STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155682	A. BUILDING -- B. WING	09/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/07/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/18/24 Facility Number: 002724 Provider Number: 155682 AIM Number: 200309330 At this PSR to the Emergency Preparedness survey, Woodmont Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 47. Quality Review completed on 09/23/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/07/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/18/24 Facility Number: 002724 Provider Number: 155682 AIM Number: 200309330	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennie Deyne	Executive Director	10/04/2024

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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	155682	A. BUILDING 01 B. WING	09/18/2024

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	At this PSR to the Life Safety Code survey, Woodmont Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and all resident sleeping rooms. The facility has a capacity of 60 and had a census of 47 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/23/24			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 32 resident room corridor doors would close complete and latch into its door frame. This deficient practice could affect at least 18 residents in the 200 hall, plus staff and visitors. Findings include: Based on observations on 09/18/24 between 10:00 a.m. and 11:45 a.m. during a tour of the facility with the Director of Plant Operations (DPO), the corridor door to resident room 210 would not	K 0363	K363 Corridor-Doors Compliance date 10/6/24 There were no negative outcomes for this alleged deficient practice. The door of resident room 210 was replaced in entirety, which now allows for the door to latch appropriately. How other residents have the potential to be affected by the	10/01/2024

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	easily close completely and latch into the door frame. The door had to be lifted and pulled into its door frame to close completely. The door appeared to be damaged in two places along the hinge side of the door. Based on interview at the time of observation, the DPO acknowledged the corridor door to room 210 failed to easily close complete and latch into its door frame. He said he removed several thin layers of wood from the door at the top with a plane, but it did not help much, and also said a new door has been ordered to replace the damaged door, but it could take at least 10 weeks or more for delivery. This finding was reviewed with the DPO during the exit conference. This deficiency was cited on 08/07/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		same deficient practice will be identified and how will corrective action be taken? Two residents on the 200 hall had the potential to be affected by the alleged deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? The Director of Plant Operations and department was educated by the Executive Director on K363 – Corridor – Doors. The door now appropriately latches and meets the conditions of 19.3.6.3. The DPO and/or designee will round once a month for 6 months to ensure all resident doors latch appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur? Monthly audits will be conducted and reviewed by QAPI for a minimum of 6 months. Exhibit C: Inservice Exhibit D: Audits Exhibit E: Photos and video of door latching.	