

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 24, 25, 26, 27, 30, October 1, 2, 17, 2013</p> <p>Facility number: 002724 Provider number: 155682 AIM number: 200309330</p> <p>Survey team: Terri Walters, RN, TC Martha Saull, RN 9/24-27, 30 &amp; 10/1-2, 2013 Dorothy Watts, RN September 24, 25, 26, 2013 Sylvia Martin, RN September 24, 25, 26, 27, 2013</p> <p>Census bed type: SNF: 15 NF: 28 SNF/NF: 8 Residential: 31 Total: 82</p> <p>Census payor type: Medicare: 15 Medicaid: 28 Other: 39 Total: 82</p>	F000000		
---------	---	---------	--	--

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 21, 2013, by Jodi Meyer, RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure documentation of Medicare Provider Non- coverage notices and appeal rights were provided within the 48 hour time period before therapy services ended for 2 of 3 residents reviewed for notices of Medicare Provider Non-coverage. Resident # 24 and Resident # 77</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 10/1/13 at 10:14 A.M., the Medicare Non Coverage Notice for Resident #77 was reviewed. The Medicare Non Coverage Notice for Resident #77, indicated therapy service would end on 7/20/13. Resident # 77's daughter signed on 7/20/13, that she had received the Medicare Non coverage notice of therapy service ending on 7/20/13. On 10/1/13 at 12:16 P.M., during interview with the Business Office Manager, she indicated she was unaware of the 48 hour notification before ending of Medicare services.</li> <li>On 10/1/13 at 10:20 A.M., the Medicare Non Coverage Notice for Resident # 24 was reviewed. The Medicare Non Coverage notice for</li> </ol>	F000156	<p>Res #24 was provided an explanation of Medicare non-coverage.Completion Date 11-16-13Res # 77 was discharged from the facility.There were no other residents affected and through inservicing will ensure Medicare Provider Non-coverage notices and appeal rights are provided 48 hours before therapy services ends unless resident/family chooses to discharge without notice (which will be noted on the form).Completion Date 11-16-13Business office staff inserviced on requirement of notice to be provided.Completion Date 11-16-13Executive Director will audit Medicare non-coverage log weekly to ensure compliance with requirement of notification. Monthly QA meeting will include the review of the log and cut letters x3 months and quarterly thereafter.</p>	11/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Resident #24, indicated therapy service would end on 8/8/13. Resident #24 signed on 8/8/13, that she had received the Medicare Non coverage notice of therapy service ending on 8/8/13. On 10/1/13 at 12:16 P.M., during interview with the Business Office Manager, she indicated she was unaware of the 48 hour notification before the ending of Medicare services.</p> <p>3.1-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure adequate supervision was provided to a resident with an alarm and recent history of falls for 1 of 4 residents reviewed for falls. Resident #47's fall resulted in a transfer to the emergency room with a small subdural hematoma. Resident #47</p> <p>Findings include:</p> <p>Resident #47's closed record was reviewed on 9/30/13 at 4:00 P.M. On 5/17/13 at 4:50 P.M., Resident # 47 was admitted to the facility. His diagnoses included but were not limited to: iron deficiency anemia, status post hip replacement, and chronic falls. His admission Minimum Data Set Assessment (MDS) dated 5/24/13, indicated a summary score of 14 (cognition intact). He needed extensive assistance of 2 or more staff for transfers. He needed limited assistance of 2 or more staff for ambulation in his room.</p>	F000323	F 323Res #47 no longer resides at the facility and was discharged to home in prior function level. All residents who are fall risk have the potential to be affected by the deficient practice and therefore have been assessed to ensure care plan contains interventions to reduce falls and that these interventions are clearly communicated to staff. Through corrective actions will ensure residents with a history of falls are provided a safe environment and that devices are provided and in use when deemed appropriate. Completion Date 11-16-13 Licensed nurses, CNA's, and QMA's inserviced on: Fall Prevention, what causes falls, common Medical Conditions or Diagnosis contributing to falls, keeping environment safe, providing assistance, being patient with new residents, the natural aging process, things to do to prevent a fall again, and final tips on ways to help decrease the risk of falls. Inservicing included assignment sheet information for individualized interventions and rounding in rooms to address comfort, pain, toileting needs and	11/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>His care plan with an initiation dated of 10/20/11(used from previous facility admissions) indicated a history of falls and potential for falls. Interventions included but were not limited to: bed in low position, walker, wheelchair, and occupational and physical therapy.</p> <p>A facility fall circumstance, assessment, and intervention form dated 6/7/13, indicated a fall had occurred on 6/7/13 at 12:35 P.M. Documentation indicated the fall had occurred in the resident's room and the resident had been found on the floor. The activity documented at the time of the fall was that the resident was transferring his self. New interventions after the fall were to move urinal within reach and to add a bed and chair alarm.</p> <p>A nursing progress note dated 6/10/13 at 11:55 P.M., indicated, "CNA walking in hallway observed resident fall backwards &amp; strike head on floor. Was unable to reach him in time to intervene. Manual cervical traction applied. I could feel hematoma on back of head It (left) side &amp; visualized laceration et (and) back of head. Resident was non responsive approx (approximately) 2</p>		<p>safety inspection of roomCompletion Date 11-16-13Systemic change is to have residents with alarms on hourly rounding checks with specific focus on fall prevention interventions on assignment sheet and those that are at risk identified on assignment sheet with general fall prevention guidelines available for staff to use. Completion Date 11-16-13DHS/Designee will audit random residents with alarms and C.N.A. assignment sheets to ensure fall prevention interventions and rounding is in place for 4 residents/day for 4 weeks, 4 residents/week for 8 weeks and 4 residents monthly thereafter.Results of monitoring will be forwarded to QA committee monthly x12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>minutes when began to respond, was slow @ first but quickly became alert, oriented &amp; appropriate c (with) responses. PEARL (pupils equal and react to light) bil.(bilateral) Grasp= bil &amp; strong. C (cervical) spine stabilization continued manually until EMS arrived. Dr. (physician's name) triage notified, order received..."</p> <p>A nursing progress note dated 6/10/13 at 12:15 A.M., indicated, "EMS departed facility to (name of hospital) hospital..."</p> <p>On 9/30/13 at 4:10 P.M., the Director of Nursing Services (DON) was interviewed. She indicated the resident was admitted on 5/17/13 from the hospital. She indicated according the nursing admission assessment (5/17/13) he was alert and oriented on admission. The DON indicated the resident on admission was to use a walker and wheelchair. She indicated the resident had received therapy on admission and used 1/2 side rails. The DON stated he had a history of falls and required the assist of 2 staff with transfers.</p> <p>The DON indicated regarding the 6/7/13 fall the resident had reached for the urinal and fell. She indicated new interventions after the 6/7/13 fall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>were to apply bed and chair pressure alarms and give the resident a urinal. The DON stated the resident did not have any injuries from the 6/7/13 fall.</p> <p>The DON stated his next fall occurred on 6/9/13 at 11:55 P.M. She indicated the resident had been restless and lost his balance and was sent out to the hospital. The DON indicated the alarm had been sounding at the time of the fall. The DON indicated the resident's alarm was sounding but staff was unable to get to the resident in time. She also indicated the resident should not have been up by himself without assistance.</p> <p>A hospital Discharge Summary dated 6/14/13, indicated final diagnoses: status post fall, very small subdural hematoma, and hyponatremia.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication administration error rate did not exceed 5% for 3 of 29 medication administration opportunities observed, which resulted in an error rate of 10.34%. Resident #27</p> <p>Findings include:</p> <p>On 9/30/13 at 8:45 A.M., LPN #2 was observed to prepare insulin medication for Resident #27. LPN #2 indicated at the time, she was going to prepare the insulin "Novolog 10 units." At the time, LPN #2 read the physician order from the MAR (medication administration record). The physician order on the MAR indicated the following: "Novolog Flexpen...inject 10 units...before meals..." At the time, LPN #2 indicated Resident #27 had already eaten his breakfast. The resident was observed to be sitting in the hall in his wheelchair (wc) and indicated he was on his way to therapy.</p> <p>At the time, LPN #2 was observed to</p>	F000332	<p>F 332Resident #27 suffered no ill effects from the medication error and through observation of medication passes and inservicing will ensure medications and insulin are administered as ordered.Completion Date 11-16-13All residents receiving medication have the potential to be affected by the alleged deficient practice and through inservicing and observations will ensure insulin and medications are given as ordered. Completion Date 11-16-13LPN #2 has completed medication administration course and will have 5 med pass observations completed by a nurse manager. Completion Date 11-16-13All other staff that pass medications will be inserviced on insulin administration and general medication administration guidelines. Completion Date 11-16-13 DHS/designee will: perform medication pass audit monthly for 6 months and then quarterly, observe 2 random residents for proper insulin administration daily for 2 weeks then one time weekly for one month then continue with pharmacist audits monthly. Results of audits will be</p>	11/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>pick up the vial of "Novolin R" insulin and indicated she was going to draw up 10 units of "Novolog insulin." At the time, LPN #2 was interviewed regarding "Novolin R" being the same insulin and/or interchangeable as/with "Novolog." LPN #2 indicated at that time, she would call the pharmacy to verify the insulins (Novolin R and Novolog) were or were not the same. At 9:05 A.M., LPN #2 called the pharmacy. LPN #2 indicated the pharmacy indicated Novolin R and Novolog were not the same. LPN #2 was unable to locate Novolog insulin in the medication cart at the time.</p> <p>At the time, LPN #2, went to the medication room to get the insulin "Novolog." LPN #2 removed the insulin "Humalog" from the EDK (emergency drug kit). LPN #2 stated at the time, "I'm sure Humalog and Novolog are the same insulins." At the time, LPN #2 drew up 10 units of insulin from the "Humalog" vial.</p> <p>At 9:10 A.M., LPN #2 indicated Resident #27's blood sugar "this morning" had been 298." She indicated the resident also had SSI (sliding scale insulin) coverage. LPN #2 reviewed the physician order in the MAR and indicated for a blood sugar of 298, the resident was to have</p>		forwarded to QA committee monthly x6 months and then quarterly for review and further suggestion..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>received 6 units of Novolin R. She then drew up 6 units of Novolin R insulin.</p> <p>At 9:15 A.M., she assisted the resident back to his room and gave him the 3 separate insulin injections.</p> <p>On 9/30/13 at 10 A.M., LPN #2 was interviewed. She indicated during the medication pass, prior to being interviewed, she was going to draw up the "Novolog" insulin dose from the "Novolin R" vial.</p> <p>On 9/30/13 at 10:40 A.M., Resident #27 was interviewed. He indicated he ate his breakfast today before he received his insulin. He indicated he was feeling fine at this time.</p> <p>The Diabetic Monitoring Flow Sheet indicated on 9/30/13, the resident's blood sugar at 11:30 A.M., was 111.</p> <p>On 9/30/13 at 12:15 P.M., the DON (Director of Nursing) was interviewed. She indicated the resident did have a Novolog flex pen in the med cart and the nurse did not need to get the Humalog from the medication room. The DON indicated LPN #2 must have overlooked the Novolog flex pen in the medication cart. The DON indicated at the time, LPN #2 should</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>have used the Novolog flex pen instead of the Humalog she got out of the medication room. The DON indicated Humalog and Novolog insulins were not interchangeable per the pharmacists.</p> <p>At the time, the DON provided a copy of the current "Diabetic Monitoring Flow Sheet." At the time, the form was reviewed. The DON indicated this form had documented on it the time the BS (blood sugars) were done but not specifically the time the insulin was given. The form indicated on 9/30/13, at 6:30 A.M., the resident's blood sugar was 298. Documented on the same line on the form, was "Insulin Administered, Type/Amount: Nov (Novolin R), 6 u (units)." Documentation was lacking as to the specific time the Novolin R insulin was administered (9:15 A.M.). At the time, the current MAR was reviewed. The MAR indicated for "Novolin R..." SSI coverage. "See Diabetic Monitoring flow sheet for results." Documentation indicated nursing did "initial" daily when the SSI coverage is completed.</p> <p>At the time, the DON indicated the nurses document on the MAR, the time the meds were given "all upon rising meds." Documentation for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>9/30/13 indicated the "All upon rising meds (medications)" were documented as given at 8:30 A.M.</p> <p>On 9/30/13 at 12 P.M., the DON provided a copy "Insulin Products." The information had a copyright of 2013. The DON indicated the pharmacy stated the insulins Humalog and Novolog are NOT interchangeable at that time but both are considered rapid acting insulins. The form indicated "Rapid-acting" insulins were listed as Humalog and Novolog. The form listed the "onset" of Humalog insulin as 0.25 - 0.5 hour and Novolog as 0.2 - 0.3 hour. The peak glycemic effect for Humalog was listed as 0.5 - 2.5 hour and Novolog was 1 - 3 hour. The "short-acting" insulins, included but were not limited to, "Novolin R." The form indicated the "onset" of short acting insulins as 0.5 hour and the peak glycemic effect was 2.5 - 5.0 hour.</p> <p>On 9/30/13 at 3:15 P.M., the DON provided a copy of the policy and procedure for "Medication Administration Times Procedural Guidelines." The policy was dated November 2011. The policy included, but was not limited to, the following: "...The nurse administering the medications shall record the time the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	medication was administered along with his/her initials..."  3.1-25(b)(9)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F000364	F 364Resident # 200, #201, and #202, suffered no ill effects from the alleged allegations.Completion Date 11-16-2013All residents have the potential to be affected by the deficient practice and through alterations and in-services the campus will ensure each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and the proper temperature.Completion Date 11-16-2013 An in-service was provided to nursing and dietary staff on ensuring timely distribution of meals to residents being served on the halls for management of appropriate meal temperatures. Systemic change is the heated food cart should go from hall to hall and be plugged in each hall. Taking one resident tray out at a time to match it up with the dry tray preparation (ensuring the door to the heated cart is closed afterward). Cold food will be placed under storage container portion of cart to maintain temperature below 41 degrees. Taking one resident tray out at a time to match it up with	11/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Based on observation and interview, the facility failed to ensure meal temperatures, of residents who ate in their rooms, were served at a palatable temperature for 1 of 2 meals observed and/or temperatures checked.</p> <p>Resident # 200, Resident #201, Resident #202</p> <p>Findings include:</p> <p>On 9/24/13 at 12:33 P.M., Resident #200 was interviewed confidentially. Resident #200 indicated when she eats in her room, the food is cold.</p> <p>On 9/24/13 at 12:41 P.M., Resident #201 was interviewed confidentially. She indicated when she eats the evening meal in her room, the food is</p>		<p>the dry tray preparation. These changes are implemented to assure resident meals are served at the appropriate temperature. Completion Date 11-16-2013 DFS/designee will monitor 3 resident meals to assure food is served at the proper temperature 5 x a week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 11-16-2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>not hot.</p> <p>On 9/24/13 at 12:57 P.M., the meal tray cart was observed at the end of the 300 hall. The door to the cart was observed to be opened with undisturbed, prepared trays observed on the cart. At 1:06 P.M., the ADON (Assistant Director of Nursing) was observed putting plates covered with a dome lid, from another insulated, closed tray cart. The cart, which housed the covered plates, had just been brought to the hall by the kitchen staff. The ADON was observed to put the domed, covered plates from the insulated cart to the other cart that had the door open. When all the domed covered plates had been moved to the cart housing the trays, the ADON then closed the door and began passing the trays.</p> <p>At 1:08 P.M., the ADON was interviewed. She indicated the Dietary staff brought the domed covered entrees out from the kitchen later as it "saves them from having to heat them (the food) up." The staff was observed to first pass the hall trays to resident's on the 300 hall, then the 200 hall and lastly the 100 hall.</p> <p>At 1:20 P.M., the last tray passed on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the 100 hall had the temperatures checked with the food on the tray. A slice of ham, 1/4 inch thick, had the facility provided thermometer inserted into the thickness of ham. The ADON read the temperature of the ham to be 113 F (Fahrenheit). The ADON read the temperature of the sweet potatoes to be 113.2 F and the cooked broccoli was read at 107 F, per the ADON, with the same thermometer. The ADON stated this was an extra tray and all the other trays on the hall had been passed at the time.</p> <p>On 9/25/13 at 12:05 P.M., a large covered cart was brought to the end of the 300 hall. At 12:37 P.M., the meal cart with the covered entrees, was brought to the hall by Dietary Staff #1. At the time, Dietary Staff #1 was interviewed. She indicated the Dietary Staff brought down with the "desserts and cold items" on the first cart and then brought down the entrees/hot foods later in an insulated cart so the "food stays hot."</p> <p>On 9/25/13 at 12:17 P.M., a confidential interview was conducted with Resident #202. She indicated sometimes her lunch and supper are cold. She indicated sometimes she has to wait a long time to get her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>food.</p> <p>On 10/1/13 at 9:30 A.M., the FSM (Food Service Manager) provided the following information: "Policy for Dining Room and Meal Service." The policy was revised in 2009 and included, but was not limited to, the following: "...Food...temperatures will be taken prior to meal service." The Policy and Procedure for "Food Temperatures-Serving Line." The policy was revised 7/2013 and included, but was not limited to, the following: "Hot foods in the steam table are maintained at or above 135 degrees Fahrenheit so that items arrive at palatable temperature when the resident is served. Exceptions include foods such as hot breads, bacon and eggs." The policy and procedure for "Hot and Cold Temperature Holding Guidelines" was reviewed at this time. The policy was dated revised 12/2012 and included, but was not limited to, the following: "...Hot food in the steam table should be at least 135-140 degrees Fahrenheit and arrive approximately at great than or equal to 120 degrees Fahrenheit when the resident is served. This is a guideline as certain foods like hot breads and eggs will not be this hot..."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>On 10/1/13 at 10:46 A.M., the FSM (Food Service Manager) was interviewed. He indicated the food temperatures were checked when the food was put on the steam table and prior to tray service starting. He stated they wanted the temperatures to be at least 145 degrees F. He was made aware at the time of resident complaints on the halls that the food was cold when served.</p> <p>3.1-21(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure dietary equipment was clean and/ or food sanitation practices were in place for 3 of 3 kitchen observations. This had the potential to affect 51 of 51 residents who resided at the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 9/24/13 at 8:30 A.M., on initial tour of the kitchen the hand sink in the front of the kitchen had food spills and mineral build-up. The tan plastic trash container next to the sink had a large amount of accumulated brown staining and/ or dried food spills. A trash bag or liner was missing in the trash container.</li> <li>The food storage room was toured next on the initial kitchen tour. Four stacked cardboard boxes containing coke products were observed to be stacked on the floor. The Food</li> </ol>	F000371	<p>F 371No residents were adversely affected by the alleged deficiency.Completion Date 11-16-2013All items identified on the 2567 have been cleaned. All dietary employees have been in services on sanitizing food prep surfaces and daily completion of job duties to include cleaning scheduled items on an ongoing and consistent basis.Completion Date 11-16-2013The systemic change is that the dietary manager will bring the cleaning schedule to morning meeting and review with executive director the completed schedule for the previous day, ED/designee will complete a sanitation report in the kitchen 5x a week for 3 weeks, 3x a week for a month then weekly with results forwarded to QA committe montly X6 months and quarterly thereafter for review and further suggestions/comments.Completi n Date 11-16-2013</p>	11/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Service Manager (FSM) indicated the coke products should not be placed on the floor. He began moving the boxes of the floor on to shelving in the room. Three large plastic containers were observed to contain oats, sugar, and flour. All 3 of these containers had lids that were soiled with food particles and sticky to touch.</p> <p>3. On 9/27/13 at 7:50 A.M., the steam table in the main dining room was observed. Two of the four compartments had white and green food particles floating in a small amount of water.</p> <p>4. On 9/27/13 at 9:55 A.M., in the food storage room, three large containers of flour, sugar, and oats were observed. The lids of those containers continued to be soiled with a large amount of food particles and sticky to touch.</p> <p>5. On 9/27/13 at 10:00 A.M., the tile floor in the kitchen area next to the ice machine had soilage of a wet black substance on the grout and flooring under one side of the ice machine and under 4 canisters of CO2 (carbon dioxide). The soiling was approximately 12 x 24 inches.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>6. On 9/30/13 at 8:35 A.M., the food storage room was toured. The large plastic container with sugar had been left open approximately 2 inches. The 3 plastic containers of flour, sugar, and oats, continued to have a sticky film of flour, oats, and sugar, on the lids.</p> <p>7. On 9/30/13 at 8:50 A.M., in the kitchen a metal shelving unit container 3 shelves of spices in plastic containers. The plastic spice containers had soiling of spice particles and dust. Two of the spices, cumin and white pepper, had been left open. The shelving unit also contained a large cookie sheet pan which contained a large bottle of honey, a shaker container with powdered sugar (lid soiled with powdered sugar), and a large container of soy sauce and a small salt shaker that were over turned on the tray with spills of salt and soy sauce noted throughout the tray. At that time dietary staff #2 was made aware of food spills on tray and removed the tray from shelving for cleaning. Also at that time the other hand sink in the kitchen was observed to have corrosion and soiling. Food spills and particles were observed on the bowl of the sink and in the sink drain. The caulking which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>attached the hand sink to the wall was soiled brown. The tan plastic trash can next to the sink had numerous brown food spills on the lid's surface.</p> <p>8. On 9/30/13 at 9:25 A.M., three of four steam table compartments on the steam table in the main dining room were uncovered. Orange, white, and green food particles were observed floating in a small amount of water in these 3 compartments.</p> <p>9. On 9/30/13 at 9:35 A.M., during interview with the FSM, he indicated he was aware of the kitchen hand sink on the initial tour of the kitchen being soiled and without a trash can liner. He indicated he had scrubbed the trash container with bleach and added a trash can liner. At that time the FSM was made aware of the other hand sink in the kitchen with food soiling in drain area and the trash can with numerous food spills on the lid. He indicated at that time the sink and trash container were soiled and needed cleaning. Also at that time the FSM was made aware of the black soiled area of the kitchen floor under the ice machine and under the CO2 canisters and of 4 clean glass carafes lying on the floor behind the CO2 canisters. The FSM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>indicated at that time the floor area needed to be cleaned and the carafes removed off the floor and washed.</p> <p>10. On 9/30/13 at 11:12 A.M., a sink in the stainless steel island food preparation area was observed to be soiled. A brown soil build up was observed on the sink's base and facet handles. The FSM was made aware of the soilage and began to clean the facet area. The bottom metal shelf of the food preparation island and the bottom shelf of the steam table in the kitchen were observed to be soiled. When a hand was swiped across the shelves, black soil and dust were observed. The island shelf contained boxes of plastic wrap and the steam table shelve was used to store clean pans and coffee mugs. The FSM was made aware of the soilage on the shelves. He indicated he had staff clean last week.</p> <p>11. On 9/30/13 at 4:25 P.M., evening dietary staff #1 was observed placing pans of food on the steam table in the main dining room. All 4 compartments of the steam table were visible and food particles of orange, white, and green (including a green bean) were observed in the steam table water. Dietary staff #1 was made aware of the food particles</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>in the steam table water. She indicated she would clean steam table tonight after the supper meal.</p> <p>On 10/1/13 at 11:00 A.M., the FSM was interviewed regarding kitchen sanitization. He provided cleaning schedules for the kitchen. He indicated the evening cook does the cleaning of the main dining room steam table. The P.M. cook cleaning schedule listed "delime steamer" on the first day of the month. The A.M. Aides duties included daily "dining room(S) steam tables." The FSM indicated at that time that steam tables should be cleaned as needed if food particles were present. He also indicated at that time that green beans had been served to the residents on Sunday 9/29/13.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and</p>	F000441	Residents suffered no ill effects from the findings on the 2567	11/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>record review, the facility failed to ensure multiple use glucometers, were adequately sanitized and decontaminated for 1 of 1 observations of glucometer usage.</p> <p>Findings include:</p> <p>On 9/24/13 at 4:10 P.M., LPN #1 was observed at the medication cart in the 100 unit hall. He was observed to take a glucometer from the 100 hall med cart. At the time, he was observed to clean the glucometer with an alcohol wipe and then covered it was a Kleenex. He indicated he was going to do a glucometer check shortly.</p> <p>At the time, LPN #1 was interviewed. He indicated he had just cleaned the glucometer with an alcohol wipe as the glucometer was used to check blood sugars on multiple residents. He indicated after he completed the glucometer check on the resident, he would then clean the glucometer again with an alcohol wipe. LPN #1 indicated there were also bleach wipes on the medication carts and he thinks they were told they could use either the bleach wipes or the alcohol wipes. LPN #1 indicated he thought bleach wipes are more sanitary. LPN #1 was instructed at that time to</p>		<p>related to glucometer sanitation and decontaminated through inservicing and observations will ensure corrective actions to prevent the spread of infection are followed. Completion Date 11-16-13 LPN #1 will have directed in-service with infection control procedures and return demonstration of glucometer cleaning. Completion Date 11-16-13 All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing will ensure corrective actions to prevent spread of infection are followed. Completion Date 11-16-13 Nursing staff will be in-serviced on proper glucometer cleaning to prevent spreading of infection. Nursing staff will have return demonstration of sanitizing procedures. Completion Date 11-16-13 DHS/Designee will monitor glucometer use and cleaning techniques 5xweek for 3weeks, 3xweek for 2 months and then weekly. Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/17/2013	
NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>check with the DON (Director of Nursing) regarding cleaning of the glucometers before and after use. LPN #1 indicated there was one glucometer stored on each medication cart.</p> <p>On 9/24/13 at 4:18 P.M., the DON was interviewed. She stated the facility does use the PDI (Professional Disposable International) wipes to clean the glucometers with and she clarified that with LPN #1. At the time, the DON stated that they currently had no residents in the building with HIV (Human Immunodeficiency Virus) or Hepatitis. The DON indicated at the time, LPN #1 should have cleaned the multi use glucometer with the PDI (Professional Disposable International) wipes before and after use and not the alcohol wipes.</p> <p>On 9/27/13 at 8:40 A.M. a copy of the current policy and procedure for "Glucometer Cleaning Guidelines" was received from the DON (Director of Nursing). The policy was undated. The policy included, but was not limited to, the following: "...The following recommendations provide the guidance for cleaning and decontamination of glucometers that may be contaminated with blood and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155682	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODMONT HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>body fluids...HBV (hepatitis B virus)/HIV (human....virus) label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration. (Note: recommend the Sani-cloth bleach wipes by PDI...Alcohol should not be used because it can damage the light emitting diodes (LED) readout, causing "fogging" of the plastic screens. Alcohol is also not an EPA-registered detergent/disinfectant..."</p> <p>3.1-18(b)</p>			