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	07/26/2024

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 21, 22, 23, 24, 25, 26, 2024 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census Bed Type: SNF/NF: 41 SNF: 6 Residential: 32 Total: 79 Census Payor Type: Medicare: 5 Medicaid: 33 Other: 5 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 6, 2024.	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 Annual Survey conducted July 21-26th, 2024. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennie Deyne	Executive Director	08/22/2024

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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	(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan conferences were completed. Quarterly care plan conferences were not completed for 4 of 5 residents reviewed for unnecessary medications. (Resident 28, Resident 8, Resident 19, Resident 29) Findings include: 1. On 7/23/24 at 1:59 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors and hypertension.	F 0657	1. The Social Service Director ensured Resident First care conferences were completed by (8/22/2024) for residents # 28, #8, #19 and #29. 2. All residents have the potential to be affected. Education completed with SSD (social services director) and IDT (interdisciplinary team) regarding Care plan conference completion and required frequency per regulatory requirement. SSD	08/28/2024

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	Resident 28's clinical record lacked a care conference between 1/2/24 and 6/3/24. 2. On 7/23/24 at 8:12 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder and depression. Resident 8's clinical record lacked a care conference between 12/12/23 and 5/8/24. 3. On 7/24/24 at 9:21 A.M., Resident 19's clinical record was reviewed. Diagnoses included, but was not limited to, hypertension and anxiety disorder. Resident 19 lacked a care conference between 8/27/23 and 1/3/24 and 5/30/24. 4. On 7/23/24 at 10:39 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, fibromyalgia and depression. Resident 29 lacked a care conference between 8/27/23 and 12/12/23 and 6/11/24. During an interview on 7/24/24 at 9:23 A.M., the Social Service Director (SSD) indicated Resident 28, Resident 8, Resident 19, and Resident 29 should have had a care plan conference every 3 months. On 7/25/23 at 1:03 P.M., Regional Support 2 provided a current Resident's First Meeting Guidelines policy, reviewed 12/31/23 that indicated, "...communication and participation regarding the resident's plan of care, medical condition and care needs between the resident, family, resident and care givers...2. Subsequent meeting for...residents should be conducted at a		audited all residents to ensure they had a care conference within the previous 90 days. Deficiencies noted were corrected at the time of discovery and care conferences were scheduled to include IDT members. All residents will have a resident first meeting scheduled quarterly moving forward. 3. As a measure of ongoing compliance, the SSD will audit 5 random residents to ensure they have had a care conference completed quarterly per the regulatory requirement 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the SSD/designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance is achieved. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met. Completion Date: 8/28/24	

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	minimum of quarterly..." 3.1-35(d)(2)(B)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention			

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	requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted and contained the correct information daily for 1 of 6 days reviewed during the survey. (July 21) Findings include: On 7/21/24 at 10:09 A.M., the Posted Nurse Staffing form was observed sitting on the 100, 200, 300 Hall nurse's station dated 7/19/24. During an interview on 7/25/24 at 1:41 P.M., the ADON (Assistant Director of Nursing) indicated the Scheduler posted the Posted Nurse Staffing form daily in the morning at the beginning of the shift. On the weekend, the 300 Hall nurse posted it in the morning at change of shift. On 7/25/24 at 1:02 P.M., Regional Support 2 provided a Guidelines for Staff Posting policy, revised 5/11/16, which indicated "At the beginning of the day the number and amount of hours of licensed nurses (RN [Registered Nurse] and LPN [Licensed Practical Nurse]) and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted..."	F 0732	1. No residents were affected by the deficient practice. An updated daily staffing sheet with counts was immediately posted for the date identified. 2. No residents have the potential to be affected by the alleged deficient practice. Education was provided to the interdisciplinary team on the requirements and process of posting the daily staffing sheet with counts. 3. As a measure of ongoing compliance, the ED/designee will audit the posted daily staffing sheet with counts for accuracy 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the ED/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: 8/28/24	08/28/2024
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure storage of food in a safe and sanitary manner and failed to follow proper sanitation for 2 of 2 kitchen observations. Food items were observed unlabeled and open to air. The dishwasher did not reach the proper rinse temperature. Temperature logs were not completed correctly. (Kitchen) Findings include: 1. On 7/21/24 at 9:10 A.M., a box of beef patties and a box of chicken breasts were observed open to air and not labeled in the walk in freezer. On 7/22/24 at 9:34 A.M., a box of beef patties was observed open to air and unlabeled in the walk in freezer.	F 0812	1. Unlabeled and open to air food items were discarded immediately. The dishwasher was taken out of service immediately and service requested. All temperatures were taken, verified as within acceptable range, and logged immediately. Dietary staff immediately educated on food storage, dishwasher rinse temperature, process for reporting out of range temperature/service request and temperature logs. 2. All residents have the potential to be affected by the alleged deficient practice. DFS (Director of	08/28/2024

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	2. On 7/21/24 at 9:45 A.M., the high temperature dish washer was observed to reach a temperature of 168 degrees during the rinse cycle. On 7/21/24 at 9:56 A.M., Daily Data Sheets were provided for 7/14/24 through 7/20/24 which lacked documentation of food temperatures, dish machine temperatures, refrigerator and freezer temperatures and manual ware washing concentration for the evening shift on 7/14/24, 7/15/24, and 7/20/24. One sheet lacked a date, evening meal temperatures, dish machine temperatures for all meals, A.M. and P.M. refrigerator and freezer temperatures, and manual ware washing concentration for all meals. The dishwasher rinse temperature on 7/20/24 was logged as 170 for breakfast and 172 for noon meal. During an interview on 7/21/24 at 9:53 A.M., Cook 17 indicated if the dishwasher rinse cycle did not reach 180 degrees, he would notify the Dietary Manager or if he saw the maintenance man he would tell him. Neither one was here yesterday when he recorded the rinse temperature at 170 degrees at breakfast and 172 degrees at lunch so he didn't notify anyone. He had not notified anyone that morning about the rinse temperature being below 180. He indicated he didn't know when the company had been there last for maintenance. The Dietary Manager or Maintenance Director would call the company to work on the dishwasher. During an interview on 7/21/24 at 11:25 A.M., the Administrator indicated that she had just been notified that the dishwasher had not been reaching 180 degrees rinse temperature, and the facility was going to start using a three compartment sink to wash all dishes.		food services) and dietary staff educated on policies and processes for food storage, dishwasher temperature and maintenance, service request process, and temperature logs. All items were verified as properly labeled and stored. Dishwasher maintenance completed, and dishwasher returned to service. Temperature logs in place and completed per policy. 3. As a measure of ongoing compliance: a) The DFS/designee will audit food storage areas for appropriate labeling and storage 3 times weekly for 4 weeks, two times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. b) The DFS/designee will audit dishwasher rinse temperature 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. c) The DFS/designee will audit temperature logs for completion 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. 4. As a quality measure, the DFS/designee will review any findings and corrective action at least quarterly and ongoing in the	

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	During an interview on 7/21/24 at 11:37 A.M., the Administrator indicated all dishes washed this morning will be rewashed in three compartment sink and plastic would be used for lunch if the dishes couldn't be rewashed in time. Since there have been inconsistencies in the rinse temperatures, a service man has been called to service the dishwasher. During an interview on 7/21/24 at 11:42 A.M., the Administrator indicated the kitchen staff was going to run the dishes back through the dishwasher since it was back up to 180 degrees. The staff felt they have time to rewash them before lunch. During an interview on 7/21/24 at 12:03 P.M., two cognitively intact random residents indicated there have been no Styrofoam dishes used for meals recently. On 7/22/24 at 9:34 A.M. The rinse cycle temperature was observed to be 174 degrees on the dish washer. Dishes were used to serve meals from 7/21/24 through 7/26/24. No disposable dishes were used. During an interview on 7/24/24 at 10:02 A.M., the Dietary Manager indicated all temperatures should be logged 3 (three) times a day with each meal for the kitchen. During an interview on 7/24/24 at 11:32 A.M., the Dietary Manager indicated food in freezers should be in plastic containers with lids with the food left in plastic bags with labels or kept in plastic bags rolled down with box closed and labeled. On 7/21/24 at 11:25 A.M., the Administrator		campus Quality Assurance Performance Improvement meetings until 100% compliance is achieved. The plan will be reviewed and updated as warranted. Completion Date: 8/28/24	

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	provided a Dish Machine Standard Operating Policy, dated 5/31/2016, which indicated "...Check that temperatures are appropriate: High Temp-...Rinse temp (temperature) should be 180-185 degrees F (Fahrenheit)..." On 7/21/24 at 11:25 A.M., the Administrator provided a Dishmachine Temp (Temperature)/Sanitizer Policy, dated 5/31/2016, which indicated "...2. Dishmachine temperatures and sanitizer concentration will be recorded at each meal...3. If the wash or rinse cycle temperatures or sanitizer concentration do not meet the minimum requirements, the Dining Services manager will be notified..." On 7/22/24 at 9:49 A.M., the Administrator provided a Hot and Cold Temperature Holding Guideline Policy, dated 5/31/2016, which indicated "The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal..." On 7/22/24 at 2:55 P.M., the Administrator provided a Storage Procedures Policy, dated 5/31/2016, which indicated "...3. All food in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents observed for incontinence care. Gloves were not changed and hands were not sanitized between dirty and clean tasks. A resident's incontinence pad was laid on the bathroom floor before it was placed on the resident. (Resident 39, Resident 7) Findings include: 1. On 7/25/24 at 10:40 A.M., CNA (Certified Nurse Aide) 48 and CNA 56 were observed providing	F 0880	1. Residents #39 and 7 suffered no ill effects from the alleged deficient practice. Resident assessed and monitored for adverse effects with no findings. Nursing staff were immediately educated on hand hygiene, donning and doffing gloves and clean/dirty surfaces. 2. All residents have the potential to be affected. Nursing department staff educated by the Infection Preventionist (IP nurse) on hand hygiene and infection control	08/28/2024

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	incontinence care on Resident 39. CNA 48 put on shoes on the resident, transferred resident from her bed to her wheelchair, and pushed Resident 39 into the bathroom. She washed her hands with a 5 second lather and put gloves on. CNA 56 washed her hands with a 10 second lather and put on gloves. CNA 48 then went out of the bathroom and back into the bathroom using a gloved hand to open the door and close it. CNA 48 and CNA 56 assisted the resident to stand from the wheelchair and transfer to the toilet. While resident was sitting, CNA 48 laid the clean incontinence pad on the bathroom floor, took off the residents pants and dirty incontinence pad, picked up the incontinence pad from the bathroom floor, put it and her pants back on. She assisted resident to stand and grabbed a wipe. She wiped the resident from front to back, folded the wipe, and wiped the resident from front to back again. After discarding the wipe, she pulled up the incontinence pad and pants, pulled her shirt down, pushed the wheelchair to the sink for the resident to wash her hands. She pushed for the soap to dispense, and grabbed paper towels for the resident to wipe her hands with. CNA 48 pushed the resident out of the bathroom into the hallway. CNA 56 washed her hands with a 4 second lather and exited the room. As CNA 48 was walking away, CNA 48 was questioned her about about performing hand hygiene. At that time, she indicated she did not perform hand hygiene and proceeded to enter Resident 39's bathroom and washed her hands with a 6 second lather. 2. On 7/25/24 at 10:32 A.M., Certified Nurse Aide (CNA) 23 and CNA in training 21 provided incontinence care on Resident 7. CNA 23 used her gloved hands to move the bedside table, grabbed a trash bag from the trash can, opened the trash bag and placed it on the bed. Next, CNA 23 used		during incontinence care. IP nurse and nursing leadership will complete visual observations during daily rounds to ensure appropriate hand hygiene, donning/doffing gloves and that incontinence care is provided utilizing infection control practices. 3. As a measure of ongoing compliance: a) The DHS/IP, or designee, will complete an audit of 5 staff to ensure appropriate hand hygiene and donning/doffing gloves 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 incontinence care for 3 residents 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: 8/28/24	

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	155682	A. BUILDING 00 B. WING	07/26/2024

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	the same gloved hands to raise Resident 7's head of the bed with the remote, moved an oxygen tank, removed the blankets, and removed 2 pillows that were under the resident. CNA in training 21 wiped Resident 7 while CNA 23 used the same gloved hands to hold Resident 7's panus (excess skin and fat that hangs down from the abdomen). At that time, CNA 23 rolled Resident 7 by touching her leg and arm with her gloved hands and CNA in training 21 used 5 wipes to clean Resident 7's bottom. CNA in training 21 failed to change gloves and perform hand hygiene before she placed the clean brief under the resident. CNA in training 21 used both gloved hands to assist Resident 7 to roll. CNA 23 and CNA in training 21 both fastened the clean brief and pulled down Resident 7's gown. At that time, CNA 23 and CNA in training 21 removed gloves, and CNA 23 failed to perform hand hygiene before she pulled up Resident 7's blankets. CNA 23 donned a new pair of gloves and placed a pillow under the resident's feet, handed Resident 7 her phone, and then lowered the head of the bed with the remote. CNA 23 removed gloves, but failed to perform hand hygiene and placed the bedside table next to resident 7 and then opened the door to leave the room. During an interview on 7/25/24 at 1:41 P.M., the DON (Director of Nursing) indicated staff should lather their hands with soap for 20-30 seconds during hand hygiene. She would expect staff to wash hands, put gloves on, and perform incontinence care without touching other items. If they would touch other items such as doorknobs, bed controller, or bedside table, she would expect gloves to be changed and hand hygiene performed between. At that time, the DON indicated staff should not lay the incontinence pad on the bathroom floor.			

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	On 7/25/24 at 1:00 P.M., Regional Support 2 provided a current Guideline for Handwashing/Hand Hygiene policy, reviewed 12/31/23 that indicated, "Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of antiseptic hand rub...1. All health care workers shall utilize hand hygiene frequently and appropriately...After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen,etc..." 3.1-18(b) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a sanitary and homelike environment was provided for 3 of 3 resident halls observed and 1 of 1 shower room. Resident toilets were visibly soiled, fracture pans and urine hats were uncovered and placed between the handrail and wall, vitals machine and lift equipment were visibly soiled. The carpet was stained on the 200 Hall. The shower room grout was soiled, tiles were chipped, and there was a broken tile by the bathroom wall. (100 Hall, 200 Hall, 300 Hall, Shower Room) Findings Include:	F 0921	1. No residents were affected by the deficient practice. Soiled resident toilets were immediately cleaned by environmental services staff. Uncovered fracture pans and urine hats were removed from handrail, discarded and replaced. Visibly soiled vital machines and lift equipment were immediately cleaned. The 200 hall carpet stains treated, and carpet cleaned per environmental services staff. Shower room grout cleaned and work order in progress for tile repair/replacement. Nursing and	08/28/2024

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	1. On 7/22/24 at 11:02 A.M., the bathroom of Room 109 was observed. There was a brown substance on the back of the toilet and an uncovered fractured (flattened) bedpan on the handrail. There were black scuffs on the walls. On 7/26/24 8:21 A.M., the same was observed. 2. On 7/22/24 at 9:14 A.M., the bathroom of Room 110 was shared by 2 residents and was observed to have an uncovered fractured bedpan on the handrail. On 7/26/24 at 8:22 A.M., the same was observed. 3. On 7/21/24 at 8:56 A.M., a sit to stand lift was observed in Room 101 with food and other debris on the area where the residents place their feet. On 7/26/24 at 8:47 A.M., the same was observed. 4. On 7/22/24 at 10:08 A.M., Room 209 was observed. In the bathroom, the vent fan and handrail behind the toilet were dusty. In Room 209, there was a package of open wipes on the bedside table, the bar under the bottom of the bed closest to the door was dusty, the walls under the clock and facing the bathroom door were plastered without paint, a brown substance was on the door frame and wall, and black scuff marks were along the walls by the bathroom door. There was a wheelchair sitting next to the bed closest to the window with flaking leather on both armrests. On 7/26/24 at 9:12 A.M., the same was observed except for the open wipes on the bedside table. 5. On 7/22/24 at 10:18 A.M., Room 208 was observed. In the bathroom, there was an uncovered gray fractured bedpan on the handrail		Environmental staff were immediately educated on fracture pan and urine hat sanitation/storage, equipment cleaning process when visibly soiled, carpet and tile cleaning request processes. 2. All residents have the potential to be affected by the alleged deficient practice. Education was provided to nursing and environment staff on requirements of a safe, functional, sanitary and comfortable environment per regulatory requirements, fracture pan/urine hat sanitation and storage, equipment cleaning process and schedule, carpet cleaning schedule and stain treatment, process for grout cleaning and tile maintenance. 3. As a measure of ongoing compliance: a) The DHS, or designee, will audit 5 resident rooms for proper placement and storage of fracture pans and/or urine hats 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. b) The DHS, or designee, will audit 3 items of medical equipment (vital sign machine or mechanical lift) for cleanliness 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months.	

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	and the vent fan was dusty. In Room 208, there was large sized area of the wall to the left of the head of bed where the wallpaper had been taken off and not covered, a fan by the bedside in use that was dusty, and linens for the bed stored on a stand by the air conditioner unit. Out in the hallway, there was a black smear and scuffs that went down the hall from the entrance door of Room 208 to the exit doors at the back of the hall. On 7/26/24 at 9:25 A.M., the same was observed except there were no linens stored in the room. 6. On 7/22/24 at 10:24 A.M., Room 207 was observed. In the bathroom, there was paint rubbed away by the handrail, the call light cord was brown, there was a black substance smeared in front of the toilet, the inside of the toilet bowl was soiled, a used glove behind the trash can on the floor, brown smears on the wall behind the trash can, a package of open wipes on the back of the toilet, an uncovered urine hat on the handrail, and above the cabinet there was peeling paint and plaster hanging from the ceiling. In Room 207, there was an uncovered cracker and pieces of chips on a paper towel on the cabinet by the closet, the closet door was propped open, and food debris was scattered on the floor around the recliner. On 7/26/24 at 9:08 A.M., the same was observed in the bathroom except for the used glove behind the trash can. The food in the room was now in bags on the cabinet by the closet and there was less food debris on the floor. 7. On 7/22/24 at 10:32 A.M., Room 205 was observed. In the bathroom, there were 2 uncovered pink dish pans and 1 gray uncovered bed pan laying under the sink on the floor, the		c) The ESD, or designee, will audit 5 resident bathroom toilets for cleanliness 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. d) The ESD, or designee, will audit the carpet on 2 halls or common areas for untreated stains 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. e) The DPO, or designee, will audit the shower room tile floor for dirty grout/cracked or broken tiles 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the ED 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: 8/28/24	

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	floor was sticky and the bathroom had a strong urine smell. On 7/26/24 at 9:06 A.M., the same was observed except the gray bed pan was covered. 8. On 7/22/24 10:48 A.M., the Shower Room was observed. There was an upholstered chair with stains on the seat, a brown substance and dust were behind the door in the corner, the door frame had a brown substance on it, the grout in the tiles throughout the room were soiled, there was a broken tile by the bathroom door, and tiles throughout the floor were chipped. There was a black substance smeared throughout the shower room on the floor. The cloth covering where the towels are kept had 3 brown smudges on the top, the inside of the toilet bowl was soiled and there was a blackish brown substance on the toilet seat, used paper towels were on the floor, and a spider web was in the corner behind toilet. The toilet paper holder was missing on one side, the vent fan was dusty, and the sink facet had brown along the caulking. Over by the spa, there was hair, dust, food debris, and trash scattered on the floor. The carpet outside the shower room was blackened. Wallpaper just past the Shower Room door was peeling off. On 7/26/24 at 8:48 A.M., the same was observed. 9. On 7/22/24 at 10:37 A.M., the following was observed in the 200 Hall. The vitals machine by Room 202 was dusty, there was black smears and brown spots. On 7/26/24 at 8:47 A.M., the same was observed. 10. The ABHR (Anti Bacterial Hand Rub) dispensers by Rooms 210, 207, 206, 204, and 203			

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	were dusty on top and had black dust on the bottom catch plate. On 7/26/24 at 8:47 A.M., the same was observed. 11. A sit to stand lift in the hall by Room 202 was rusty, dusty, and had food and other debris on the foot plate and black scuffs on the legs. On 7/26/24 at 8:47 A.M., the same was observed. 12. The carpet in the 200 hall had blackish/brown spots by the medication cart and black and brown marks in hall between Room 205 and 206. There was random food and trash debris throughout. On 7/26/24 at 8:47 A.M., the same was observed. 13. On 7/22/24 at 2:18 P.M., where the 300 Hall starts, there was a piece of the wood floor missing and the carpet was observed coming loose. On 7/26/24 at 9:21 A.M., the same was observed. On 7/26/24 at 10:00 A.M., the resident grievances for the past 6 months were reviewed and indicated the following: 3/6/24 "Dirty carpet - carpet in TV room has had spots of food on it for a while" 4/30/24 "Recliner and carpet needs cleaned" 5/5/24 "TV room dusty - Son stated TV room was dusty and did not want grandchildren in room with the dust. Got washrag from staff and dusted room himself" 6/25/24 "Room had a odor of urine - resident had a complaint of room smelling like urine ... " 7/14/24 "smell in room (urine) - asking to change to a different room d/t [due to] urine smell in current room, stated has smelled like this since arrival"			

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	On 7/26/24 at 10:15 A.M., a "Daily Cleaning Schedule" was provided by the Environmental Services Director and she indicated the the following should be done in each room daily, staff should sign and date that it was completed, and list any comments about the room: Restroom: clean toilet and toilet bottom clean sink and sink pipes mirrors/lights/vents check toilet paper/soap/towels clean handrail shower if needed sweep and mop Resident Room: wash mattress dust all furniture dust flat surfaces dust overbed light clean bedside table and bottom check bed for dust clean window vacuum room During an interview on 7/26/24 at 10:51 A.M., the Environmental Service Director indicated the housekeeping staff have a schedule for deep cleans performed monthly but they should do the daily cleaning list on every room every day. She indicated the carpets were cleaned monthly with the big machines and done weekly with a smaller one usually on Wednesdays. They are not in charge of cleaning the resident equipment such as the vitals machines or sit to stand lifts. The shower room should be cleaned daily in the afternoon and the last housekeeper here and evening shift laundry should do it before they leave, but there wasn't a checklist for that. She			

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	would expect them to dust, sweep, mop, and sanitize. The grout has not been cleaned in awhile but they do clean it. She was unsure if the upholstered chair in the shower room was kept in there or how they clean or sanitize it. She indicated the hand sanitizer dispensers on the walls should be cleaned daily and the fractured bed pans and urine hats should be stored in plastic bags in the resident nightstands. During an interview on 7/26/24 at 11:01 A.M., the Maintenance Director indicated staff should notify him via TELS (electronic maintenance software) program that he has on his phone and computer and he addresses things from there. Staff was aware of what to look for and should notify him of rooms needing attention. During an interview on 7/26/24 at 11:10 A.M., the Administrator indicated CNAs (Certified Nurse Aides) were in charge of cleaning the resident equipment. During an interview on 7/26/24 at 11:11 A.M., CNA 23 indicated she was not sure who was supposed to clean the resident equipment. She did know she was to notify nurse/housekeeping/maintenance if there was a concern in a room, but she was not shown how to enter a work order into the system so she tells them verbally. At that time, she indicated linens, clean or dirty, were not to be kept in resident rooms. During an interview on 7/26/24 at 11:30 A.M., Regional Support 2 indicated there was not a policy for the cleanliness of equipment but it should be done when found soiled or dirty and anyone could do it. It is not said in the policy, but the urine hats were to be single use so those hats			

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	should not be stored and the fractured bedpans/dishpans should be covered. During an interview on 7/26/24 at 11:46 A.M., Regional Support 4 indicated there was not a policy for environment but it would be their policy to strive to provide a homelike environment. 3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 21, 22, 23, 24, 25, 26, 2024 Facility number: 002724 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 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 Annual Survey	

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			conducted July 21-26th, 2024. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure it attempted to collaborate with a local fire department during a routine fire drill at least once every six months. No documentation was available to indicate that the facility provided training in conjunction with the local fire department or invited the local fire department to attend fire drill training.	R 0092	1. No residents were affected by the alleged deficient practice. The Director of Plant Ops and the Executive Director immediately educated on inviting the fire department to a fire drill every 6 months. The fire department has been invited to attend the following	08/28/2024

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	Finding includes: During a review of monthly fire drills on 7/24/24 at 8:57 A.M., no documentation was included that indicated a local fire department was invited or attended any of the drills from July 2023 through July 2024. During an interview on 7/24/24 at 8:57 A.M., the Maintenance Director indicated that he had reached out to the fire department, but they had not gotten back to him. He indicated he had no documentation, he just called them. During an interview on 7/24/24 at 2:32 P.M., the Administrator indicated she contacted corporate and there was no documentation that the fire department was invited to fire drills every six months by the previous maintenance director. During an interview on 7/26/24 at 8:45 A.M., Administrator indicated they did not have a policy that specifically included that a local fire department would be invited to participate in fire drills and trainings, but the facility should follow the state requirements.		fire drills: ***(7/24/24 and 8/20/24).*** 2. All residents have the potential to be affected. The Interdisciplinary team (IDT) was educated on the regulation regarding Fire Department invitation/participation for fire drills. 3. As measure of ongoing compliance: The ED/designee will monitor documentation of fire department invitation/attendance for the facility's fire drills weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure every 6 month compliance. 4. As a quality measure, the ED/designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings until 100% compliance is achieved. The plan will be reviewed and updated as warranted.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure storage of food in a safe and sanitary manner and failed to follow proper sanitation for 2 of 2 kitchen observations. Food items were observed unlabeled and open to	R 0273	1. Unlabeled and open to air food items were discarded immediately. The dishwasher was taken out of service immediately and service requested. All	08/28/2024

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	155682	A. BUILDING 00 B. WING	07/26/2024

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

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	air. The dishwasher did not reach the proper rinse temperature. Temperature logs were not completed correctly. (Kitchen) Findings include: 1. On 7/21/24 at 9:10 A.M., a box of beef patties and a box of chicken breasts were observed open to air and not labeled in the walk in freezer. On 7/22/24 at 9:34 A.M., a box of beef patties was observed open to air and unlabeled in the walk in freezer. 2. On 7/21/24 at 9:45 A.M., the high temperature dish washer was observed to reach a temperature of 168 degrees during the rinse cycle. On 7/21/24 at 9:56 A.M., Daily Data Sheets were provided for 7/14/24 through 7/20/24 which lacked documentation of food temperatures, dish machine temperatures, refrigerator and freezer temperatures and manual ware washing concentration for the evening shift on 7/14/24, 7/15/24, and 7/20/24. One sheet lacked a date, evening meal temperatures, dish machine temperatures for all meals, A.M. and P.M. refrigerator and freezer temperatures, and manual ware washing concentration for all meals. The dishwasher rinse temperature on 7/20/24 was logged as 170 for breakfast and 172 for noon meal. During an interview on 7/21/24 at 9:53 A.M., Cook 17 indicated if the dishwasher rinse cycle did not reach 180 degrees, he would notify the Dietary Manager or if he saw the maintenance man he would tell him. Neither one was here yesterday when he recorded the rinse temperature at 170 degrees at breakfast and 172 degrees at lunch so he didn't notify anyone. He had not notified anyone that morning about the rinse temperature being below 180. He indicated he didn't know		temperatures were taken, verified as within acceptable range, and logged immediately. Dietary staff immediately educated on food storage, dishwasher rinse temperature and temperature logs. 2. All residents have the potential to be affected by the alleged deficient practice. DFS (Director of food services) and dietary staff educated on policies and processes for food storage, dishwasher temperature and maintenance, temperature logs. All items were verified as properly labeled and stored. Dishwasher maintenance completed, and dishwasher returned to service. Temperature logs in place and completed per policy. 3. As a measure of ongoing compliance: a) The DFS, or designee, will audit food storage areas for appropriate labeling and storage 3 times weekly for 4 weeks, two times weekly for 4 weeks, weekly for 4 weeks, then monthly for 3 months. b) The DFS, or designee, audit dishwasher rinse temperature 5 times weekly for 4 weeks, 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. c) The DFS, or designee, audit temperature logs for completion 5	

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	when the company had been there last for maintenance. The Dietary Manager or Maintenance Director would call the company to work on the dishwasher. During an interview on 7/21/24 at 11:25 A.M., the Administrator indicated that she had just been notified that the dishwasher had not been reaching 180 degrees rinse temperature, and the facility was going to start using a three compartment sink to wash all dishes. During an interview on 7/21/24 at 11:37 A.M., the Administrator indicated all dishes washed this morning will be rewashed in three compartment sink and plastic would be used for lunch if the dishes couldn't be rewashed in time. Since there have been inconsistencies in the rinse temperatures, a service man has been called to service the dishwasher. During an interview on 7/21/24 at 11:42 A.M., the Administrator indicated the kitchen staff was going to run the dishes back through the dishwasher since it was back up to 180 degrees. The staff felt they have time to rewash them before lunch. During an interview on 7/21/24 at 12:03 P.M., two cognitively intact random residents indicated there have been no Styrofoam dishes used for meals recently. On 7/22/24 at 9:34 A.M. The rinse cycle temperature was observed to be 174 degrees on the dish washer. Dishes were used to serve meals from 7/21/24 through 7/26/24. No disposable dishes were used.		times weekly for 4 weeks, 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, then monthly for 2 months. 4. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance is achieved. The plan will be reviewed and updated as warranted. Completion Date: 8/28/24	

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	During an interview on 7/24/24 at 10:02 A.M., the Dietary Manager indicated all temperatures should be logged 3 (three) times a day with each meal for the kitchen. During an interview on 7/24/24 at 11:32 A.M., the Dietary Manager indicated food in freezers should be in plastic containers with lids with the food left in plastic bags with labels or kept in plastic bags rolled down with box closed and labeled. On 7/21/24 at 11:25 A.M., the Administrator provided a Dish Machine Standard Operating Policy, dated 5/31/2016, which indicated "...Check that temperatures are appropriate: High Temp-...Rinse temp (temperature) should be 180-185 degrees F (Fahrenheit)..." On 7/21/24 at 11:25 A.M., the Administrator provided a Dishmachine Temp (Temperature)/Sanitizer Policy, dated 5/31/2016, which indicated "...2. Dishmachine temperatures and sanitizer concentration will be recorded at each meal...3. If the wash or rinse cycle temperatures or sanitizer concentration do not meet the minimum requirements, the Dining Services manager will be notified..." On 7/22/24 at 9:49 A.M., the Administrator provided a Hot and Cold Temperature Holding Guideline Policy, dated 5/31/2016, which indicated "The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal..." On 7/22/24 at 2:55 P.M., the Administrator provided a Storage Procedures Policy, dated 5/31/2016, which indicated "...3. All food in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer			

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	burn. Items are labeled and dated..."			