

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  07/31/2012
--	---	--	---

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 PERCEDED 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
F0000	<p>This visit was for a Recertification and State Licensure Survey</p> <p>Survey dates: July 23, 24, 25, 26, 27, 30 &amp; 31, 2012</p> <p>Facility number: 002724 Provider number: 155682 AIM number: 200309330</p> <p>Survey team: Terri Walters, RN-TC 7/23, 7/25, 7/26, 7/27, 7/30, 7/31, 2012 Carole McDaniel, RN 7/23, 7/25, 7/26, 7/27, 7/30, 7/31, 2012 Martha Saull, RN Dorothy Watts, RN</p> <p>Census bed type: SNF: 12 SNF/NF: 41 Residential: 32 Total: 85</p> <p>Census payor type: Medicare: 12 Medicaid: 26 Other: 47 Total: 85</p> <p>Residential sample: 8</p>	F0000		

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  07/31/2012
--	---	--	---

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 PERCEDED 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 reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 7, 2012 by Bev Faulkner, 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  07/31/2012	
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			
F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to respond to call lights in a timely manner for 3 of 20 residents interviewed. Resident #57, Resident #6, Resident #19</p> <p>Findings include:</p> <p>On 7/23/2012 at 9:41 A.M., Resident #57 indicated that sometimes during the night she has had to wait up to an hour for a response to her call light. She stated that after waiting 40 minutes for a CNA to respond to her call light, she called the nurses station requesting bathroom assistance. The staff person that answered the phone told the resident not to call on the phone again.</p> <p>On 7/24/2012 at 12:05 P.M., Resident #6 indicated more staff were needed on all shifts. The resident indicated call light response times frequently take 15 to 20 minutes, and sometimes as long as an hour. Resident #6 indicated that on one occasion, after waiting 45 minutes for</p>	F0241	<p>This Plan of Correction for Survey Event ID J21P11 is submitted under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Furthermore, we request this 2567 (Plan of Correction) serve as our credible allegation of compliance.</p> <p>Listed below are the actions we implemented to comply with Survey Event ID J21P11 for correction of: F 241 ss=D - Individuality, F 371 ss=F - Food Procure, Store/Prepare/Serve - Sanitary, F 428 ss=D -Drug Regimen Review, Report Irregular, Act On R 091 - Administration and</p>	08/30/2012			

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  07/31/2012	
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 CNA to respond, she called the nurses station on her phone and asked to be assisted to the bathroom.</p> <p>On 7/30/2012 at 11:00 A.M., Resident #19 indicated two weeks earlier she awoke during the night feeling dizzy and experiencing a headache. Concerned, she used her call light to request a nurse check her blood pressure. A CNA responded and said a nurse would be in soon. The resident indicated it took 45 minutes for the nurse to come to her room and check her blood pressure. Resident # 19 indicated the staff had tried to improve the response times, and for awhile the response times had improved, but after awhile the staff backslide, and it had taken a long time to get someone to respond. The resident indicated that last night she turned the call light on to request bathroom assistance. After 20 minutes, there was no staff response, so she walked to the bathroom by herself. The CNA arrived later and asked if assistance was needed.</p> <p>On 7/30/2012 at 3:30 P.M., the Director of Health Services (DHS) indicated during an interview there are some residents who call the nurses' station by telephone and request assistance. The DHS</p>		<p>Management - Non Compliance</p> <p><b>Health Center</b></p> <p><b>F 241 - Immediate Action -</b> An in-service started on 7/31/2012 to communicate concerns from ISDH upon exit from facility.</p> <p><b>F 241 - Review of Residents</b> Resident # 6,19, and 57 suffered no ill effects from the alleged deficiency. No other residents were adversely affected by this action as it relates to ensure the campus promotes care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <b>Completion Date 8-30-2012</b></p> <p><b>F 241 - On Going Corrective Action</b> Through alterations in processes and in servicing will ensure the campus promotes care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All employees have been in serviced on answering call lights and leaving the light on if the employee is unable to meet the resident's need until the appropriate staff is available to assist.</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 07/31/2012	
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 sometimes a CNA would be busy helping a resident when another resident would call for assistance. The CNA would turn the call light off and tell the resident she would return to help after she had finished. The DHS indicated two inservices had been conducted about call light response times.</p> <p>Resident Council Meeting Minutes, dated 2/16/2012, were reviewed on 7/30/2012 at 3:38 P.M., and indicated call lights were a concern. The Resident Council Minutes, dated 3/20/2012, indicated the Director of Health Services had an inservice and meeting with staff regarding the call lights.</p> <p>Interview with DHS on 7/30/12 at 4:00 P.M., she indicated they had an inservice twice on this issue. The facility found the problem was the CNA would respond to the call light, turn it off, and go finish the task they were involved in at the time. The task may take longer than anticipated. Since they turned the call light off no one else will know to respond . We inserviced on 3/15/2012 and still had some complaints again during the resident council president meeting, so we had inservice again on 3/21/2012.</p>		<p><b>Completion Date 8-30-2012</b></p> <p><b>F241 - On Going Monitoring -</b> The Systemic change is that the campus will complete random timed call light tests every week. DHS/designee will question 2 random residents concerning timeliness of answering call lights 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. <b>Completion Date 8-30-2012</b></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  07/31/2012
--	---	--	---

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>An "In service Training Class Report," dated 3/15/2012 and 3/21/2012, were reviewed on 7/30/2012 at 4:00 P.M. The report indicated the following concerns were addressed: Call light expectations, everyone (all departments) were responsible to answer call lights. Staff were to answer and then leave the light on if they could not complete the task at that time.</p> <p>On 7/31/2012 at 9:42 A.M., a family satisfaction survey provided by the DHS for Resident #40, dated 7/26/2012, had a note written indicating sometimes the alarms and lights were ringing for a long time.</p> <p>During on interview on 7/31/2012 at 9:00 A.M.,the DHS said,"we follow up on our inservices during the resident council meetings and periodic questionnaires, we don't time response lights anymore. We used to, but not anymore."</p> <p>3.1-3(t)</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  07/31/2012	
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			
F0371 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, record review and interview, the facility failed to ensure sanitation practices during food preparation, service and storage for 2 of 2 kitchen tours. This had the potential to impact all 52 residents receiving food and beverages from this kitchen.</p> <p>Findings include:</p> <p>1. On 7/23/12 at 8:40 A.M., during the first kitchen tour the following were observed: Cook #1 was in the main food prep area beginning to cook the noon meal. The prep area was littered over with food debris and containers from the breakfast meal. The area was soiled with brown sugar, a smear of butter, cinnamon and flour. The cook placed two unskinned raw onions, 2 green peppers and an open bag of frozen spinach on the debris littered prep counter. She indicated she was going to make creamed spinach for lunch, but it was a little too soon. She</p>	F0371	<p><b>F 371- Immediate Action -</b> All items identified on the 2567 have been cleaned. All dietary employees have been in serviced on testing sanitizing solutions, food prep surfaces, identifying appropriate wash temperatures, personal items in the kitchen, kitchen dress code, cleaning of the beverage dispensers, and general cleaning schedules of the kitchen. Cook #1 was terminated r/t violation of policy and procedure. <b>Completion Date 7-30-2012</b></p> <p><b>F 371 - Review of Residents -</b> All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus procures food from sources approved or considered satisfactory by Federal, State, or local authorities and stores, prepares, distributes, and serves food under sanitary conditions. No residents were adversely affected by the alleged deficiency practice. <b>Completion Date 8-30-2012</b></p>	08/30/2012			

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  07/31/2012	
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>took the open bag of spinach, with its food soiled bottom, into the refrigerator. She had 4 dry rags scattered in her area that she was observed to use during cooking. There were two on the food prep surface, one on the steamer top and one on the stainless counter beside the stove. The rags were soiled with eggs and oatmeal from breakfast.</p> <p>There was a rag in the food contact sanitizing solution that had not been used.</p> <p>The cook was observed testing the solution inaccurately 2 of 2 times by dipping testing strips and reading them at 7 seconds and 8 seconds. The Manufacturer's direction on the test tape container was to dip for 10 seconds.</p> <p>Dietary aide (DA) #1, who was assisting in the food preparation, was observed to be wearing a wrist watch which she periodically adjusted with her hand. She was also running soiled loads through the dishwasher. When asked how she knew if the dishwasher was performing at required temperatures, she was able to locate the temperature dial for the rinse cycle and could not identify the wash cycle dial. The "W" remained visible but the "ash" was worn off.</p>		<p><b>F 371 On Going Corrective Action</b> All items identified on the 2567 have been cleaned. All dietary employees have been in serviced on testing sanitizing solutions, food prep surfaces, identifying appropriate wash temperatures, personal items in the kitchen, kitchen dress code, cleaning of the beverage dispensers, and general cleaning schedules of the kitchen. <b>Completion Date 8-30-2012</b></p> <p><b>F 371 On Going Monitoring -</b> The Systemic change is that the dietary manager will bring the cleaning schedule to morning meeting and review with Executive Director that the schedule complete for the previous day. ED/designee will complete a sanitation report in the kitchen 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. <b>Completion Date 8-30-2012</b></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  07/31/2012	
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 Food Service Director (FSD) was interviewed at 9:00 A.M., and he indicated all the DAs were trained on the dishwasher use and should be able to check the temperatures. He indicated the dietary department was at full staff and functioning as usual. He indicated the staff were responsible for the cleaning of the kitchen and contents with specific assignments which were logged as completed.</p> <p>As the tour continued at 9:10 A.M., the following was observed: There were two stainless steel handwash sinks both of which had a heavy oily coating, brown soiled, jagged, white caulking and soiled faucets, which left an oily substance on hands that remained after towel drying. Each had a white hand towel dispenser which had soiled gray edges. In the area of the sink, on the wall against the FSD office, there was a food prep counter with a can opener attached to the edge near the sink. As staff washed their hands, the water was splashing onto the can opener. Above the sink there was a stainless steel shelf. The underside was dark yellow- brown with oil beads forming along the edge. On the shelf there was a fan laden with oily dust, 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  07/31/2012
--	---	--	---

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>heavily soiled CD player and graduated plastic cooking pitchers. The fan was blowing air across the clean area in which a dirty cart had been parked. The cart had food from post meal plate scraping smeared around the top edges. The flow of air from the fan ran over the scraped food and onto a cart of clean goblets with folded napkins set in each goblet.</p> <p>The exterior and interior cabinet of the microwave had food accumulation and was tacky to the touch. Clean menus, destined to go for resident's trays, were set on top the microwave. All handles and drawer pulls were heavily soiled with tacky food build-up. Refrigerator handles and the primary touch surfaces on both sides of the main door to the kitchen were heavily soiled. The door was located between the kitchen and dining room and used by staff of all disciplines.</p> <p>The ice machine had accumulated turquoise water deposits forming chunks in crevices which had fallen into the ice scoop holder. The interior cabinet had a white plastic horizontal guard which had formations of slimy, charcoal gray/black matter in patches. The same character growth was</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  07/31/2012
--	---	--	---

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>noted in vertical streaks on both sides of the interior cabinet walls, extending up from the ice.</p> <p>There was a beverage dispenser with 5 of 5 spouts having an accumulation of black matter on and around the base of each. The same black matter was noted accumulated in the overspill tray and moist surfaces of the machine.</p> <p>The plastic coffee canister drawers located between the beverage machine and iced tea machine were heavily soiled and tacky to the touch.</p> <p>The iced tea machine lid was off and there was tan dry matter accumulated at the liquid line and flaking onto the surface of the tea.</p> <p>There were 2 of 2 garbage barrels whose outside surfaces were laden with dried food and spatters.</p> <p>The drain beneath the dishwasher emptied onto the floor near the drain and partially pooled at the floor drain grate. There was an accumulation of matter and debris on the grate including a round flat lid like object and a gray clod the size of an egg</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  07/31/2012
--	---	--	---

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>2. On 7/27/12 between 9:30 A.M. and 10:00 A.M., the following was noted:</p> <p>There was a worn quilted cloth cosmetic bag on the lower open shelf of the main food prep table. It had been placed inside an open black plastic box on top of a portable mixer and beaters. Next to the box there was a tall plastic glass with a straw. The straw was touching the lid of a plastic container of thickening powder used in foods. Cook #1 indicated the glass was hers and there was just a little left. She indicated the cosmetic bag was stored as she needed it often during the day to do her blood sugar test as she was having diabetic problems.</p> <p>The beverage machine continued to be soiled as during the first tour. The 5 beverage spouts were disassembled to reveal interior mechanisms made of white plastic. Beverages flowed through these mechanisms. They were coated with a black, slimy matter, nearly clogging the filter ports and obscuring the color of the plastic.</p> <p>At that time, the FSD indicated they were to have been cleaned daily but "obviously weren't" and would be soaked immediately in sanitizing solution and cleaned.</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  07/31/2012
--	---	--	---

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 PERCEDED 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 drain beneath the dishwasher continued to be partially obstructed at the floor drain with the same matter observed 7/23/12 and additional accumulated matter.</p> <p>The juice machine dispenser in the main dining room had a thick coat of dark brown, sticky matter below 4 of 4 dispensing handles.</p> <p>3. The FSD provided the cleaning logs, for all assignments during July, on 7/31/12 at 10:00 A.M. The logs specified which position assignment was responsible for each cleaning task whether daily, or three times per month.</p> <p>The logs for 21 separate cleaning tasks to be performed daily by day shift DAs were blank for periods as long as 5 days twice a month. The trash can scrubbing assigned for 3 times between 7/1 and 7/27/12 was not completed.</p> <p>The logs for 18 daily cleaning tasks, assigned to the morning cook, had not been completed for the last 15 days from the 12th to the 27th of July.</p> <p>The logs for 22 daily cleaning assignments for evening shift DAs were incomplete on 11 days from 7/1 to 7/27/12.</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  07/31/2012
--	---	--	---

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 PERCEDED 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 undated cleaning schedule Policy and Procedure reviewed on 7/30/12 at 10:50 A.M., indicated, "6. The Food Service Director will review completed cleaning schedules to evaluate the results and look for unsatisfactory areas or items. If unsatisfactory areas or items are found the Director of Food Services will address with the specific employee any discrepancies or areas of concern. Any discrepancies in the completion of the cleaning schedule tasks will be brought to the attention of the Executive Director by the Director of Food Services on a weekly basis."</p> <p>Review of the undated policy for Storage of Personal items included "No personal property shall be allowed in the kitchen. All personal items (including beverages) brought in the building must be kept in the break room or area designated by the Director of Food Service."</p> <p>Also reviewed was the undated policy for Kitchen dress code, which prohibited jewelry including watches.</p> <p>The undated Inservice for "Food Prep Surfaces." was reviewed. It failed to address when or in what circumstances surfaces should be</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  07/31/2012
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>sanitized.</p> <p>On 7/30/12 at 10:50 A.M., the undated "Cleaning inservice for Beverage dispensers" was reviewed and the FSD indicated was in use. It instructed "all beverage dispensing machines exterior (including drip pans) are to be cleaned and sanitized after every meal. Do not forget back splash and all flat surfaces where product could potentially splatter... Juice machine...Remove drip pan, tray and dispensing nozzles by running through a cycle of the dish machine....Tea machine...Urn is to be manually washed using the wash, rinse, sanitize method....Fountain beverage unit...Remove drip tray, clean by running through a cycle in the dish machine. Drip pan must be hand cleaned and sanitized, be sure to run hot water to flush drain line , sanitize. Remove all nozzles and diffusers, place in designated container filled with sanitizing solution, shake vigorously, drain the contents. Refill with clean warm water, allow the nozzles and diffusers to soak over night. In the A.M. repeat this sanitizing procedure, rinse and then reassemble."</p> <p>3.1-21(i)(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  07/31/2012
--	---	--	---

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
	3.1-21(i)(3)			

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  07/31/2012
--	---	--	---

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
F0428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the physician or Director or Nursing responded to the pharmacist recommendations for a gradual dose reduction of an antianxiety medications for 1 of 5 residents reviewed for psychotropic medications.</p> <p>Resident #12</p> <p>Findings include:</p> <p>The current July 2012 Medication Administration Record (MAR) for Resident #12 was reviewed on 7/30/12 at 9 A.M., and indicated the following: " Ativan 0.25 mg q (every) hs (bedtime) for anxiety." This order was dated 12/3/11.</p> <p>"Medication Regimen Review/ Pharmacist Progress Notes" were reviewed on 7/29/12 at 8 A.M. These</p>	F0428	<p><b>F 428 Immediate Action -</b> Physician of Resident #12 was contacted on 7/30/12 and a new order received for gradual dose reduction and her antianxiety medication.</p> <p><b>F428 Review of Residents -</b> Resident #12 suffered no ill effects from the alleged deficiency. Reviewed July Pharmacy recommendations to ensure that no other residents were affected by this action. <b>Completion Date 8-30-2012</b></p> <p><b>F428 On Going Corrective Action</b> All nurses have been in serviced on the alert charting binders where recommendations will remain until a response is received from the physician. <b>Completion Date 8-30-2012</b></p> <p><b>F428 On Going Monitoring -</b> The Systemic change is that the recommendations will be reviewed in the daily clinical meeting to assure timely</p>	08/30/2012

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 07/31/2012
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>notes included, but were not limited to, the following: "6/8/12: Ativan GDR (gradual dose reduction); 7/5/12: Repeat GDR request."</p> <p>On 7/29/12 at 9:04 A.M., the DON (Director of Nursing) was interviewed. She indicated the resident was initially ordered on Ativan 0.25 mg at bedtime on 12/3/11. She reviewed the Pharmacist Progress notes, dated 6/8/12 and 7/5/12. She reviewed the current clinical record and indicated documentation was lacking of a GDR for Ativan. The DON indicated the resident had been seen by the NP (Nurse Practitioner) on 7/18/12, but documentation was lacking regarding the GDR. The DON indicated the facility typically puts the pharmacy recommendations in a folder for the physician but the facility was unable to find the pharmacy recommendations.</p> <p>On 7/29/12 at 1:13 P.M., the DON was again interviewed. She indicated she had notified the physician of the pharmacist's GDR recommendations.</p> <p>On 7/30/12 (no time documented) an order was obtained from the physician for the following: "D/C (discontinue) Ativan 0.25 mg 1 po (by mouth) every HS r/t (related to)</p>		<p>response. Through alterations in processes and in servicing, the campus will ensure the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports will be acted upon. DHS/designee will audit the monthly recommendations weekly till complete with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. <b>Completion Date 8-30-2012</b></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  07/31/2012
--	---	--	---

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>pharmasists [sic] consultant." [sic]</p> <p>A form "Resident First Conference Notes," dated 7/26/12, included, but was not limited to, the following: "Psychotropic Medications reviewed:" This section included, but was not limited to the following comments to be checked if applicable: "...recommended reductions to MD...med (medication) reduction contraindicated per MD..." The blanks corresponding to these statements were left unmarked.</p> <p>On 7/30/12 at 3:20 P.M., a current copy of the facility policy and procedure for "Documentation and Communication of Consultant Pharmacist Recommendations" was received from the DON. This policy was dated 2/1/10 and included, but was not limited to, the following: "Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review...Recommendations are acted upon and documented by the facility staff and/or the prescriber. "</p> <p>3.1-25(i)</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 07/31/2012
---	--	--	--

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

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  07/31/2012	
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			
R0091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on interview and record review, the facility failed to implement their policy related to monitoring of elopement surveillance equipment or updating identifying information in the Elopement album for 2 of 2 residents at risk of elopement from a sample of 8. Resident # R1 Resident # R 2</p> <p>Findings include:</p> <p>1. The clinical record of Resident # R1 was reviewed on 7/31/12 at 10:00 A.M. The resident diagnosis included but was not limited to Alzheimer's Dementia. The resident was admitted on 4/13/12. A 4/16/12 Elopement assessment was scored 8 with range of 8 or higher being at risk for the first 90 days after admission and a Wanderguard device was initiated 4/13/12 as precautionary, and was maintained as part of the continuing</p>	R0091	<p><b>Assisted Living</b></p> <p><b>R 091 - Immediate Action -</b> Residents R1 and 2 have orders to check wander guard function (which is documented in MAR) and picture/ profiles updated in the elopement book. <b>Completion Date 7/31?2012</b></p> <p><b>R 091 - Review of Residents -</b> Residents R1 and 2 were not adversely affected by the elopement risk program. No other residents were adversely affected by this action as it relates to the elopement risk program. <b>Completion Date 8-30-2012</b></p> <p><b>R 091 - On Going Corrective Action -</b> Through changes in provision of care and in servicing will prevent the recurrence of the deficient practice. All nursing staff have been in serviced concerning the elopement risk program. <b>Completion Date 8-30-2012</b></p>	08/30/2012			

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  07/31/2012	
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 PERCEDED 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>plan of care.</p> <p>Nurse's notes on 6/03/12 at 3:45 P.M., included " Resident noted outside of the building by a visitor. Staff promptly redirected resident back indoors. No alarm sounded. Wanderguard is noted on left ankle. Resident assisted to room into recliner. I asked if he was glad to see that (Recliner) he responded 'you got that right.' Replaced malfunctioning Wanderguard..."</p> <p>An Exit Seeking Circumstance Assessment and Intervention form was completed on 6/3/12. It indicated, as part of the Prevention Update category, a new and functioning Wanderguard bracelet which had been applied after the elopement. An Interdisciplinary team review on 6/04/12 indicated the resident was moved to the locked/secured unit of Residential accommodations, referred to as Legacy unit.</p> <p>On 7/31/12 at 11:15 A.M., the routine QMA #1 (Qualified Medication Aide) in charge of the unit, indicated the system of ensuring functioning of Wanderguard bracelets was for the nurse or QMA to check them with a special wand device each shift and</p>		<p><b>R 091 - On Going Monitoring -</b> The Systemic change includes campus to complete the elopement audit monthly. DHS/designee will complete an audit of two residents at risk for elopement daily to assure policy followed 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/comment. <b>Completion Date 8-30-2012</b></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  07/31/2012
--	---	--	---

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 each check on the MAR (Medication Administration Record). Upon review of the July MAR, at that time, it did not address alarm checks. Documentation was lacking of alarm checks performed except once on the day it was initiated 4/13/12, once on 4/20/12, and once on 4/30/12. On 7/31/12 at 11:20 A.M., interview with QMA #1, he indicated the checks must have been missed during rewrites and exit seeking behavior was not occurring.</p> <p>2. On 7/31/12 at 12:10 P.M., the clinical record of Resident # R2 was reviewed. The resident had been admitted to the non locked Residential unit on 5/05/12 and was still there as of 7/31/12. The unit was the same from which Resident # R1 had eloped. Diagnosis included but were not limited to Dementia.</p> <p>Nurses notes on 7/17/12 at 6:00 A.M., indicated "Resident wandering around facility and exit seeking throughout the night. Confused and going into other residents' rooms telling them the facility is closing and everyone needs to leave...redirected without success...packing stuff..." The 7/17/12 9:00 P.M., nurse's notes indicated plans had been made to move the resident to the next</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  07/31/2012	
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>available bed on the Legacy locked unit. A plan of care instituted on that date for "exit seeking behavior, attempts to leave building" included use of a Wanderguard bracelet and inclusion of the "resident's picture in the Elopement Risk Book informing staff to observe potential exit seeking behavior."</p> <p>On 7/31/12 at 12:10 P.M., LPN # 10 (substitute charge nurse for the unlocked Residential unit) was interviewed. She indicated she was working the shift on this unit but it was not her routine assignment. In response to which residents were wearing a Wanderguard, she indicated she did not know. She indicated the information was recorded by the charge person on the MARs, where Wanderguard checks were recorded each shift. She went through each residents' MAR and indicated she believed there were no residents wearing Wanderguards or on elopement precautions. CNA # 11, also working the unit at that time, indicated one resident wore a bracelet and named Resident # R 2. The July MAR was reviewed at that time and documentation was lacking to indicate presence of, or checks of the Wanderguard. CNA #11 indicated Resident # R 2 had</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  07/31/2012
--	---	--	---

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>developed a pattern of exiting the building into an enclosed courtyard and being redirected into the building from there.</p> <p>On interview with the Director of Nursing (DON) on 7/13/12 at 12:15 P.M., she indicated pictures of residents on elopement precautions and vital statistics were included in two identification books available to staff. Both ID books were reviewed and lacked any documentation for Resident # R 2.</p> <p>3. The 10/19/2007 Procedure Guidelines for Elopement Risk Reduction and Alarm Checks was reviewed on 7/31/12 at 12:40 P.M. Guidelines included: "...2. Resident wander guard alarms...should be checked for proper functioning...Frequency of individual alarm checks should be based in individual resident need...An album will be kept at a secure location ...that contains a photograph and identification information about each resident who may be at risk for elopement..."</p>			