STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002724	A. BUILDING: _____ B. WING _____	R-C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	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) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00185754 completed on December 18, 2015. This visit was in Conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 25th, 2016. Survey dates: February 24 and 25, 2016 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Residential: 36 Sample: 3 Woodmont Health Campus was found to be in compliance with 410 IAC 16.2-5, in regard to the Investigation of Complaint IN00185754.	{R 000}		