

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 03/24/2017
--	---	--	---

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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the State Residential Survey.</p> <p>Survey dates: March 19, 20, 21, 22, 23, 24, 2017</p> <p>Facility number: 002724 Provider number: 155682 AIM number: 200309330</p> <p>Census bed type: SNF: 11 SNF/NF: 25 Residential: 29 Total: 76</p> <p>Census payor type: Medicare: 11 Medicaid: 25 Other: 11 Total: 47</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 30, 2017</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission by Woodmont Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Woodmont Health Campus This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs) and asks to be considered for paper/desk review.</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	

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 03/24/2017
--	---	--	---

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
F 0157 SS=D Bldg. 00	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</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 03/24/2017
--	---	--	---

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>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician of a change in resident status for 2 of 3 residents reviewed for nutrition. (Resident 22, Resident 23)</p> <p>Findings include:</p> <p>1. On 3/21/17 at 10:19 A.M., Resident 23's clinical record was reviewed. Resident 23 was admitted on 12/8/16. Resident 23's diagnoses included, but were not limited to, dysphagia (a swallowing disorder).</p> <p>Resident 23's Quarterly MDS (Minimum Data Set) assessment, dated 2/22/17, indicated Resident 23 had severe cognitive impairment. The MDS indicated Resident 23 required extensive assistance of one person for eating.</p>	F 0157	<p>Resident # 22 and #23 physician has been updated related to current weight.</p> <p>Completion Date 4-21-2017</p> <p>All other residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure physician notification is completed with change in condition. All resident's current weights have been reviewed and notifications have been completed as required.</p> <p>Completion Date 4-21-2017</p> <p>All nurses have been in serviced concerning the campus procedure for physician notification guidelines. Systemic</p>	04/21/2017

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 03/24/2017
--	---	--	---

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 23's weight measurements included, but were not limited to: 12/16/16: 170 pounds 1/5/17: 168 pounds 2/2/17: 171 pounds 3/2/17: 162 pounds 3/9/17: 159 pounds 3/13/17: 161 pounds</p> <p>An Event Report, dated 3/9/17, included, but was not limited to: The report indicated Resident 23 had an 11.7 pound weight loss in 30 days. The notes included, but were not limited to: This is an 11.7 pound weight loss 6.8 percent over the past 30 days. The event indicated the physician was notified on 3/9/17.</p> <p>The clinical record lacked physician's notification of significant weight loss from 3/2/17 until 3/9/17.</p> <p>On 3/21/17 at 1:34 P.M., Resident 23 was observed to be sitting up in bed eating lunch. No staff members were observed to be present.</p> <p>On 3/22/17 at 10:25 A.M., Resident 23 was observed to be sitting up in bed. Resident 23's breakfast tray was in front of her. No staff members were observed to be present.</p>		<p>change is nurse leaders will run a weight variance report daily to assure notifications completed timely.</p> <p>Completion Date 4-21-2017</p> <p>The weight variance Report will be reviewed by nurse leaders in Clinical Care Meeting to ensure physician notification complete on 3 random residents as applicable on 3 random residents 5x a week for a month then 3x 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.</p> <p>Completion Date 4-21-2017</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 03/24/2017
--	---	--	---

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 3/22/17 at 10:29 A.M., LPN 1 indicated Resident 23 was capable of feeding herself and preferred to do so.</p> <p>On 3/22/17 at 1:01 P.M., Resident 23 was observed to be eating lunch in her room. No staff members were observed to be present.</p> <p>On 3/22/17 at 1:39 P.M., the DON indicated Resident 23 was adamant about feeding herself.</p> <p>2. On 3/21/17 at 10:49 A.M., Resident 22 was observed sitting in her chair in her room. Resident 22 indicated she had a good breakfast that morning.</p> <p>On 3/21/17 at 12:43 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 1/4/17. Resident 22's diagnoses included, but were not limited to, mood disorder and generalized anxiety disorder.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 1/3/17, indicated Resident 22 had moderate cognitive impairment. The MDS indicated Resident 22 required supervision of one person for eating.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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 22's weights included, but were not limited to:</p> <p>1/5/17: 180 pounds 2/2/17: 176 pounds 3/1/17: 142 pounds 3/9/17: 165 pounds</p> <p>A Dietetic Progress Note, dated 3/13/17, included, but was not limited to: RDN (Registered Dietician Note) note related to referral. Decrease 12 pounds/6.7% times one month.....recommend change diet to regular with fortified foods to promote weight maintenance.</p> <p>A Physician Progress Note, dated 3/6/17, indicated Resident 22's weight was stable.</p> <p>The clinical record lacked physician notification of significant weight loss from 3/1/17 until 3/6/17.</p> <p>On 3/22/17 at 2:04 P.M., the DON indicated resident weights were obtained at the beginning of the month. The DON indicated the interdisciplinary team then met to review weights, attain re-weights if needed, gather information, and notify the dietician and physician if necessary.</p> <p>On 3/23/17 at 10:34 A.M., the Regional Clinical Support Nurse provided the "Guidelines for Weight Tracking" policy,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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
F 0241 SS=D Bldg. 00	<p>reviewed 5/15/16. The policy included, but was not limited to: The physician, responsible party, and dietician shall be notified of a weight variance of greater than 5 percent.</p> <p>3.1-5(a)(3)</p> <p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>Based on observation, record review, and interview the facility failed to ensure dignity for all residents by lining residents along the hallway to be taken to the restorative dining room for breakfast for 3 of 30 residents reviewed during Stage 1 of the survey. (Resident 18, Resident 27, and Resident 28)</p> <p>Findings include:</p> <p>1. During an observation on 3/22/17 at</p>	F 0241	<p>Residents # 18,27, and 28 have suffered no ill effects from the alleged deficiency.</p> <p>Completion Date 4-21-2017</p> <p>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 promotes care for the residents in a manner and in an environment that maintains or enhances each</p>	04/21/2017

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 03/24/2017
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>8:37 A.M., Resident 18 was seen sleeping in her wheelchair in the hallway waiting to be taken to restorative dining for breakfast.</p> <p>2. During an observation on 3/22/17 at 8:37 A.M., Resident 27 was seen in her wheelchair in the hallway waiting to be taken to restorative dining for breakfast.</p> <p>3. During an observation on 3/22/17 at 8:37 A.M., Resident 27 was seen in his geriatric chair in the hallway waiting to be taken to restorative dining for breakfast.</p> <p>During an interview with CNA 1 on 3/22/17 at 8:40 A.M., she indicated the residents were lined up in the hallway because they were waiting their turn to be taken to restorative dining for breakfast.</p> <p>During a review of the facility's current policy, Resident Rights Guidelines, revised on 8/11/16, provided by the Regional Consultant on 3/23/17 at 10:30 A.M., the policy indicated all or in part, but not limited to: To ensure resident right are respected and protected and provide an environment in which they can be exercised. Our residents have a right to be treated with dignity and respect.</p>		<p>resident's dignity and respect in full recognition of his or her individuality.</p> <p>Completion Date 4-21-2017</p> <p>All staff will be in serviced related to dignity when interacting with residents. Systemic change is residents will be transported to common area in am or area of resident's choice.</p> <p>Completion Date 4-21-2017</p> <p>SSD or designee will audit 3 random resident's periodic times during the day to assure dignity is provided 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.</p> <p>Completion Date 4-21-2017</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 03/24/2017
--	---	--	---

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
F 0278 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</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 03/24/2017
--	---	--	---

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) Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure resident assessments were accurate for 1 of 18 residents reviewed during stage 2 of the survey. The MDS was coded incorrectly for antipsychotic medication use. (Resident 52)</p> <p>Findings include:</p> <p>On 3/21/17 at 12:57 P.M., Resident 52's clinical record was reviewed. Resident 52's diagnoses included, but was not limited to, major depressive disorder.</p> <p>Resident 52's Quarterly MDS (Minimum Data Set) assessment, dated 2/16/17, indicated Resident 52 had not received an antipsychotic medication during the assessment period.</p> <p>The physician's orders included, but were not limited to: Abilify (an antipsychotic medication) 5 mg (milligrams), by mouth, once a day.</p> <p>The February MAR (Medication Administration Record) indicated Resident 52 received Abilify February 10-16, 2017.</p> <p>A GDR (Gradual Dose Reduction)</p>	F 0278	<p>F 278</p> <p>Resident # 52 has had a modification completed to her MDS to capture the use of the antipsychotic during the assessment reference time.</p> <p>Completion Date 4-21-2017</p> <p>All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure the campus</p> <p>ensures each resident's Minimum Data Set (MDS) assessment accurately reflects the resident's medication administration. The campus has completed an audit of all resident's receiving antipsychotics to assure accurate coding on the MDS.</p> <p>Completion Date 4-21-2017</p> <p>MDS nurses have been in</p>	04/21/2017

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 03/24/2017	
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			
F 0279 SS=D Bldg. 00	<p>Request, dated 1/7/17, requested a decrease in Abilify. The GDR Request indicated the Abilify had been in use since 7/7/16.</p> <p>On 3/23/17 at 8:51 P.M., the MDS Coordinator indicated she thought Abilify was an antidepressant. The MDS Coordinator verified at that time Resident 52 received Abilify during the assessment period.</p> <p>On 3/23/17 at 10:34 A.M., the Clinical Regional Support Nurse indicated the facility followed the RAI manual for MDS assessments.</p> <p>3.1-31(d)</p> <p>483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record</p>		<p>serviced on coding antipsychotics. Systemic change is the MDS nurse will obtain monthly pharmacy reports to assure all medications coded correctly.</p> <p>Completion Date 4-21-2017</p> <p>DHS/designee will review 2 random residents MDS to assure accuracy 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</p> <p>Completion Date 4-21-2017</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 03/24/2017
--	---	--	---

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 use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</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 03/24/2017
--	---	--	---

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) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan based on the resident assessment for 1 of 18 residents reviewed during stage 2 of the survey. A care plan for psychoactive medications was not developed. (Resident 65)</p> <p>Findings include:</p> <p>On 3/21/17 at 11:15 A.M. Resident 65's clinical record was reviewed. Resident 65 was admitted on 1/31/17 with diagnoses including, but not limited to, major depressive disorder.</p> <p>The physician's orders included, but were not limited to: amitriptyline (an antidepressant medication) 25 mg (milligrams), orally, at bedtime, initiated on 1/31/17</p>	F 0279	<p>Resident # 65's care plans have been reviewed and updated as applicable</p> <p>Completion Date 4-21-2017</p> <p>All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the resident's plan of care is current. The campus completed an audit of all residents with psychoactive medication and updated care plan as necessary.</p> <p>Completion Date 4-21-2017</p>	04/21/2017
--	--	--------	--	------------

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 03/24/2017
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>Lexapro (an antidepressant medication) 10 mg, orally, once a day, initiated on 1/31/17</p> <p>zolpidem (a hypnotic medication) 5 mg, orally, at bedtime, as needed, ordered on 1/31/17</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 2/7/17, indicated Resident 65 had received an antidepressant medication seven out of seven days during the assessment period.</p> <p>The clinical record lacked a care plan regarding Resident 65's psychoactive medication.</p> <p>On 3/23/17 at 8:50 A.M., the MDS Coordinator indicated she was unable to locate a care plan regarding Resident 65's psychoactive medications.</p> <p>On 3/23/17 at 10:34 A.M., the Regional Clinical Support Nurse provided the "Interdisciplinary Team Care Guidelines" policy, revised 6/2015. The policy included, but was not limited to: A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment.</p> <p>3.1-35(a)</p>		<p>An in service was provided to MDS and SS concerning care planning of psychoactive medications. Systemic change is SS will complete audit of monthly pharmacy psychoactive report to assure care plans implemented.</p> <p>Completion Date 4-21-2017</p> <p>DHS/designee will perform audits of 2 random residents with psychoactive medications to assure care plans are current and in place 5x 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</p> <p>Completion Date 4-21-2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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
--------------------	--	---------------	---	----------------------

F 0325 SS=D Bldg. 00	<p>483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure nutritional status was maintained for 2 of 3 residents reviewed for nutrition. Interventions for significant weight loss were not implemented for 12-13 days. (Resident 22, Resident 23)</p> <p>Findings include:</p> <p>1. On 3/21/17 at 10:19 A.M., Resident 23's clinical record was reviewed. Resident 23 was admitted on 12/8/16. Resident 23's diagnoses included, but were not limited to, dysphagia (a</p>	F 0325	<p>Resident # 22 and #23 have been reviewed by the RD and physician and nutrition approaches updated as necessary.</p> <p>Completion Date 4-21-2017</p> <p>All other residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing will ensure physician notification is completed with change in condition. All resident's current weights have been reviewed and interventions have</p>	04/21/2017
----------------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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>swallowing disorder).</p> <p>Resident 23's Quarterly MDS (Minimum Data Set) assessment, dated 2/22/17, indicated Resident 23 had severe cognitive impairment. The MDS indicated Resident 23 required extensive assistance of one person for eating.</p> <p>Resident 23's weight measurements included, but were not limited to: 12/16/16: 170 pounds 1/5/17: 168 pounds 2/2/17: 171 pounds 3/2/17: 162 pounds 3/9/17: 159 pounds 3/13/17: 161 pounds</p> <p>The Progress Notes included, but were not limited to: 3/8/17: CNA reported open area to coccyx, red with moist yellow center.</p> <p>An Event Report, dated 3/9/17, included, but was not limited to: The report indicated Resident 23 had an 11.7 pound weight loss in 30 days. The notes included, but were not limited to: This is an 11.7 pound weight loss 6.8 percent over the past 30 days. The event indicated the physician was notified on 3/9/17.</p> <p>The physician's orders included, but were</p>		<p>been completed as required.</p> <p>Completion Date 4-21-2017</p> <p>All nurses have been in serviced concerning the campus procedure for weight tracking and nutrition approaches. Systemic change is nurse leaders will run a weight variance report daily to assure interventions completed timely.</p> <p>Completion Date 4-21-2017</p> <p>The weight variance Report will be reviewed by nurse leaders in Clinical Care Meeting to ensure interventions implemented timely on 3 random residents as applicable on 3 random residents 5x a week for a month then 3x 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.</p> <p>Completion Date 4-21-2017</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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 limited to: Med pass (a dietary supplement) 60 ml (milliliters), twice a day, ordered on 3/14/17.</p> <p>The clinical record lacked interventions for Resident 23's significant weight loss from 3/2/17-3/14/17.</p> <p>On 3/21/17 at 1:34 P.M., Resident 23 was observed to be sitting up in bed eating lunch. No staff members were observed to be present.</p> <p>On 3/22/17 at 1:39 P.M., the DON indicated Resident 23 was adamant about feeding herself.</p> <p>On 3/22/17 at 1:01 P.M., Resident 23 was observed to be eating lunch in her room. No staff members were observed to be present.</p> <p>On 3/22/17 at 10:25 A.M., Resident 23 was observed to be sitting up in bed. Resident 23's breakfast tray was in front of her. No staff members were observed to be present.</p> <p>On 3/22/17 at 10:29 A.M., LPN 1 indicated Resident 23 was capable of feeding herself and preferred to do so.</p> <p>2. On 3/21/17 at 10:49 A.M., Resident 22 was observed sitting in her chair in 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 03/24/2017
--	---	--	---

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>room. Resident 22 indicated she had a good breakfast that morning.</p> <p>On 3/21/17 at 12:43 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 1/4/17. Resident 22's diagnoses included, but were not limited to, mood disorder and generalized anxiety disorder.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 1/3/17, indicated Resident 22 had moderate cognitive impairment. The MDS indicated Resident 22 required supervision of one person for eating.</p> <p>Resident 22's weights included, but were not limited to: 1/5/17: 180 pounds 2/2/17: 176 pounds 3/1/17: 142 pounds 3/9/17: 165 pounds</p> <p>A CMP (Complete Metabolic Profile) laboratory results, dated 3/7/17, included, but were not limited to: Creatinine: 1.3H, normal range 0.4-1.1 Total Protein: 5.6L, normal range 6.0-8.2 Albumin: 3.0L, normal range 3.4-4.8</p> <p>A Dietetic Progress Note, dated 3/13/17, included, but was not limited to: RDN note related to referral. Decrease 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 03/24/2017
--	---	--	---

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>pounds/6.7% times one month.....recommend change diet to regular with fortified foods to promote weight maintenance.</p> <p>The Physician's Orders included, but were not limited to: regular diet with fortified foods, dated 3/14/17.</p> <p>The clinical record lacked interventions for significant weight loss from 3/1/17-3/14/17.</p> <p>On 3/22/17 at 2:04 P.M., the DON indicated resident weights were obtained at the beginning of the month. The DON indicated the interdisciplinary team then meets to review weights, attain re-weights if needed, gather information, and notify the dietician and physician if necessary.</p> <p>On 3/23/17 at 10:34 A.M., the Regional Clinical Support Nurse provided the "Guidelines for Weight Tracking" policy, reviewed 5/15/16. The policy included, but was not limited to: Residents who have a weight that seem out of normal range shall be re-weighted to determine the accuracy of the original weight. This should be completed when the discrepancy is noted and not wait until the dietician recommends a re-weight.....</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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
F 0371 SS=E Bldg. 00	<p>3.1-46(a)(1)</p> <p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.</p>	F 0371	All residents have the potential to be affected by the alleged	04/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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, record review, and interview, the facility failed to ensure food was served in a sanitary manner. Hand hygiene was not performed during meal service and the kitchen and main dining room floors were dirty and sticky for 3 of 3 dining observations. (Kitchen, Resident 22, Resident 42, Resident 48)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 3/20/17 at 11:56 A.M., LED (Life Enrichment Director) 1 was observed to put his hands in his pockets, walked to beverage station, scooped soup into a bowl while holding its rim, and then served Resident 22. No hand hygiene was observed prior to serving Resident 22. 2. During an observation on 3/20/17 at 12:52 P.M., RN 1 was observed to enter Resident 42's room with her meal tray. No hand hygiene was observed prior to entering the resident's room. 3. During an observation on 3/20/17 at 12:55 P.M., LPN 1 was observed to enter Resident 48's room with her meal tray. No hand hygiene was observed prior to entering the room. LPN 1 repositioned the resident and sat down at her bedside to feed her. 		<p>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.</p> <p>Completion Date 4-21-2017</p> <p>All items identified on the 2567 have been cleaned. All dietary employees have been in serviced on general cleaning schedules of the kitchen. Systemic change is the dietary manager will bring the cleaning schedule to morning meeting and review with Executive Director that schedule complete for the previous day. All staff have completed a hand washing competency and in serviced on infection control when passing trays.</p> <p>Completion Date 4-21-2017</p> <p>ED/designee will complete a sanitation report in the kitchen and observe one meal pass 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 03/24/2017
--	---	--	---

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>4. During an observation on 3/20/17 at 9:25 A.M., the kitchen floor under and around the ice maker was covered in a white substance.</p> <p>5. During an observation on 3/20/17 at 9:30 A.M., the kitchen floor in the dry storage area was dirty.</p> <p>6. During an observation on 3/21/17 at 7:55 A.M., the kitchen floor under and around the ice maker was covered in a white substance.</p> <p>7. During an observation on 3/21/17 at 7:55 A.M., the kitchen floor in the dry storage area was dirty.</p> <p>8. During an observation on 3/21/17 at 8:10 A.M., the floor in front of the beverage station in the main dining room was sticky.</p> <p>9. During an observation on 3/22/17 at 11:00 A.M., the floor in front of the beverage station in the main dining room was sticky.</p> <p>During an interview with the Administrator on 3/23/17 at 1:34 A.M., she indicated the kitchen has a cleaning schedule that is completed each evening, and if the tasks were not completed the Dietary Manager left a note for the next</p>		<p>handwashing 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</p> <p>Completion Date 4-21-2017</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 03/24/2017
--	---	--	---

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>shift to complete them. She indicated the kitchen staff was also responsible for mopping in front of the beverage station and cleaning the station every day. She indicated spot cleaning was done as needed. She further indicated the facility did not have a current kitchen policy regarding a cleaning schedule, the facility utilized daily cleaning logs.</p> <p>During an interview with FSA (Food Service Assistant) 1 on 3/23/17 at 2:15 P.M., she indicated she washed her hands before leaving the kitchen to serve residents. When questioned she indicated she washed them, "long enough to sing Happy Birthday twice." She further indicated she did not wash or sanitize her hands any other time in the dining room.</p> <p>During a review of the current facility policy, Guideline for Handwashing/Hand Hygiene, revised 2/9/17, provided by the Regional Consultant on 3/23/17 at 10:30 A.M., it indicated all or in part, but not limited to: Health care workers shall use hand hygiene at times such as: Before/after preparing/serving meals, drinks, tube feedings, etc. Before/After having direct physical contact with residents.</p> <p>3.1-21(i)(1) 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 03/24/2017
--	---	--	---

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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 29</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The submission of this plan of correction does not indicate an admission by Woodmont Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Woodmont Health Campus This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner.</p> <p>The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs) and asks to be considered for paper/desk review.</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as</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 03/24/2017
--	---	--	---

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
R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on interview and record review, the facility failed to ensure a First Aid Certified staff member was on duty for 7 of 7 days reviewed.</p> <p>Findings include:</p>	R 0117	<p>a matter of statute only.</p> <p>All residents have the potential to be affected by the deficient practice and through alterations and in services the campus will ensure a First Aid certified staff member is scheduled for all shifts.</p> <p>Completion Date 4-21-2017</p>	04/21/2017

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 03/24/2017
--	---	--	---

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
R 0246 Bldg. 00	<p>On 3/24/17 at 9:45 A.M., the staffing schedules were reviewed form 3/13/17 through 3/19/17. The staffing schedules lacked a First Aid Certified Staff Member on all shifts.</p> <p>On 3/24/17 at 9:50 A.M., the Administrator indicated the MDS Coordinator was First Aid Certified. The Administrator indicated the MDS Coordinator regularly worked Monday through Friday from approximately 8:00 A.M. to 5:00 P.M. The Administrator indicated there was no First Aid Certified staff member present outside of those hours.</p> <p>On 3/24/17 at 10:35 A.M., the Administrator provided the "AL-Staffing Requirements Guidelines" policy, revised 8/11/16. The policy included, but was not limited to: the campus shall schedule staff sufficient in number, qualifications and training in accordance with applicable state laws and rules to meet the twenty-four hour scheduled and unscheduled needs of the residents and services provided.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only</p>		<p>An in service was completed to certify multiple staff in first aid Systemic change is a heart will be placed on the daily work assignment to identify the employee who is first aid certified.</p> <p>Completion Date 4-21-2017</p> <p>ED/Designee will review daily work assignment to assure a staff member is scheduled for all shifts who is first aid certified 5x 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</p> <p>Completion Date 4-21-2017</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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>upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure as needed medications administered by a QMA had a documented nurses' authorization prior to administration for 2 of 7 residents reviewed. (Resident 18, Resident 30)</p> <p>Findings include:</p> <p>1. On 3/24/17 at 7:33 A.M., Resident 18's clinical record was reviewed. Resident 18 was admitted 12/16/16.</p> <p>Resident 18's physician's orders included, but were not limited to: Hydrocodone-acetaminophen (an opioid analgesic medication) 5-325 mg (milligrams), by mouth, every 4 hours, as needed for pain.</p> <p>The March MAR (Medication Administration Record) indicated a QMA (Qualified Medication Aide) had administered the hydrocodone-acetaminophen on 3/10/17, 3/11/17, 3/12/17, and 3/13/17. The record lacked a documented authorization</p>	R 0246	<p>Res # 18 and 30 suffered no ill effects from the alleged deficient practice.</p> <p>Completion Date 4-21-2017</p> <p>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 ensures unlicensed staff request permission from licensed staff and document according to campus guidelines concerning prn medication administration.</p> <p>Completion Date 4-21-2017</p> <p>Nursing staff have been in serviced regarding the procedure for non licensed staff to administer prn medication. Systemic change is non licensed staff will request permission to</p>	04/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2017
--	---	---	---

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>prior to the administration by a licensed nurse.</p> <p>2. On 3/24/17 at 8:21 A.M., Resident 30's clinical record was reviewed. Resident 30 was admitted on 8/1/16.</p> <p>Resident 30's physician's orders included, but were not limited to: Tylenol (an analgesic medication) 325 mg, 2 tablets, by mouth, every 4 hours, as needed for pain or fever.</p> <p>The March MAR indicated a QMA had administered the Tylenol on 3/10/17 and 3/11/17. The record lacked a documented authorization prior to the administration by a licensed nurse.</p> <p>On 3/24/17 at 9:41 A.M., QMA #1 indicated if a resident requested an as needed medication from a QMA, the QMA was to call the nurse for authorization and document it in the comments section on the MAR.</p> <p>On 3/24/17 at 10:35 A.M., the Administrator provided the "Administration of PRN Medications Guideline" policy, revised 5/10/16. The policy included, but was not limited to: If a PRN medication is to be administered by a QMA the Standards of Practice for PRN medication</p>		<p>administer a prn medication and the nurse will document administration of prn medication along with assessment</p> <p>Completion Date 4-21-2017</p> <p>DHS/ designee will review 3 random resident's prn medication sheet to assure compliance 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</p> <p>Completion Date 4-21-2017</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2017
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	
	administration by a Qualified Medication Assistant shall be observed.				