STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	03/16/2018

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00248765. Complaint IN00248765 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689 . Survey dates: March 15 and 16, 2018 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census Bed Type: SNF/NF: 14 SNF: 27 Residential: 33 Total: 74 Census Payor Type: Medicare: 4 Medicaid: 29 Other: 8 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 20, 2018.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 3/16/2018 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before April 4,2018 We respectfully request paper compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide supervision to prevent accidents, for 2 of 3 residents reviewed for falls, in a sample of 6. (Residents C and D) Findings include: 1. On 3/15/18 at 9:00 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident C had recently fallen out of bed. The DON indicated the facility had recently utilized a weighted blanket for the resident, because they felt like the resident may have been cold and also had periods of restlessness. The clinical record of Resident C was reviewed on 3/15/18 at 2:30 P.M. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 12/5/17, indicated Resident C had a memory problem and required extensive assistance of two+ staff for bed mobility and transfer. The resident required total dependence of one staff for ambulation. A test for "Balance During Transitions and Walking" did not occur. Resident C had fallen "2+" times since the past assessment with no injury. A Resident Progress Note, dated 1/5/18 at 2:38 P.M., indicated, "...Resident currently has air	F 0689	Resident C and D's safety plans of care have been reviewed and updated as applicable. **Completion Date :4/4/18** All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will 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. All residents who have fallen with in the last 30 days have been reviewed for appropriate interventions **Completion Date :4/4/2018** All staff have been in serviced on fall prevention and each team member's responsibility to prevent falls related to supervision. Systemic change is campus will review falls daily in CCM to assure interventions in place and supervision adequate. **Completion Date: 4/4/2018** DHS /designee will monitor 3	04/04/2018

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	mattress with bolsters and care plan to have side of bed next to wall for safety. Resident has not made attempts to get out of bed unassisted and has not rolled out of bed since air mattress with bolsters put in place. Additional safety measure include low bed and floor mat beside bed when resident laying down...." A "Fall Event," dated 1/12/18 at 5:48 A.M., included: "Location of Fall: Resident Room. What was resident doing just prior to fall? Lying in bed...Was Fall Witnessed? No...Had been up all noc [night] and fell asleep in her chair so staff put her in her bed approx. 30 min. prior. Resident has cognitive or memory impairment that effects [sic] safety and judgement. Resident has difficulty understanding and following directions. Resident requires assistance to ambulate safely with or without assistive device. Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc...Indicate new measures taken to prevent reoccurrence: Bed in lowest position...." A Resident Progress Note, dated 1/15/18 at 12:54 P.M., indicated, "IDT [Interdisciplinary Team} Review...Resident rolled out of bed onto fall mat. Prior intervention proven effective with no injury...." Resident Progress Notes continued: 1/18/18 at 6:15 A.M.: "(Recorded as Late Entry on 01/25/2018 05:13 PM) CNA came to nurse explaining resident was sitting on mat beside bed...Resident just looked at nurse when nurse asked her what she was trying to do. 2 man lift into bed...." 1/18/18 at 10:50 A.M.: "CNA reported resident		random residents at risk for falls to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 4/4/2018**	

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	sitting on mat by low bed...attempting to get up. New intervention is to get her up first. CNA stated i [sic] usually get her up first but 2 lights going off...." 1/25/18 at 4:45 P.M.: "IDT note...Reviewed documentation related to resident being found on floor mat. Resident without injury and assisted back to bed...Current intervention effective in preventing injury. Goal met." 2/8/18 at 6:40 A.M.: Resident was found sitting on fall mat beside bed. No injury noted...." 2/8/18 at 5:44 P.M.: "IDT review: Resident was resting in her bed and rolled out onto mat resulting in no injury. Root cause: Resident rolled off side of bed. New intervention: Resident is in safest environment possible and goal of care plan met no new intervention required at this time." 2/8/18 at 10:30 P.M.: "Responded to resident yelling out entered room and noted resident on knees on fall mat beside bed...At this time safety interventions deemed safe AEB [as evidenced by] no injuries...." 2/9/18 at 7:34 A.M.: "IDT review...New intervention: Resident met goal of care plan to roll onto mat without injury. Campus is scheduling care conference with hospice to review plan of care and noted increased anxiety...Activities will complete individual updated preference of activities. Campus will ask MD for labs...." 3/2/18 at 12:46 P.M.: "Pertaining to fall, this morning resident awake and calling at approximately at 0700 [7:00 A.M.]. Resident reassured given therapeutic doll, CRCA [CNA] alerted that resident awake. Checked on resident			

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	again when CRCA gathering equipment and assistance. Resident was calm and quiet. CRCA's [sic] entered room within minutes and resident laying on mat next to bed...." 3/3/18 at 10:17 A.M.: "IDT Review:...Root cause: resident does not identify edge of bed and rolls off mattress. New intervention: Resident met goal of care plan to roll onto mat without injury." 3/8/18 at 11:46 A.M.: "CAR [clinically at risk] Note: Resident has had falls on 2/8 and 3/2. Resident has air mattress with built in bolsters, bed against wall, bed in lowest position, fall mat beside bed, and checked/changed every 2 hours, transfers with Hoyer lift [mechanical lift]...." A Care Plan, initially dated 9/19/17 with a Goal Target Date of 3/19/18, indicated: "Problem: Resident at risk for falling R/T [related to]: balance problems, psychotropic meds, dementia." The Approaches included: "2/4/18 low air loss mattress with bolsters. 12/19/17 Bed against wall for a more open floor plan. 9/19/17 Low bed against wall for 1 entry/exit." On 3/15/18 at 1:15 P.M., Resident C was observed partially behind the room's privacy curtain, sitting in a wheelchair by her bed. It was difficult to visualize the resident from the hallway. On 3/16/18 at 11:05 A.M., Resident C was observed lying in bed asleep. The bed was in a low position, but still approximately 20 inches from the floor. A mat was at the bedside. On 3/16/18 at 2:15 P.M., during an interview with the Executive Director (ED) and Corporate Nurse, the Corporate Nurse indicated the facility had done everything they could for Resident C			

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	regarding keeping the resident safe. The Corporate Nurse indicated the resident's care plan was effective, in that the resident was not suffering any injuries when she fell. 2. On 3/15/18 at 9:00 A.M., during the initial tour, the DON indicated Resident D had recently fallen. The DON indicated prior to the fall, Resident D transferred independently. She added the resident was "very forgetful." On 3/15/18 at 1:15 P.M., Resident B was observed lying asleep, diagonally across the bed. A wheelchair was by her bed. Her bed was behind the privacy curtain, and she was not able to be visualized from the hallway. The clinical record of Resident D was reviewed on 3/15/18 at 3:10 P.M. Diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, lack of coordination, and difficulty walking. A quarterly MDS assessment, dated 12/10/17, indicated Resident D had an impaired memory, and required extensive assistance of one staff for bed mobility and transfer. A test for "Balance During Transitions and Walking" indicated the resident was "Not steady, only able to stabilize with human assistance" while moving from seated to standing position, walking, and surface-to-surface transfers. Nursing Progress Notes included the following notations: 12/14/17 at 5:53 A.M.: "Roommate came out of room and told us resident on floor. Emmediately [sic] responded and resident was sitting up on the floor leaning against night stand...Resident said			

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	she was going to the bathroom. Pull tab alarm had been taken off which she said she did...Intervention will be to offer toileting q [every] 2 hours during the noc...." 12/22/17 at 7:50 A.M.: "CAR Note: Resident had another fall on 12/14/17 with no injuries, fell beside bed while trying to transfer self to bathroom, new intervention is to toilet every 2 hours...." 1/2/18 at 2:01 P.M.: "Found resident on the floor between her w/c [wheelchair] and bed at 1312 [1:12 P.M.], stated she slid down side of chair while attempting to get into bed, alarms in place, no injuries noted...will continue to monitor...." 1/5/18 at 7:16 A.M.: "IDT Review:...Root cause: Wheelchair was not placed close enough to bed to initiate transfer. Intervention: Therapy to evaluate and work with resident on transfers." 1/25/18 at 9:45 P.M.: "...Upon entering room noted client on floor by bedside laying on her back. Smiling and said 'I guess I slipped.' She stated she was going to get up and see what everyone was doing and slid to the floor...Client allowed shoes to be put an and with 2 staff and EA [extensive assist] she stood with no c/o [complaints of] pain or dizziness...call light is in immediate reach." A Physical Therapy Plan of Care, dated 1/26/18, included: "Reason For Referral:...presents to therapy with a decline in ADLs [activities of daily living] of functional transfers due to weakness...Therapy necessary for strengthening, activity tolerance, balance and transfers...Precautions: Fall Risk...Current Level: Chair or bed-to-chair transfer...Partial/Moderate Assistance...Long Term Goal: Transfers, The			

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	patient will complete all functional transfers safely with stand by assistance (close enough to reach patient if assist needed)." Progress Notes continued: 1/28/18 a 12:51 P.M.: "CAR Note:...implemented a new intervention of tape on wall at mobility bar to assure bed at proper height for optimal transfers. Resident continues to work with therapy on strengthening." A PT [Physical Therapy] note, dated 2/15/18, included: "Pt demonstrates deficits in strength, activity tolerance and balance limiting safety and independence with functional mobility and placing pt at increased risk for falls. Pt significantly impacted by impaired cognition and decreased safety awareness." Progress Notes continued: 2/16/18 at 3:44 P.M.: "Resident was transferring self from bed to w/c and slid off of bed onto floor...All prior interventions in place and functioning." 2/19/18 at 3:12 P.M.: "IDT:...Resident slid from her bed to the floor 2/16/18...The fitted sheet was pulled off of both top corners and was hanging off the bed...Resident did not have shoes on. Root cause sheets sliding off bed as resident sitting on side of bed. Dysen [sic] placed on mattress under sheet where resident gets in and out of bed...Therapy continues to treat and will make necessary adjustments." 3/9/18 at 5:28 P.M.: "Entered pt [patient] room and found pt on floor on right side between bed and wheelchair...Asst [sic] 3 to asst [assist] pt from			

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	floor to w/c. Pt was wearing shoes as RCA [CNA] had just gotten pt up for supper 5 min prior to fall. RCA reports she had instructed pt not to transfer back to bed at that time as it was time to get ready for evening meal. Noted bed was in position with marking on wall as care planned. W/C brakes were noted to be locked as well...Order for PT [physical therapy] evaluation for w/c to bed trasfer [sic] safety." A PT note, dated 3/9/18, indicated, "Upon arrival to pt's room this AM, pt was found sitting in bathroom in the dark stating she needed to go to the bathroom. This therapist turned on the bathroom light for the pt and instructed pt in safe positioning and sequencing...Pt requiring min>modA [minimal>moderate assist] for stability. Noted increased confusion contributing to increased assistance needed to safely complete transfers...." A PT note, dated 3/14/18, indicated, "...pt noted to be laying diagonally in bed. Pt attempted to complete supine [laying] to sit transition when this PTA [Physical Therapy Assistant] noted pt was very close to edge of bed...[Bed to wheelchair] transfer performed with pt requiring CGA [contact guard assistance] for safety and v/c's [verbal cues] provided for correct hand placement and to turn completely around to w/c prior to sitting to improve transfer performance." A Care Plan, initially dated 10/24/17 and reviewed 3/13/18, indicated: "Problem: Resident is at risk for falling R/T: balance problems & decreased mobility." The Approaches included: "Therapy eval [evaluation] and treat as needed. Staff to assist resident with transfers as needed. Keep call light within reach. Encourage resident to assume standing position slowly. Offer to toilet every 2			

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	hours through the noc. 12/28/17 Resident moved closer to nursing station. Therapy to assess bed for appropriate height for transfers & mark appropriate height on wall." On 3/16/18 at 9:00 A.M., Resident D was observed lying in bed, asleep. The room's privacy curtain was pulled, and the resident was unable to be seen from the hallway. Tape was marked on the wall, and the resident's bed was at that height. On 3/16/18 at 2:20 P.M., the Executive Director provided the current facility policy "Falls Management Program Guidelines," dated 5/31/17. The policy included: "...A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred...Care plan interventions should be implemented that address the resident's risk factors...Should a resident experience a fall the attending nurse shall complete the 'Fall Event' [sic] This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode [sic] and a review by the IDT [interdisciplinary team] to evaluate thoroughness of the investigation and appropriateness of the interventions...The resident care plan should be updated to reflect any new or change in interventions... This Federal tag relates to Complaint IN00248765. 3.1-45(a)(2)			