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	08/16/2023

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 Complaint IN00411865. Complaint IN00411865 - Federal/State deficiency related to the allegations are cited at F0689. Survey dates: August 15, 16, 2023 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census Bed Type: SNF/NF: 42 SNF: 8 Residential: 31 Total: 81 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 6 Total: 50 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2023.	F 0000	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, true representation of the quality of care provided, or living environment provided to the residents of Woodmont Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted August 15-16, 2023. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica West	Executive Director	09/07/2023

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.

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	08/16/2023

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
	The facility must ensure that - §483.25(d)(1) The resident environment 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 observation, interview, and record review, the facility failed to provide adequate supervision and prevent falls for 1 of 3 residents reviewed for accidents. Fall interventions were not in place for a resident with multiple falls. Current physician orders differed from the care plan in place. (Resident B) Finding includes: On 8/15/23 at 1:09 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety disorder, and a history of falling. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/17/23, indicated Resident B was severely cognitively impaired. The MDS indicated Resident B required an extensive assist of 1 staff member for bed mobility, transfers, and toileting. The MDS indicated Resident B had 2 or more falls since admission/ reentry. Resident B's care plan included, but was not limited to, "Resident is at risk for falling R/T [related to]: requires assistance with ADL's [activities of daily living], has balance issues, on antidepressant, hx [history] of falls and has diagnoses of dementia, anxiety, HTN [hypertension], hypothyroidism, and diabetes," revised 5/31/23. Interventions included, but were not limited to, non skid strips in front of the toilet,	F 0689	F689 D Free of Accident Hazards/Supervision/Devices 1. Resident B suffered no ill effects from the alleged deficient practice. Resident assessed with no findings. All physician orders verified. Fall interventions reviewed, plan of care updated, and interventions put in place as appropriate. Nursing department staff were immediately educated on fall interventions. 2. All residents have the potential to be affected. Nursing staff educated by the DHS on the fall management policy. All health center residents' plan of care and fall interventions reviewed and plan of care updated as indicated. Nursing leaders will complete visual observation during daily rounds to ensure that fall interventions are in place per plan of care. 3. As a measure of ongoing compliance, the DHS, or designee, will complete an audit of 3 residents to ensure that fall interventions are in place per plan of care 5 x per week for 4 weeks,	09/08/2023

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	08/16/2023

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
	dated 6/28/23. "Resident has impairment in functional status in regards to bed mobility, transfers, toileting, and eating R/T: requires assistance with ADL's, has balance issues..." dated 4/12/23. Interventions included, but were not limited to, "Resident requires...1-2 assist with transfers, 1-2 assist with bed mobility, and 1-2 assist with toileting..." Resident B's current Physician Orders included, but were not limited to, "Activity: up ad lib," dated 3/30/23 and "Non skid strips to floor in front of toilet; check placement q [every] shift 06:00 PM - 06:00 AM, 06:00 AM - 06:00 PM," dated 6/28/23. On 8/15/23 at 2:30 P.M., LPN (Licensed Practical Nurse) 7 provided a CNA (Certified Nurse Aide) Assignment Form for that day that indicated that Resident B was "I" for transfers and the sheet indicated "...encourage activities, she likes to clean. Toilet frequently in a.m., night light in room, enco [sic] non skid strips by toilet..." Resident B's fall history included the following for the last 90 days: Fall 1: On 6/7/23 at 11:45 P.M., Resident B tripped over shoes when going to the bathroom. The new intervention at that time was, "Keep resident's shoes on table in eyesight at night." Fall 2: On 6/8/23 at 8:38 A.M., Resident B was found on the floor between the bathroom and bedroom. The new intervention at that time was, "Non skid strips by doorway of bathroom." Fall 3: On 6/27/23 at 6:05 A.M., a CNA (Certified Nurse Aide) heard a loud noise followed by the		then 3 x weekly for 4 weeks, then 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.	

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	08/16/2023

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
	bathroom call light being activated and found Resident B on her left side in front of the toilet. The new intervention at that time was, "Non skid strips in front of toilet." Fall 4: On 7/9/23 at 9:45 A.M., Resident B was found on the bathroom floor with regular socks on. The new intervention at that time was, "Encourage resident to wear non skid socks to bed." Fall 5: On 7/23/23 at 6:39 P.M., Resident B was behind the nurses station and bent over to throw something in the trashcan and when she stood up, she grabbed onto a rolling chair that rolled away which caused the resident to fall. The new intervention at that time was, "Encourage purposeful activity after meals." Fall 6: On 7/28/23 at 6:35 A.M., Resident B fell when ambulating. The new intervention at that time was, "Encourage resident to wear hipsters." During an observation on 8/16/23 at 8:01 A.M., Resident B's bathroom lacked non-skid strips in front of the toilet. During an observation on 8/16/23 at 8:28 A.M., Resident B had on shoes and pushed her walker down the hallway and entered her room with QMA (Qualified Medication Aide) 3. Resident B did not have a gait belt on. When QMA 3 prepared Resident B's bed, Resident B walked over to the other side of the room by the window and failed to take her walker. QMA 3 failed to take Resident B her walker and assist her back to bed. During an interview on 8/16/23 at 8:06 A.M., CNA			

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	08/16/2023

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
	9 indicated Resident B was an assist of 1 staff member for transfers. During an interview on 8/16/23 at 8:11 A.M., QMA 5 indicated she was unsure if Resident B was up independently or if she was a standby assist. She indicated that some interventions put in place to keep Resident B from falling included non skid socks, non skid strips in the bathroom entrance, and non skid strips should be in front of the toilet, but they were pulled off the floor by another resident. At that time, she indicated Resident B had so many falls due to being impulsive. During an interview on 8/16/23 at 8:25 A.M., CNA 11 indicated Resident B was an assist of 1 staff member for transfers and she should have non skid strips in front of the toilet. CNA 11 indicated the "I" on the CNA Assignment Form is to alert staff that Resident B can stand up by herself, was a standby assist, and a gait belt should be utilized. During an interview on 8/16/23 at 10:37 A.M., LPN 7 indicated Resident B had a Physician's Order to be up ad lib therefore, the resident was able to transfer without assistance. On 8/16/23 at 10:15 A.M., the Administrator provided the Falls Management Program Guidelines policy, reviewed, 3/16/22. The policy indicated "[name of company] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...The resident care plan should be updated to reflect any new or change in interventions..." This Federal tag relates to Complaint IN00411865. 3.1-45(a)			