findings cited in	F 000	00	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The far requests the plan of correction considered our allegation of compliance effective June 13, 2025, to the state findings of the Complaint Survey conducted of May 21, 2025.	ic of nese cility be	
F 0602 SS=D Bldg. 00		ropriation/Exploitation and record review, the facility	E 060	12	F - 602		06/12/2025
	failed to ensure resi	dents were free from or 1 of 1 residents reviewed for	F 060	02	The corrective action taken for those residents found to have		06/13/2025

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

(X6) DATE

TITLE

Robin L McCarty Executive Director 06/06/2025

Any defiency statement 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.

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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 B. WING 05/21/2025 155508 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 725 S SECOND ST TRANSCENDENT HEALTHCARE OF BOONVILLE 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 misappropriation. A resident's debit card was been affected by the deficient taken without consent and used by staff to make practice is that the event that multiple unauthorized purchases. (Resident D) occurred involving the resident identified as resident D and the Finding includes: CNA identified as CNA 13 was thoroughly investigated by the During a review of facility reported incidents on facility and all appropriate 5/21/25 at 11:15 A.M., an incident dated 5/2/25, agencies (local police and ISDH) indicated Resident D contacted local police to were notified in accordance with report a stolen debit card. Resident D identified on the regulation. The matter has a bank statement several unauthorized now been turned over to the local transactions. The local police reviewed prosecutor for the appropriate legal surveillance footage from the locations where the action. The CNA 13 has been unauthorized purchases were made that showed removed from the facility schedule CNA 13 had been responsible for the and resident D has had not transactions. CNA 13 was placed on suspension additional reports of during an investigation. misappropriation of funds. The corrective action taken for the During a review of the facility's investigation into other residents that have the the incident on 5/21/25 at 11:30 A.M., a facility potential to be affected by the grievance form, dated 4/30/25, indicated Resident same deficient practice is that all D had a bank statement with unknown charges. residents have the potential to be Resident D claimed someone used her debit card affected by this deficient practice. without her permission. A housewide audit of all residents has now been conducted and no An undated and unsigned, typed, note in the other issues related to the facility investigation indicated on 5/1/25 at misappropriation of funds were approximately 7:00 P.M., Resident D stated she identified. was missing her entire wallet, however a few a The measures that have been put items from the wallet were located on her bed. The into place to ensure that the local police department were called and arrived to deficient practice does not recur is the facility. On 5/5/25, a local police detective that a mandatory in-service has indicated that CNA 13 was observed on camera been conducted for all employees with Resident D's debit card. on the facilities resident rights policies and procedures. The staff During record review on 5/21/25 at 11:50 A.M., was re-educated on the fact that Resident D's diagnoses included, but were not only specific key personnel may limited to, dementia, anxiety, depression, and do shopping business for the psychotic disorder. residents and only with the resident's direction and approval.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOOM	/ILLE, IN 47601		
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
		recent quarterly minimum data			Appropriate receipts will be		
		ent, dated 4/8/25, indicated the			provided to the resident for an	V	
	` ′	ate cognitive impairment.			purchases that they request.	J	
					The corrective action taken to		
	During an interview	v on 5/21/25 at 12:35 P.M.,			monitor to ensure the deficien		
	_	ed she had placed her purse at			practice will not recur is that a	-	
		and fell asleep, when she			Quality Assurance tool has be		
		id debit card was missing.			developed and implement to	CII	
		I she called the local police to			monitor this process. The QA	tool	
		allet. She later reviewed a bank			will monitor to ensure that the	looi	
		ed several unauthorized			resident has in fact requested	the	
		th her debit card. Resident D			specific purchases be made for		
	*	mine the total sum of			1 -		
		es, but indicated there were			them and that they have been		
	_	ss, but indicated there were			provided with receipts for each	1	
	paid phone bill that				purchase. This tool will be		
	pard phone om that	was not ners.			completed by the Social Servi		
	D				Director and/or their designee		
	_	v on 5/21/25 at 11:40 A.M., the			weekly for four weeks, then		
	1	tor indicated the facility did not			monthly for three months and		
	_	cy related to shopping or			quarterly for three quarters. T	ne	
		or residents. The Facility			outcome of this tool will be		
		eated the CNA's and nursing			reviewed at the facility's Quali	-	
		itted to make purchases for			Assurance meetings to detern	ııne	
		only department heads or the			if any additional action is		
		rector could make purchases on			warranted.		
	a resident's behalf,	with the resident's permission.					
	On 5/19/25 at 11:55						
		lied an undated facility policy					
	titled, Abuse, Negle	•					
		Reporting and Investigating.					
	The policy included	-					
		ion of resident property are					
	reported to local, st	ate and federal agencies"					
	3.1-28(a)						
F 0658	402 24/h\/2\/:\						
SS=D	483.21(b)(3)(i)	Most Profession -					
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE SIGNARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MEST BE PRECEDED BY FULL TAG Based on interview, and record review, the facility failed to ensure the physicians 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 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 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 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 from dressing and apply three layer compression was prevery 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 design as filler to wound bed. Cover with	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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Cleanse with wound cleanser. Place collagen wound treatments as ordered by		5/9/25 and discontin	nued on 5/15/25),			1	1	
		Right dorsal lateral	foot:			wound are receiving the neces	ssary	
dressing as filler to wound bed, cover with						wound treatments as ordered	by	
						their physician. Weekly skin		
alginate dressing. Cover with abdominal pad. assessments of all residents are						assessments of all residents a	are	
Cover with absorbent wound dressing. Wrap with being completed and documented						being completed and docume	nted	
Kerlix (medical gauze). Apply medical tape, then in the clinical records. Any new						1	eW.	
wrap with four layer compression wrap. Wear skin issues will be promptly						skin issues will be promptly		
post-operative shoe for offloading of wound. To reported to their physician and			_			1 .	t	
bed done three times a week every day shift, appropriate treatment orders		bed done three time	es a week every day shift,			appropriate treatment orders		

STATEMEN	IT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DAT		(X3) DATE	OATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155508	B. W	· · · · · · · · · · · · · · · · · · ·		05/21/	2025
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD SECOND ST		
TDANCO	CNDENT HEALTH	CARE OF BOONVILLE					
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		BOONV	/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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	every Monday, We	dnesday, and Friday (started			obtained and provided in		
	5/15/25),				accordance with each individu	ıal	
	Right medial foot:				physician orders.		
	Cleanse area and pe	eri-wound with wound			The measures that have been	put	
	cleanser, apply algi	nate border dressing every			into place to ensure that the		
	Monday, Wednesda	ay, and Friday (discontinued			deficient practice does not rec	ur is	
	5/15/25),				that a mandatory in-service ha		
	Right dorsal mid-fo	oot:			been provided for all nursing s		
	Cleanse area with v	vound cleanser, cover with			on their responsibility of		
	Mepilex Transfer (v	wound dressing), cover with			monitoring and reporting of the	е	
	gauze, cover with a	bdominal pad, wrap with Kerlix			residents' skin condition. The		
	and apply medical t	tape. Wrap with four layer			licensed nurses and QMAs we	ere	
	compression wrap.	Wound to be offloaded with			also in-serviced on their		
	post operative shoe	. Three times a week, every			responsibility related to skin		
	Monday, Wednesda	ay, and Friday (started			assessments and providing		
	5/16/25), and week	ly skin assessment every day			physician ordered wound		
	shift, every Thursda	ay.			treatments in accordance with	1	
					each resident's individualized	plan	
	Resident F's care pl	lan included, but was not			of care.	-	
	limited to, resident	has surgical wound on			The corrective action taken to		
	top/dorsal side of fo	oot (initiated 4/19/25) with an			monitor to ensure the deficien	t	
	intervention of; pro	vide treatment as ordered.			practice will not recur is that a		
					Quality Assurance tool has be	en	
	Resident F's Medic	ation Administration Record			developed and implemented to	0	
	(MAR) and Treatm	ent Administration Record			monitor the care and services		
	(TAR) for May 202	25 lacked documentation			are being provided for the resi	ident	
	_	ent received the following			with a skin condition in		
	orders on the follow	ving dates and times:			accordance with their		
		foot: Cleanse with wound			individualized physician's orde	ers.	
	cleanser and pat dry	y, Apply collagen moistened			The tool will monitor to ensure	that	
	with sodium chloric	de to wound bed. Cover with			treatments are being provided	las	
	bordered foam dres	sing and apply three layer			ordered and that weekly skin		
		every day shift, Monday,			assessments are documented	l in	
	Wednesday, and Fr	iday (started 5/9/25 and			the clinical record. This tool w	/ill	
	discontinued on 5/1	5/25) - not completed Monday			be completed by the Director	of	
	5/12/25.				Nursing and/or their designee		
	Right dorsal lateral	foot: cleanse with wound			weekly for four weeks, then		
	cleanser. Place coll	agen dressing as filler to			monthly for three months and	then	
	wound bed. cover v	vith alginate dressing. Cover			quarterly for three quarters. T	he	
	with abdominal pac	d. Cover with absorbent wound	1		outcome of this tool will be		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155508	B. W	ING		05/21	/2025
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			SECOND ST		
TRANSO	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601		
HANSO	LINDLINI HEALID	CALL OF BOOMVILLE		BOOM	, ILLE, IIN 47 00 I		_
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		h Kerlix (medical gauze). Apply			reviewed at the facility's Quali	-	
	* '	wrap with four layer			Assurance meetings to deterr	nine	
		Wear post-operative shoe for			if any additional action is		
	_	d. To bed done three times a			warranted.		
	week every day shi						
	1	riday (started 5/15/25) - not					
	completed Monday						
	_	Cleanse area and peri-wound					
		er, apply alginate border					
		nday, Wednesday, and Friday					
		(25) - not completed Friday					
	5/2/25 and Monday						
	_	oot: Cleanse area with wound h Mepilex Transfer (wound					
		th gauze, cover with abdominal					
		lix and apply medical tape.					
		er compression wrap. Wound					
		h post operative shoe. Three					
		Monday, Wednesday, and					
		6/25) - not completed Monday					
	5/19/25.	(125) - not completed Worlday					
		ment every day shift, every					
	1	ppleted Thursday 5/8/25.					
	l location	1					
	2. During record re	view on 5/21/25 at 10:00 A.M.,					
	_	oses included, but were not					
	_	ulcer to right heel, type II					
	diabetes, and edema						1
	Resident G's most r	recent admission MDS					
	(Minimum Data Se	et) dated 4/11/25, indicated the					
	· ·	the facility with one unhealed					
	stage IV pressure w	vound.					
	Resident G's physic	cian orders included, but were					
	not limited to; Righ	nt Heel: Cleanse with					
	wound cleanser, pa	t dry. Cover with bordered					
	gauze dressing, init	ial and date every day shift for					
	wound care (started	d 4/11/25 and discontinued					
	4/19/25), Right Hee	el: Cleanse with wound cleanser,					1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	· /	JILDING	instruction 00	(X3) DATE : COMPL 05/21/	ETED
	PROVIDER OR SUPPLIEF	CARE OF BOONVILLE		725 S S	ADDRESS, CITY, STATE, ZIP COD ECOND ST (ILLE, IN 47601		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	pat dry. Cover with Initial and date ever (started 4/20/25 and Check placement or shift and replace if 4/19/25). Resident G's care p limited to; resident (initiated 4/16/25). were not limited to, every shift. Replace provide treatment a Resident G's MAR/lacked documentati received the follow dates: Right Heel: Cleanse Cover with bordere date every day shift 4/11/25 and discont 4/11/25, 4/15/25, at Right Heel: Cleanse Cover with bordere date every day shift 4/20/25 and discont 4/20/25, 4/21/25, 4/20/25 (and 5/18/25. Check placement or shift and replace if 4/19/25) - 4/20/25 (day shift), shift), 5/12/25 (day shift). During an interview Director of Nursing uncompleted treatment or shift and replace if 4/19/25 (day shift).	on that indicated the resident ing orders on the following with wound cleanser, pat dry. d gauze dressing, initial and for wound care (started finued 4/19/25) - not completed and 4/19/25. with wound cleanser, pat dry. d gauze dressing. Initial and for wound care (started finued 5/20/25) - not completed finued 5/20/25) - not completed finued 5/20/25) - not completed finued 5/20/25, 4/30/25, 5/4/25, 5/12/25, for dressing to right heel every not present every shift (started fday shift), 4/21/25 (day shift), 4/30/25 (day shift), 5/14/25 (nightshift), and		TAG	DEFICIENCY)		DATE

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155508	A. BUILDING B. WING	00	COMPLETED 05/21/2025
		100000	<u> </u>		00/21/2020
NAME OF F	PROVIDER OR SUPPLIER	t .		FADDRESS, CITY, STATE, ZIP COD SECOND ST	
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE		NVILLE, IN 47601	<u>,</u>
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		uld not provide a rational for	TAG		DATE
	not providing all tre	-			
	indicated a residents should be document resident's record or	on 5/21/25 at 1:20 P.M., LPN 4 s routine treatment orders ted as completed in the if the treatment was not should be documented.			
	provided an undated Medication and Tre included, "Orders for will be consistent w effective order writing				
		ates to complaint IN00458151.			
F 0755 SS=D Bldg. 00	Based on interview failed to ensure aderwere available to proutine treatments f pharmaceutical service treatment on hand a that the treatment (c) by the pharmacy. (Finding include: During an interview Resident C indicate ordered medications	/Pharmacist/Records and record review, the facility quate pharmaceutical services rovide physician prescribed for 1 of 3 residents reviewed for rices. A facility did not have a and could not provide proof pintment) had been delivered Resident C) / on 5/21/25 at 12:50 P.M., d that he typically received his s, however he had not been themorrhoid cream and had	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 medication and treatments as ordered by physician. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents have the potential to affected by this deficient practice upon completion of a housew	ons their tr the f all b be tice.

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155508	B. W	B. WING 05/2		05/21/	/2025	
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R			SECOND ST			
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE			/ILLE, IN 47601			
111/11/100	LIADEINI IIEMEIII	O, II.L OI DOONVILLE		DOOM	, ILLE, IIV 77 00 I			
(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	
	_	ew, Resident C's diagnoses			medications and treatments a			
		not limited to, anxiety, irritable			now available for each resider	nt in		
	bowel syndrome, as	nd hypertension.			accordance with their			
					individualized physician's orde	ers.		
		eian orders included but were			The measures that have been	put		
	not limited to; "2-B				into place to ensure that the			
		/Amitriptyline topical: apply to			deficient practice does not rec			
	hemorrhoids twice				that a mandatory in-service ha	as		
	_	related to rectal fissure (started			now been conducted for all			
	3/20/25).				licensed nurses and QMAs on	1		
					medication/treatment			
	_	v on on 5/21/25 at 1:00 P.M., the			administration. All nurses and	l		
		of Nursing (ADON) indicated			QMAs have been re-educated			
		rhoid cream was not in the			their responsibility to ensure e	ach		
		should be in the treatment cart			resident receives all of their			
		the building. The ADON			medications/treatments as			
		ad not administered the			ordered by their physician. Th	ne		
		ose yet that shift. The ADON			staff was re-educated on the			
		reatment cart and could not			process that they are to follow			
	locate the resident's	s hemorrhoid cream.			medication and/or treatment is			
					readily available at the time of			
	_	v on 5/21/25 at 1:45 P.M., the			administration. The facility ha			
		g (DON) indicated she was			backup pharmacy who is avail			
		harmacy delivery receipt for			to meet those needs. In addit			
	Resident C's ordere	ed hemorrhoid cream.			the staff was reminded that the	е		
					physician must be notified if a			
		P.M., the Facility Administrator			medication/treatment is not			
		d facility policy titled,			available so that the physician			
		eatment Orders. The policy			determine a possible different			
		ugs and biologicals that are			choice of treatment if needed.			
		must be reordered from the			This notification will be entered			
	, ,	ot less than three (3) days			into the resident's clinical reco			
	1 ~	age being administered to			The corrective action taken to			
	ensure that refills a	re readily available"			monitor to ensure the deficien			
	and the state of	1.1 D.100.150205			practice will not recur is that a			
	This citation relates	s to complaint IN00459395.	1		Quality Assurance tool has be			
					developed and implemented to	0		
	3.1-25(a)				ensure that each resident is			
					receiving the necessary			
			1		medications and treatment in			

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

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155508	ĺ	ILDING	onstruction 00	(X3) DATE : COMPL 05/21 /	ETED
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 725 S SECOND ST BOONVILLE, IN 47601				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
					accordance with their current physician's orders and plan of care. This tool will be complet by the Director of Nursing and 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.	ted /or of	

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