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	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Health Campus	1325 Rockport Rd Boonville, IN 47601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45933 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. 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 minimum of quarterly . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-35(d)(2)(B)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46882 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 .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46882 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. 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., [NAME] 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. 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 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 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. 45933 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 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 [NAME] (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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 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: 1. On 7/22/24 at 11:02 A.M., the bathroom of room [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] was observed. In the bathroom, the vent fan and handrail behind the toilet were dusty. In room [ROOM NUMBER], 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 [ROOM NUMBER] was observed. In the bathroom, there was an uncovered gray fractured bedpan on the handrail and the vent fan was dusty. In room [ROOM NUMBER], 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 [ROOM NUMBER] 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. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 7/22/24 at 10:24 A.M., room [ROOM NUMBER] 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 [ROOM NUMBER], 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 [ROOM NUMBER] 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 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 [ROOM NUMBER] 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 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 [ROOM NUMBER] 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. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. The carpet in the 200 hall had blackish/brown spots by the medication cart and black and brown marks in hall between room [ROOM NUMBER] 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 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: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 should not be stored and the fractured bedpans/dishpans should be covered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Health Campus	1325 Rockport Rd Boonville, IN 47601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)