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	10/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the Investigation of Nursing Home Complaint IN00441635 and the Nursing Home COVID-19 Focused Infection Control Survey. This visit included the Investigation of Residential Complaint IN00441635 and the Residential COVID-19 Focused Infection Control Survey. Complaint IN00441635: Federal/state deficiencies are cited at F880. Survey dates: October 29, 2024 Facility number: 002724 Provider number: 155628 AIM number: 200309330 Census Bed Type: SNF: 12 SNF/NF: 39 Residential: 31 Total: 82 Census Payor Type: Medicare: 12 Medicaid: 32 Other: 7 Total: 52 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2024.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennie Deyne	Executive Director	11/15/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to maintain infection control practices to help mitigate the spread of COVID-19. Staff failed to complete proper hand hygiene, touched resident furnishings without performing hand hygiene, and placed a dirty glove on top of a medication cart during 2 of 3 observations of care. (Resident C, Resident D) Findings include: 1. During an observation on 10/29/24 at 10:49 A.M., CNA 7 was providing urostomy care and incontinence care for Resident C. CNA 7 indicated Resident C required Enhanced Barrier Precautions due to the urostomy. Following urostomy care, CNA 7 removed Resident C's soiled brief and provided peri-care. CNA 7 then removed both gloves and completed a 10 second handwashing. CNA 7 then applied new gloves and placed a new brief on the resident. CNA 7 indicated they had forgotten to apply a pad around the urostomy insertion site. CNA 7 removed gloves and completed a 12 second handwashing. CNA 7 applied new gloves and placed a pad around the ostomy insertion site. CNA 7 then removed and disposed of gloves, pulled the trash bag from the bin next to the resident's bed, grabbed the resident's privacy curtain with bare hands and pulled the curtain to the side, then entered the resident's bathroom to complete hand hygiene. 2. During an observation on 10/29/24 at 11:05 A.M., RN 4 completed glucose monitoring for Resident D. RN 4 completed hand hygiene, donned gloves, pricked Resident D's finger with a lancet drawing a drop of blood from the finger,	F 0880	1. Residents C and D suffered no ill effects from the alleged deficient practice. Residents assessed and monitored for adverse effects with no findings. Nursing staff were immediately educated on proper hand hygiene, identification of clean/dirty surfaces and proper disposal of dirty gloves by the Director of Health Services (DHS). 2. All residents have the potential to be affected. Nursing department staff educated by the Infection Preventionist (IP) on proper length of time for hand hygiene, identification of clean/dirty surfaces and proper procedure for disposal of dirty gloves. IP nurse and nursing leadership will complete visual observations during daily rounds to ensure appropriate hand hygiene, appropriate contact with clean/dirty surfaces, and appropriate disposal of dirty gloves. 3. As a measure of ongoing compliance: a) The DHS/IP, or designee, will complete an audit of 5 staff to ensure appropriate length of time for hand hygiene 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, twice weekly for 4 weeks, then weekly for 3 months. b) The DHS/IP, or designee, will complete an audit of 3 staff	11/20/2024

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	then checked the resident's blood sugar level with a glucometer. RN 4 instructed Resident D to grab a tissue for her finger, then RN 4 removed one glove as she exited the resident's room, carrying the glucometer in the other hand. RN 4 then placed one used glove on a medication cart in the hall, placed the glucometer on the medication cart, removed the other glove, and then threw both gloves in the trash on the medication cart. RN 4 then completed hand hygiene. RN 4 proceeded to ask a resident across the hall if they would like a pain medication. During an interview on 10/29/24 at 12:30 P.M., CNA 7 indicated that staff should wash hands with a scrub time of 20 seconds. CNA 7 indicated she was counting during hand hygiene and counted between 15-20 seconds during all handwashing, then stated she may have been counting fast. On 10/29/24 at 11:20 A.M., the Director of Nursing (DON) supplied a facility policy titled, Guideline for Handwashing/ Hand Hygiene, dated 2/9/17. The policy indicated, "...3. Health Care Workers (HCW) shall use hand hygiene at times such as: ...c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc... Procedures 1. Hand Washing a) Turn on water... b) wet hands with running water. Apply liquid soap and work into lather. c) Wash well for at least 20 seconds..." This citation relates to complaint IN00441635. 3.1-18(b) 3.1-18(l)		providing incontinence care for appropriate contact with clean/dirty surfaces 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. c) The DHS/IP, or designee, will complete an audit of 3 staff providing care for appropriate disposal of dirty gloves 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 11/20/24	

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00441635 and the Residential Covid-19 Focused Infection Control survey. This visit included the Investigation of Nursing Home Complaint IN00441635 and the Nursing Home COVID-19 Focused Infection Control Survey. Survey date: October 29, 2024 Facility number: 002724 Residential Census: 31 Woodmont Health Campus was found to be in compliance with 410 IAC 16.2-5 in regards to the Investigation of Residential Complaint IN00441635 and the Residential Covid-19 Focused Infection Control Survey..	R 0000		