PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

	K MEDICAKE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155682	B. WING		08/07/2024
	PROVIDER OR SUPPLIEF		STREET A 1325 R BOON		
				1	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the Irraccordance with 42 Survey Date: 08/07 Facility Number: 0 Provider Number: 200 At this Emergency Woodmont Health compliance with Er Requirements for N Participating Provid 483.73 The facility has 60 the survey, the cens Quality Review cor	02724 155682 309330 Preparedness survey, Campus was found not in nergency Preparedness fedicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of rus was 46. Impleted on 08/15/24 42 CFR, Subpart 483.73 is NOT	E 0000	The submission of this plan of correction does not indicate a admission by Woodmont Hea Campus that the findings and allegations contained herein a an accurate, true representati the quality of care provided, o living environment provided to residents of Woodmont Health Campus. The facility recogniz its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with requirements of participation of skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with state and federal requirement governing the management of facility. The Plan of Correction submitted to respond to the allegation of noncompliance of during the life safety Survey conducted August 7, 2024. Tfacility respectfully requests from the department a desk review.	n ltth are on of r o the es r and er. t is enthe for o the for o the for o the first it is enthe
E 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.542(a	416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a))(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)		substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Jennie Deyne Executive Director 08/30/2024

Any defiency statement 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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COMPLETED B. WING 08/07/2024						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1325 ROCKPORT RD BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	(1)-(2), 486.360(a 494.62(a)(1)-(2) Plan Based on All §403.748(a)(1)-(2) §418.113(a)(1)-(2) §483.73(a)(1)-(2) §484.102(a)(1)-(2) §485.542(a)(1)-(2) §486.360(a)(1)-(2) §494.62(a)(1)-(2) [(a) Emergency Pl develop and main preparedness plan and updated at learn must do the follow (1) Be based on a facility-based and assessment. * [For Hospices at Plan. The Hospice maintain an emergency events assessment. * [For Hospices at Plan. The Hospice maintain an emergency events assessment. * [For Hospices at Plan. The Hospice maintain an emergency events assessment. (2) Include strategency events assessment. (3) Include strategency events assessment.	Hazards Risk Assessment), §416.54(a)(1)-(2),), §441.184(a)(1)-(2), §482.15(a)(1)-(2), §485.68(a)(1)-(2),), §485.625(a)(1)-(2),), §485.920(a)(1)-(2),), §491.12(a)(1)-(2), Ian. The [facility] must tain an emergency on that must be reviewed, east every 2 years. The plan ring:] Ind include a documented, community-based risk ing an all-hazards Is §418.113(a):] Emergency on must develop and gency preparedness plan wed, and updated at least on plan must do the Ind include a documented, community-based risk on plan must do the Ind include a documented, community-based risk on plan must do the Ind include a documented, community-based risk on plan must do the Ind include a documented, community-based risk on plan must do the						

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Event ID:

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Facility ID: 002724

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682			JILDING	INSTRUCTION	COMPLETED 08/07/2024		
	PROVIDER OR SUPPLIER			1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	the consequences disasters, and oth affect the hospice. *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lea do the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg emergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency prebe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg	The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ag missing residents. Given the risk and the risk ing an all-hazards are identified by the risk ing an all-hazards are identified by the risk ing an all-hazards are updated at least every 2 ust do the following: Ind include a documented, community-based risk ing an all-hazards are missing clients.					
	Based on record rev failed to maintain as plan that was (1) ba documented, facility risk assessment, util which was reviewed month period and (2)	view and interview, the facility in emergency preparedness sed on and includes a sy-based and community-based lizing an all-hazards approach d within the most recent twelve (2) included strategies for acy events identified by the	E 00	006	Immediate Intervention: Executive Director updated an expanded Hazard Vulnerability Assessment to include human created events such as Picket Weapons, work place violence and Mass casualty incident. Executive Director was educated	ing,	08/30/2024

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155682		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	E SURVEY PLETED 7/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1325 ROCKPORT RD BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE		
	483.73(a) (1) and 4. deficient practice of Findings include: Based on review of Plan (EOP) on 08/0 p.m. with the Direct Facility Maintenand Executive Director facility-based and cassessment reviewe most recent twelve review, however, it assessment. It only events and did not it events, such as, bor cyber attacks, just to interview at the tim Director said there assessment that inclevents and human celebelocated during the This finding were recent to the control of t	the Emergency Operations The Emergency Operations The Emergency Operations Total detect all occupants. The Emergency Operations The Emergency Operations Total detect all occupants. The Emergency Operations Th		by Facility Management on the Hazard Vulneral Assessment including It Natural and Human madisasters. The Executive Director the Hazard Vulnerability completeness 1 x per months for completion expanded events. Results of these inspect be presented by Execut Director to the QAPI confurther recommendation continue until the Quality Assurance Team deter substantial compliance achieved. The deficient practice of all residents, staff and with the facility. Exhibit K - Audit Exhibit L - Other document on the photos	bility both ade will inspect by for month x 3 with ctions will utive committee for ns and ity mines has been could affect visitors in			
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.625(d)(2), 484.485.920(d)(2), 484.494.62(d)(2) EP Testing Requii §416.54(d)(2), §44.8460.84(d)(2), §44.8483.475(d)(2), §44.8483.4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.542(d)(2), 5.68(d)(2), 485.727(d)(2), 6.360(d)(2), 491.12(d)(2), rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.625(d)(2), §485.727(d)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/07/2024	
		100002	Б. Т	_	ADDRESS, CITY, STATE, ZIP COD	30,01	
NAME OF I	PROVIDER OR SUPPLIEF	R			OCKPORT RD		
WOODM	IONT HEALTH CAN	1PUS		BOONV	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(2), §485.920(d)(2 (2).	?), §491.12(d)(2), §494.62(d)					
	REHs at §485.542 under §485.727, 0	6.54, CORFs at §485.68, 2, OPO, "Organizations" CMHCs at §485.920, §491.12, and ESRD 62]:					
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:						
	community-based (A) When a commot accessible, confunctional exercise (B) If the [facinatural or man-man activation of the exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, oppor functional exercise (i) of this section include, but is not (A) A second full-scommunity-based functional exercise (B) A mock disast	nunity-based exercise is induct a facility-based e every 2 years; or lity] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or					
	led by a facilitator discussion using a	and includes a group a narrated, emergency scenario, and a					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COMPLETED B. WING 08/07/2024				LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1325 ROCKPORT RD BOONVILLE, IN 47601					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	messages, or presto challenge an er (iii) Analyze the [fa maintain documer exercises, and em the [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice of man-made emerging of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercises (B) A mock disast (C)	pared questions designed mergency plan. acility's] response to and atation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do full-scale exercise that is every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full pased exercise or individual tional exercise following the gency event. Iditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group		TAG	DEFICIENCY		DATE	
	set of problem sta	emergency scenario, and a tements, directed pared questions designed						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155682	B. W	ING		08/07/	/2024
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					OCKPORT RD		
WOODM	ONT HEALTH CAN	MPUS		BOONV	/ILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to challenge an er	nergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:						
		an annual full-scale exercise					
	that is community						
	-	nunity-based exercise is not					
	' '	ict an annual individual					
	facility-based fund						
		experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospice is					
	exempt from enga	aging in its next required					
	full-scale commur	nity based or facility-based					
	functional exercise	e following the onset of the					
	emergency event.						
	(ii) Conduct an ad	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise	e; or					
	(B) A mock disas						
	. ,	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	-					
		rio, and a set of problem					
		ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.						
	. ,	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	tne hospice's eme	ergency plan, as needed.					
	*[For PRFTs at &4	l41.184(d), Hospitals at					
	§482.15(d), CAHs						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COM			COMPL 08/07/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1325 ROCKPORT RD BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community. (A) When a commaccessible, condufacility-based function (B) If the [PRTF, Han actual natural of that requires active plan, the [facility] is next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the following the onse facility-based fac	an annual full-scale exercise a-based; or aunity-based exercise is not act an annual individual, ational exercise; or alospital, CAH] experiences are man-made emergency ation of the emergency ation of the emergency s exempt from engaging in all-scale community based ty-based functional exercise at of the emergency event. an [additional] annual at may include, but is not wing: scale exercise that is or individual, a ational exercise; or act disaster drill; or actional exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. The [facility's] response to alimentation of all drills, and emergency events cility's] emergency plan, as 60.84(d):]					
	1 ' '	ACE organization must to test the emergency ally. The PACE					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. H.		A. Bl	A. BUILDING COMPLETED B. WING 08/07/2024					
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1325 ROCKPORT RD BOONVILLE, IN 47601				
PR	4) ID EFIX 'AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
		that is community- (A) When a commaccessible, condutable facility-based functions of the ending exempt from endul-scale community-based functional exercise of this section is community-based functional exercise of this section is community-based based functional exercise of this section is community-based based functional exercise of this section is community-based based functional exercise of the exemption of the endul-community-based based functional exercise (C) A tabletop exemption of the exercise of problem start exercises, and endul-community exercises, exer	an annual full-scale exercise a-based; or aunity-based exercise is not act an annual individual, ational exercise; or experiences an actual natural argency that requires argency plan, the PACE agaging in its next required aity based or individual, ational exercise following the agency event. an additional exercise every an additional exercise every are under paragraph (d)(2)(i) anducted that may include, attended that is a or individual, a facility axercise; or a ter drill; or a tercise or workshop that is and includes a group a narrated, and includes and includes and include, and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COMPLETE B. WING 08/07/20					
	F PROVIDER OR SUPPLIEF			1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, condu- facility-based function (B) If the [LTC fac- actual natural or not requires activation LTC facility is exe- required a full-scal individual, facility- following the onse- (ii) Conduct an activate may include, following: (A) A second full- community-based based functional et (B) A mock disas (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem stal messages, or pre- to challenge an er (iii) Analyze the [I response to and not all drills, tabletop exents, and revise emergency plan, activate per year. The following: (i) Participate in a that is community.	nunity-based exercise is not an annual individual, ctional exercise. ility] facility experiences an anan-made emergency that a of the emergency plan, the mpt from engaging its next alle community-based or based functional exercise at of the emergency event. In other emergency event. In other exercise but is not limited to the exercise; or the dilitional annual exercise but is not limited to the exercise; or the dility exercise; or the dility or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed exercises, and emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. [3483.475(d)]: CF/IID must conduct the emergency plan at least are ICF/IID must do the emergency plan at least are ICF/IID must do the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COMPLET 08/07/20					
	F PROVIDER OR SUPPLIEF			1325 R	DDRESS, CITY, STATE, ZIP COD DCKPORT RD ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	accessible, conduction facility-based functions of the endictivation onset of the endictivation of the endictivity of the endictivation of the endictivity of the endictivation of the endictivity of the endictiv	ect an annual individual, ectional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID gaging in its next required aity-based or individual, ectional exercise following the gency event. ditional annual exercise but is not limited to the exercise that is or an individual, ectional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a exemple a nergency plan. Er/IID's response to and exercise of energency plan. Er/IID's response to and exercise regency events, and revise regency plan, as needed. 84.102] Be HHA must conduct the emergency plan at er HHA must do the full-scale exercise that is; or ommunity-based exercise conduct an annual based functional exercise					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155682		A. BUILDING COMPLETE B. WING 08/07/202				ETED	
	F PROVIDER OR SUPPLIEF			1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD (ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	activation of the e exempt from enga full-scale commun facility based func onset of the emery (ii) Conduct an ad years, opposite th functional exercise of this section is of include, but is not (A) A second community-based facility-based func (B) A mock di (C) A tableton is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze the H maintain documer exercises, and err the HHA's emerger *[For OPOs at §48 (d)(2) Testing. The exercises to test th OPO must do the (i) Conduct a pape or workshop at lea exercise is led by group discussion, relevant emergene problem statement prepared question emergency plan. I	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/07/2024
	PROVIDER OR SUPPLIER		1325	ET ADDRESS, CITY, STATE, ZIP COD 5 ROCKPORT RD DNVILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	OPO is exempt for required testing exercises of the emergency (ii) Analyze the Olimaintain documer exercises, and enthe [RNHCl's and needed. *[RNCHIs at §40: (d)(2) Testing. The exercises to test to the total community of the exercises to test total community of the emergency period of the em	PO's response to and notation of all tabletop hergency events, and revise OPO's] emergency plan, as a 3.748]: e RNHCI must conduct the emergency plan. The her following: er-based, tabletop exercise a led by a facilitator, using a relevant emergency et of problem statements, as, or prepared questions enge an emergency plan. NHCI's response to and notation of all tabletop hergency events, and revise regency plan, as needed. When and interview, the facility hercises to test the emergency her year, including drills using the emergency of facility must do the annual full-scale exercise that dright in the response of the manual full-scale exercise is not an annual individual,	E 0039	Immediate Intervention: Plant Operations Director Completed Table top exercis Department leaders on 8/23/ addition to the already comp distaster drill on 8/23/23. Plan Operations Director was educated on the policy The facility] must conduct exercis test the emergency plan at le twice per year, including unannounced staff drills usin emergency procedures. The facility, ICF/IID] must do the following: (i) Participate in all	/24 in leted s [LTC ses to seast seg the seg [LTC

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	l í	UILDING	ONSTRUCTION	(X3) DATE COMPL 08/07 /	ETED
	OF PROVIDER OR SUPPLIEF		•	1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	community-based of full-scale functional the onset of the actri (ii) Conduct an addinclude, but is not I a. A second full-sca community-based of functional exercise. b. A mock disaster c. A tabletop exercifacilitator that incluand a set of problem messages, or preparchallenge an emerginal (iii) Analyze the LT maintain document exercises, and emer LTC facility's emeraccordance with 42 This deficient praction the facility. Findings include: Based on review of Plan on 08/07/24 be with the Executive Operations (DOP), Support (FMS) preprovide documenta warning event that however, there was exercise conducted 12 month period. Texecutive Director who said she knows	or individual, facility-based l exercise for 1 year following hal event. itional exercise that may imited to the following: the exercise that is or an individual, facility-based drill; or see or workshop that is led by a hades a group discussion, using hy-relevant emergency scenario, an statements, directed fred questions designed to hency plan. The facility's response to and hation of all drills, tabletop higher years and revise the higher years and hi			annual full-scale exercise that community-based; or (A) Whe community-based exercise is accessible, conduct an annual individual, facility-based functi exercise. (B) If the [LTC facility facility experiences an actual natural or man-made emerger that requires activation of the emergency plan, the LTC facility exempt from engaging its next required a full-scale community-based or individual facility-based functional exercifollowing the onset of the emergency event. (ii) Conduct additional annual exercise that may include, but is not limited the following: (A) A second full-scale exercise that is community-based or an individual facility based functional exercifor (B) A mock disaster drill; of (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario. The Executive Director will instead that facility is in compliance will be presented by Executive Director to the QAPI committed further recommendations and continue until the Quality Assurance Team determines substantial compliance has be	is n a not I onal y] ncy ity is t I, ise at an t to dual, ase; r	

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AND PLAN OF CORRECTION			COMPL 08/07/	ETED		
NAME OF PROVIDER OR SUPPLIES WOODMONT HEALTH CAN			1325 RC	DDRESS, CITY, STATE, ZIP COD DCKPORT RD ILLE, IN 47601		
PREFIX (EACH DEFICIEN TAG REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
_	viewed with the Executive FMS during the exit			achieved. The deficient practice could aff all residents, staff and visitors the facility. Exhibit I - Audit Exhibit J - Other documentatio and photos	in	
K 0000						
Licensure Survey we Department of Head 483.90(a). Survey Date: 08/07 Facility Number: 08/07 Facility Number: 200 At this Life Safety of Health Campus was Requirements for Perform Medicare/Medicaid Life Safety from Finational Fire Protect Life Safety Code, (Code Health Care Occupation of This one story facility has a finance detectors in the corridors and all facility has a capacity of the safety has a capacity has a capacity of the safety has	02724 155682 309330 Code survey, Woodmont so found not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. Aity was determined to be of the ruction and was sprinklered. The alarm system with hard wired the corridors, spaces open to a resident sleeping rooms. The entry of 60 and had a census of	K 000	00	The submission of this plan of correction does not indicate an admission by Woodmont Health Campus that the findings and allegations contained herein an an accurate, true representation the quality of care provided, or living environment provided to residents of Woodmont Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. The Plan of Correction submitted to respond to the allegation of noncompliance ciduring the life safety Survey conducted August 7, 2024. The facility respectfully requests from	the es and fine the es and fine the es and fine the es at the estable the esta	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155682		(X2) MUL A. BUIL B. WING	DING	nstruction 01	(X3) DATE COMPL 08/07 /	ETED	
	PROVIDER OR SUPPLIER			1325 RC	DDRESS, CITY, STATE, ZIP COD DCKPORT RD ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	services were sprinl				the department a desk review substantial compliance.	for	
	Quality Review cor	npleted on 08/15/24					
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any i automatic sprinkle 9.7.5, 9.7.7, 9.7.8	supply source RKS information on non-required or partial er system.					
	failed to ensure spri compartments cove loaded were replace 5.2.1.1.1 sprinklers leakage; shall be from materials, paint, and be installed in the cup-right, pendent, of 5.2.1.1.2 any sprink the following shall Corrosion (3) Physi the glass bulb heat a	on and interview, the facility inkler heads in 2 of 5 smoke red with corrosion, paint, or ed. NFPA 25, 2011 edition, at shall not show signs of the of corrosion, foreign and physical damage; and shall correct orientation (e.g., or sidewall). Furthermore, at the that shows signs of any of the replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in the responsive element (5) g unless painted by the	K 035	53	Immediate Intervention The Director of Plant Operation has contacted the Contractor as scheduled the replacement of sprinkler heads on the outdoor overhang off of the TV room a sprinkler heads in the spa room 200 hall. The Director of Plant Operation was educated by the Executive Director on Sprinkler System - Maintenance and testing	and 3 nd, 4 m on ns	08/30/2024

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/07/2024
	PROVIDER OR SUPPLIEF		1325 R	ADDRESS, CITY, STATE, ZIP COD COCKPORT RD VILLE, IN 47601	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	could affect at least and visitors.	rer. This deficient practice 20 resident, as well as staff		Automatic sprinkler and stand systems are inspected, tested and maintained in accordance the NFPA 25	i,
	p.m. and 2:30 p.m. the Director of Plan Facility Maintenand following was noted a. The porch overh	ang outside the Living		The Director of Plant Operation will audit sprinkler heads for corrosion and dirt 1 x weekly month and 1 x a month for 3 months.	
	with a black substant b. The 200 hall Space covered with corrost to be a light coating (white substance). Based on interview observation, the DF sprinkler heads at the with corrosion/rust, dust, and should be	O and FMS agreed the ne two locations were covered loaded, and a white paint or replaced.		Results of these audits will be presented by the Executive Director to the QAPI committed further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. This deficient practice could a at least 30 residents, as well a visitors and staff in the facility	ee for een ffect as
	_	viewed with the Executive FMS during the exit		Exhibit E: Audits Exhibit Fa: Inservice	
	3.1-19(b)			Exhibit Fb: Invoice to replace sprinkler heads.	
K 0363 SS=E Bldg. 01	than required enc exits, or hazardou of smoke and are	corridor openings in other losures of vertical openings, s areas resist the passage made of 1 3/4 inch wood or other material			

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	OF CORRECTION	IDENTIFICATION NUMBER 155682	A. BUILI B. WING	DING	01	COMPL 08/07/	ETED
	PROVIDER OR SUPPLIER		1	325 RC	DDRESS, CITY, STATE, ZIP COD DCKPORT RD ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary suffammable or come Clearance between covering is not except doors complying with the door closed with a complete door closed with a policy of the door closed with applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lail other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc.	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door celed and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments citions in area or fire as or frames in window Parts 403, 418, 460, 482, S details of doors such as ags, automatics closing	K 026		There were no regetive outcome.		09/20/2024
	failed to ensure 1 of doors would close of	on and interview, the facility 32 resident room corridor complete and latch into its efficient practice could affect at taff and visitors.	K 036	3	There were no negative outcor for this alleged deficient practic The door of resident room 210 replaced in entirety, which now allows for the door to latch	ce. was	08/30/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/07/2024
	PROVIDER OR SUPPLIEF		1325 F	ADDRESS, CITY, STATE, ZIP COD ROCKPORT RD VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	REGULATORY OF Findings include: Based on observation p.m. and 2:30 p.m. the Director of Plant Facility Maintenance door to resident root completely and lated door had to be lifted to close completely damaged in two plat door. Based on into observation, the DF door to room 210 fa and latch into its do This finding was re	ons on 08/07/24 between 1:00 during a tour of the facility with at Operations (DPO) and be Support (FMS), the corridor of 210 would not easily close the into the door frame. The diand pulled into its door frame. The door appeared to be coes along the hinge side of the erview at the time of the coexisting of the control of the desiry close complete.		appropriately. How other residents have potential to be affected by same deficient practice wi identified and how will corrective action be taken. Two residents on the 200 h the potential to be affected alleged deficient practice. What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not reoccur. The Director of Plant Opera and department was educated the Executive Director on K Corridor – Doors. The door appropriately latches and measure all resident doors late appropriately. How the corrective action will be monitored to ensure deficient practice will no longer recur? Monthly audits will be conditioned reviewed by QAPI for a	the the II be ? all had by the t into ? tions ted by 363 — now neets The bound to
				minimum of 6 months. Exhibit C: Inservice	

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	OF CORRECTION	IDENTIFICATION NUMBER 155682		JILDING	01	COMPL 08/07/	ETED
	PROVIDER OR SUPPLIER			1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills and unexpected time conditions, at lease The staff is familial aware that drills are routine. Where drills 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1 Based on record revisited to ensure fire for 1 of 3 employee	he transmission of a fire imulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of 9.7.1.7 iew and interview, the facility drills were held at varied times shifts during 4 of 4 quarters.	K 0	TAG	Exhibit D: Audits Exhibit E: Invoice to replace do The Director of Plant Operation conducted a fire drill on 8/15/24.	oor.	
	the facility. Findings include: Based on review of on 08/07/24 betwee the Director of Plan Facility Maintenanc 4 third shift (night) between 4:30 a.m. a interview at the time acknowledged the time were performed and varied enough.	the facility's fire drill reports in 10:00 a.m. and 1:00 p.m. with t Operations (DPO) and e Support (FMS) present, 4 of fire drills were performed ind 5:00 a.m. Based on e of record review, the DPO mes of the third shift fire drills agreed the times were not viewed with the Executive FMS during the exit			The Director of Plant Operation was educated by the Executive Director on NFPA 101 Fire Dril Fire drills include the transmiss of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held a expected and unexpected time under varying conditions, at leaquarterly on each shift. The Director of Plant Operation will inspect drills 1 x per month 3 months for proper varying the of fire drills. Results of these inspections we be presented by Executive Director to the QAPI committee further recommendations and	e Ills. sion at es ast ns n x ming	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/07/2024
	PROVIDER OR SUPPLIEF		1325 F	ADDRESS, CITY, STATE, ZIP COD ROCKPORT RD VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b) 3.1-51(c)			continue until the Quality Assurance Team determines substantial compliance has bee achieved. The deficient practice could aff all residents, staff and visitors in the facility. Exhibit G - Audit Exhibit H - Inservice Copy of last fire drill held.	ect
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of a the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A o for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not use wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 99) (NFPA 70), 590.3	ent - Power Cords and ent - Power Cords and catient care vicinity are only ents of movable ed electrical equipment eles that have been elified personnel and meet electronics, en care resident rooms that en E. Power strips for PCREE en UL 60601-1. Power strips ethe patient care rooms en) meet UL 1363. In electronics, en care resident rooms that en E. Power strips en uL 60601-1. Power strips e	K 0920	The Executive Director and/or	08/30/2024

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	OF CORRECTION	IDENTIFICATION NUMBER 155682	A. BUILDING B. WING	01	COMPLETED 08/07/2024
	PROVIDER OR SUPPLIER		1325 R	ADDRESS, CITY, STATE, ZIP COD ROCKPORT RD VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	adapters/extension of substitute for fixed of LSC 19.5.1 requires 9.1. LSC 9.1.2 requirequipment to comple Electrical Code, 201400.8 requires that, flexible cords and casubstitute for fixed of deficient practice coefficient practice coeffic	Il refrigerator plugged into a cheduler's Office. o plugged into a multi-plug ord in the MDS Office.		designee provided re-educational Department Heads on Electrical Equipment - Power Cords and Extension cords CFR(s): NFPA 101 Power strips a patient care vicinity are only used for components of move patient-care-related electrical equipment (PCREE) assembly that have been assembled by qualified personnel and meet conditions of 10.2.3.6. Power strips in the patient care vicinimally not be used for non-PCR (e.g., personal electronics), except in long-term care reside rooms that do not use PCREE Power strips for PCREE meet 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside ovicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standard All power strips are used with general precautions. Extension cords are not used as a substant for fixed wiring of a structure. Extension cords used tempor are removed immediately upon completion of the purpose for which it was installed and meet the conditions of 10.2.4.10.2.3 (NFPA 99), 10.2.4 (NFPA 99) 400-8 (NFPA 70), 590.3	ps in white es the est the
	1		I	in use once per week x 3 mor	เนเอ

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155682	TION NUMBER A. BUILDING <u>01</u> COMP				
NAME OF PROVIDER OR SUPPLIER WOODMONT HEALTH CAMPUS			1325 R	ADDRESS, CITY, STATE, ZIP COD OCKPORT RD /ILLE, IN 47601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					followed by once per month x The Executive Director will pre- results of inspection thru the Committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieve Exhibit A – Audit tool Exhibit B – In service Documentation	esent QAPI	

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