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	09/02/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the failed the obtain the temperature of the food prior to serving the residents for 1 of 1 plating observations. Finding includes:During an observation of plating on 8/28/25 at 6:02 A.M., [NAME] 17 utilized tongs and scoops to place the food items on the plates to serve the residents.During an interview on 8/28/25 at 6:06 A.M., [NAME] 19 indicated a computerized system was used to log the temperatures of the food items. At that time, she pulled up the temperature log on the computerized system, and the log was blank. [NAME] 17 continued plating and indicated temperatures should have been obtained by [NAME] 21. At that time, [NAME] 21 indicated the Dietary Manager should be in the facility at any time, and refused to answer on if the temperature of the food was obtained.On 6/28/25 at 6:09 A.M., the Dietary Manager entered the kitchen and looked on the computerized system to find the temperature log. At that time, he talked to [NAME] 21, and then indicated that [NAME] 17 had to stop plating food, and he began to take the temperature of all food items (oatmeal, gravy, scrambled eggs, sausage links, puree eggs, and mechanical meat).On 8/29/25 at 11:56 A.M., Clinical Support 1 provided a current Food Safety and Handling policy, reviewed 6/2016 that indicated, .reaching proper temperatures within an appropriate time period can help ensure that food is safest to eat. Cooks must know the proper temperatures.3.1-21(a)(2)

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

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	09/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to clarify a Resident's code status for 1 of 1 residents reviewed for advanced directives. A resident's current Physician's Order did not match the signed Indiana Physician Orders for Scope of Treatment form, and staff was unaware of Resident's wishes. (Resident 56)Finding includes:On 8/29/25 at 11:17 A.M., Resident 56's daughter visited while Resident 56 was asleep in bed. At that time, the daughter indicated Resident 56 did not want to be intubated.On 8/27/25 at 10:16 A.M., Resident 56's clinical record was reviewed. Diagnosis included, but were not limited to, metastatic stage 4 cancer.Resident 56's admission Minimum Data Set (MDS) assessment was in progress and had not been completed.Physician Orders included, but were not limited to the following: CODE STATUS: No chest compressions. May intubate, dated 8/22/25A current POST form indicated, Limited Additional Interventions.Do not intubate, signed 8/22/25Resident 56's clinical record lacked a care plan related to code status.During an interview on 8/29/25 at 11:19 A.M., Registered Nurse (RN) 23 indicated if Resident 56 coded, he wished to be intubated.During an interview on 8/29/25 at 11:31 A.M., Clinical Support 1 indicated Resident 56's code status was Do Not Resuscitate (DNR) which indicated he should not be intubated.On 8/29/25 at 11:56 A.M., Clinical Support 1 provided a current Guidelines for Advanced Directives policy, revised 9/26/24, that indicated, . 1. Advanced Directives will be reviewed with resident and/or resident representative by the Admissions Representative or designee at time of admission. A member of the IDT will review and/or updated quarterly and PRN thereafter. 2. The resident or representative will advise the admissions representative/designee regarding wishes for end of life directives and code status.6. The nursing staff will confirm the desired code status and obtain an order from the physician. Verbal Wishes if witnessed by 2 people will be honored until an order is officially obtained . The DNR form will be completed documenting these desires and scanned into the medical record.3.1-4(l)(5)

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	09/02/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation. interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised for 1 of 2 residents reviewed for urinary tract infections (UTI), 1 of 3 residents reviewed for pressure ulcers, and 2 of 5 reviewed for unnecessary medications. Residents who were not on antianxiety medication and no longer had a UTI had care plans that were not removed and a resident with multiple pressure ulcers did not have wound specific care plans. (Resident 6, Resident 18, Resident 45, Resident 1)Findings include:1. On 8/27/25 at 8:04 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, severe dementia with psychotic disturbance and adjustment disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 8/7/25, indicated Resident 6's cognition was severely impaired and she was taking an antipsychotic, antidepressant, diuretic and opioid medication. Current Physician's Orders lacked an order for an antianxiety medication. Current Care Plans included a Risk for Adverse Consequences related to Antianxiety Medication Care Plan, last reviewed 8/22/25. 2. On 9/2/25 at 10:23 A.M., Resident 18's clinical record was reviewed. Diagnoses included, dementia with behaviors and depression. The most recent quarterly MDS assessment, dated 7/18/25, indicated Resident 18 was cognitively intact and taking an antipsychotic, antiplatelet, hypoglycemic, anticonvulsant, and antidepressant medication. Current Physician's Orders lacked an order for an antianxiety medication. Current Care Plans included a Risk for Adverse Consequences related to Antianxiety Medication Care Plan, last reviewed 8/1/25. On 9/2/25 at 10:26 A.M., Clinical Support 2 indicated Resident 6 and Resident 18 were no longer on antianxiety medications and the care plans should have been removed. 3. On 8/27/25 at 9:27 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and neurogenic bladder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/30/25, indicated a moderate cognitive impairment, and an indwelling urinary catheter. Physician orders included, but were not limited to: Bactrim DS (sulfamethoxazole-trimethoprim) (an antibiotic) tablet; 800-160 mg; amt: 1 tablet; oral for UTI, dated 8/1/25 through 8/11/25. Macrobid (nitrofurantoin monohyd/m-cryst) (an antibiotic) capsule; 100 mg; amt: 100 mg; oral twice A (continued on next page)

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	09/02/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Day, dated 8/20/25 through 8/27/25. A current care plan for urinary tract infection (UTI) was initiated and last reviewed 8/4/25. On 7/28/25, a urinalysis was obtained that identified a UTI. A progress note, dated 8/1/25, indicated antibiotic orders were received for UTI for Resident 45 to begin that evening. An Interdisciplinary Team (IDT) note, dated 8/4/25, indicated a ten day antibiotic course had been initiated for UTI. A care plan was initiated the same day. On 8/20/25, a urinalysis was obtained that identified a UTI. A progress note, dated 8/20/25, indicated antibiotic orders were received for UTI. An IDT note, dated 8/25/25, indicated a seven day antibiotic course had been initiated for UTI. The UTI care plan was not discontinued after the UTI on 8/1/25, and was not revised for the UTI identified on 8/20/25. On 8/29/25 at 1:01 P.M., Clinical Support 2 indicated a UTI care plan would be expected to be resolved 2-3 days after completion of an antibiotic. 4. On 8/27/25 at 9:21 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and renal failure. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/31/25, indicated a moderate cognitive impairment, and two unstageable pressure ulcers present upon admission. Resident 1 was admitted to the facility on [DATE]. A current pressure ulcer care plan, dated 6/19/25 and last reviewed 8/15/25, indicated a pressure area to the sacrum as well as the left hip. The two areas were combined on one care plan. On 8/29/25 at 9:04 A.M., the Assistant Director of Nursing (ADON) indicated Resident 1's left hip pressure ulcer was healed on 8/13/25. On 8/29/25 at 12:56 P.M., the Administrator provided a current Comprehensive Care Plan policy, dated 5/22/18, that indicated The comprehensive care plan should be reviewed no less than quarterly and revised to reflect changes in the resident's condition as they occur 3.1-35(d)(2)(B)

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	09/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure services provided by the facility met professional standards of quality for 2 of 3 residents reviewed for nutrition and 1 of 4 residents reviewed for urinary tract infections (UTI) and pressure ulcers. Weights were not monitored and discontinuation of contact precautions were not completed as ordered, a dressing was not initialed or dated, staff documented treatments completed on a pressure ulcer that had been healed, and a nurse signed off on a treatment that another staff member completed. (Resident 45, Resident 1, Resident 8)Findings include: 1. On 8/27/25 at 12:45 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus type II, chronic kidney disease (CKD), hypertension, lymphedema, edema, obesity (morbid), and dementia with psychotic disturbance. The most recent quarterly MDS assessment, dated 5/16/25, indicated Resident 8's cognition was moderately impaired, was 232 pounds (lbs), 5 foot 6 inches tall, no known weight loss or gain, and was totally dependent on staff for transfers (used a Hoyer lift). Physician's Orders, included, but were not limited to, obtain monthly weight on resident, ordered 8/12/24 and discontinued 7/14/25. The current Physician's Orders did not include an order to weigh the resident. Current Care plans included, but were not limited to, the following: Resident has experienced a significant weight loss, last reviewed 8/13/25, with an intervention to weigh as ordered. Resident has been identified as morbidly obese in the past, related to Body Mass Index [BMI] classification and diagnoses, last reviewed 8/13/25, with an intervention to obtain weight as ordered/needed. Resident has CKD related to renal failure, last reviewed 8/13/25, with an intervention to monitor weight per order. The following weights on Resident 8 were documented from 1/15/25 to present: 1/15/25 1:48 P.M., Weight: 226.4 lbs 2/5/25 9:15 A.M., Weight: 223.8 lbs 3/2/25 11:01 A.M., Weight: 228.5 lbs 3/5/25 4:09 P.M., Weight: 230.5 lbs 4/2/25 10:03 A.M., Weight: 234.9 lbs 4/5/25 1:56 P.M., Weight: 234.9 lbs 5/1/25 3:26 P.M., Weight: 232.4 lbs (continued on next page)

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	09/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/2/25 9:42 A.M., Weight: 231.5 lbs 7/3/25 11:07 A.M., Weight: 227.2 lbs 7/10/25 9:11 A.M., Weight: 261.4 lbs (Resident gained 34.2 lbs) 7/14/25 7:42 P.M., Weight: 241.9 lbs (this was a re-weigh from 7/10/25. Resident gained 14.2 lbs in 11 days and the clinical record lacked documentation about what was done.) 7/29/25 8:36 P.M., Weight: 240.7 lbs 7/30/25 1:59 P.M., Weight: 242.3 lbs 7/31/25 time not noted, Weight: 242.3 lbs 8/5/25 at 3:15 P.M., Weight: 230.4 lbs (resident lost 11.9 lbs) Progress notes from July 1, 2025, to present included, but were not limited to, the following: 7/13/25 Nutrition Note: Questioning the accuracy of the current weight of 261.4 lbs on 7/10/25. Recommend to re-weigh. 7/14/25 IDT Note: Recommended re-weigh of resident (from 7/10/25) due to apparent entry error. 7/28/25 Nutrition Note: Resident's last few weights appear to be inconsistent. Recommend to re-weigh for 3 days to establish a baseline. 7/29/25 Interdisciplinary (IDT) note: Dietitian Recommendation: Get weight for 3 days to establish baseline. 8/7/25 Nutrition Weight Monitoring note: According to staff, the 7/10 weight of 261.4 lbs was an error. Recommended to invalidate. The current reason for weight loss was unknown. Per staff, she had no illness or fluid overload. Her baseline weight appears to be around 230 lbs. Will continue to monitor. On 8/28/25 at 12:45 P.M., Resident 8 was observed getting weighed by Certified Nurse Aide (CNA) 3 and CNA 5 with a Hoyer lift. Both CNAs washed their hands and put on gloves. CNA 3 zeroed the scale, Resident 8 was lifted out of her wheelchair, and indicated the resident weighed 229.8 lbs. CNA 3 indicated they weigh the residents, tell the nurse, and the nurse puts the weight in the clinical record. On 8/28/25 at 12:15 P.M., the Director of Nursing (DON) and Clinical Support 1 indicated that weights were being done monthly. They were not aware of the weight variations and were unsure of why. On 8/28/25 at 12:55 P.M., Registered Nurse (RN) 48 indicated she would get the weight from the CNA and put it in the clinical record. But, if it's more than two to 3 lbs different than the previous weight or seems out of the normal range, she has them reweigh the resident. If it's still up more than 3 lbs in 24 hours or more than 5 lbs in a week, then she would assess the resident to see if she could figure out why. It could have been that the resident was not weighed correctly, was retaining fluid, or (continued on next page)

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	09/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	constipation. She would notify the physician, family, and the DON. The weights should be monitored closely every time a weight was entered. On 8/29/25 at 9:13 A.M., the Administrator indicated she was unsure why the resident's weights were varying so much. She indicated they recently looked at the Hoyer lift scales and was unsure when they had been serviced last but they did learn recently that there were different batteries for the scale than the main battery that runs the Hoyer lift. She provided an invoice for the last service in May of 2025. 2. On 8/27/25 at 9:27 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and neurogenic bladder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/30/25, indicated a moderate cognitive impairment and use of an indwelling catheter. Current physician orders included, but were not limited to: Contact precautions related to MRSA (methicillin-resistant Staphylococcus aureus) (a type of staph bacteria) in urine. May discontinue when MRSA has cleared, dated 8/4/25. A current urinary tract infection (UTI) care plan, initiated and last revised 8/4/25, indicated use of contact precautions. A urine culture reported 8/3/25 indicated MRSA in the urine. A progress note, dated 8/20/25, indicated a new order for a urinalysis to ensure MRSA was clear and to remove from contact isolation. A urine culture reported on 8/22/25 did not indicate MRSA in the urine. On 8/29/25, the Infection Preventionist (IP) indicated that staff had Resident 45 do a follow-up urine to make sure the MRSA was cleared, and then contact precautions should have been discontinued. 3. On 8/27/25 at 9:21 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and renal failure. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/31/25, indicated a moderate cognitive impairment, significant weight loss, and two unstageable pressure ulcers present on admission. Current physician orders included, but were not limited to: Daily weight, dated 7/25/25. Wound Vac to sacral and left hip wound, change Monday, Wednesday, and Friday, dated 6/11/25 through 8/25/25. Resident 1's Medication Administration Record (MAR) for July 2025 through August 2025 included the following dates the resident's weight was not completed: (continued on next page)

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	09/02/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/27/25 (not available during shift) 8/6/25 with no reason listed 8/7/25 with no reason listed 8/8/25 with no reason listed 8/25/25 (unavailable) Resident 1's MAR indicated the wound vac to the sacral and left hip wound was changed every Monday, Wednesday, and Friday as ordered. Resident 1's MAR indicated the wound vac to the sacral and left hip wound was changed on 8/25/25 by Registered Nurse (RN) 9. On 8/27/25 at 12:17 P.M., Resident 1 was observed with a dressing to the sacrum. The dressing was not initialed or dated. On 8/29/25 at 9:04 A.M., the Assistant Director of Nursing (ADON) indicated Resident 1's wound to the left hip was healed on 8/13/25, and as a result, the wound vac to the left hip was discontinued on 8/13/25 as well. She indicated earlier that day, she had discontinued the wound vac to the sacrum was discontinued, and a regular dressing was placed on the area. On 8/29/25 at 11:20 A.M., RN 9 indicated that on 8/25/25, she did not actually change Resident 1's wound vac, only confirmed with the ADON that she had done it. She then signed off on the MAR that it had been done. She indicated at that time that she did not see the wound vac or the area and did not know what it looked like. On 8/29/25 at 12:59 P.M., Qualified Medication Aide (QMA) 7 indicated the aides were responsible for obtaining resident weights and would usually get them before breakfast unless the resident requested otherwise. If the resident was unavailable, they would then pass the information on to the next shift to get. On 8/29/25 at 11:56 A.M., the Administrator provided a current non-dated RN job description that indicated Provide direct nursing care and provide clinical supervision of patient care staff working with residents assigned on your unit to provide direct care . Administer and document medication and treatments per the physician's order and accurately record all care provided. On 8/29/25 at 11:56 A.M., the Administrator provided a current Weight Monitoring policy, last revised 5/10/24, that indicated Review of missing weights . Daily weights as ordered . Review of error weights, daily, in CCM a. Re-weighs as needed b. Correct weights as needed c. Invalidate weights as needed. 3.1-35(g)(1)

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	09/02/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident received ordered treatment and services to promote healing and prevent new ulcers from developing for 1 of 3 residents reviewed for pressure ulcers. A wound specific care plan was not developed, treatment orders were not followed, wound assessments were not completed accurately, and Enhanced Barrier Precautions (EBP) were not used when providing wound care. (Resident 6)Finding includes:On 8/27/25 at 8:04 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, severe dementia with psychotic disturbance and pressure ulcer.The most recent quarterly Minimum Data Set (MDS) assessment, dated 8/7/25, indicated Resident 6's cognition was severely impaired, was dependent on staff assistance for toileting, substantial to maximum assistance (staff performs over half the effort) for bed mobility and transferring, and had one facility-acquired unstageable pressure ulcer. Current physician's orders included, but were not limited to, the following:EBP with wound care, ordered 8/25/25lidocaine ointment 5 %, apply topically to wounds on bilateral feet prior to wound treatment on left lower extremity (LLE) wound measured 5.4 cm x 6.4 centimeters (cm) and right lower extremity (RLE) wound measured 2 cm x1.5 cm daily, ordered 8/20/25Right lateral foot: cleanse the wound with normal saline, pat dry, apply skin prep to peri-wound (around wound bed), apply Santyl Ointment (a prescription medication used to help remove dead tissue from a chronic wound bed, like ulcers, to keep the wound bed clean and promote healing), cut Calcium Aliginate (a highly absorbent, biodegradable dressing that promotes wound healing by absorbing exudate and forming a moist get) to size of wound bed and apply over Santyl Ointment, and cover with dry dressing daily and as needed. Therapy to change Monday through Friday and nursing staff to change on holidays and weekends, ordered 8/27/25 Left heel: cleanse wound with normal saline, pat dry, apply skin prep to peri-wound, apply Santyl, and cover with Allevyn LIFE heel dressing daily and as needed. Therapy to change dressing Monday through Friday and nursing staff to change on holidays and weekends, ordered 8/27/25Left lateral first metatarsal: apply skin prep to the area and apply Allevyn LIFE dressing BID, 8/27/25 The current physician's orders lacked an order for the Santyl Ointment dosage and application instructions.A current Pressure Ulcer Care Plan, last revised 6/19/25, indicated the resident had a pressure ulcer to the right bottom of her foot. The left heel was resolved. Interventions included, but were not limited to, assess and record the condition of the skin surrounding the pressure ulcer, provide treatment per medical doctor (MD) and notify MD if treatment is not effective, observe for and report signs of pain and infection of the wound (drainage amount, color, smell, and type of drainage, swelling around the wound, skin around the wound feeling warm or appearing red, and the edges of the wound may be separating), and perform weekly skin assessmentsA current EBP Care Plan, initiated and last reviewed 8/25/25, indicated the resident required EBP (gown and gloves) during wound care.Resident 6's clinical record lacked a wound-specific care plan for the left heel and the left foot first metatarsal pressure ulcers.On 8/28/25 at 12:21 P.M., all weekly skin assessments and wound care notes were requested and provided by Clinical Support 1. They included the following measurements and wound observations: Wound 1: right lateral foot wound6/15/25 1.2 cm x 1.2 cm (depth could not be measured), skin surrounding the wound were pink/normal and blanchable, without exudate and tunneling, and no wound odor was present. Stage: unstageable (a full-thickness pressure wound where the base is completely covered by slough and/or eschar. The true depth cannot be determined until the covering is removed) and suspected deep tissue pressure injury (A localized area of intact skin that is deep red, purple, or maroon. A blood-filled blister may be present. The tissue may be preceded by pain, or feeling firm, mushy, or boggy)6/18/25 1.2 cm x 1.2 cm (depth could not be measured), no exudate or odor present. Stage: unstageable- deep tissue.6/25/25 1.0 cm x 1.2 cm (depth could not be measured), no exudate or odor present. No stage noted.7/9/25 1.5 cm x 1.5 cm x 0.2 cm, no exudate or odor present. Slough tissue was present, and the skin surrounding the wound was pink/normal. No (continued on next page)

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	09/02/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stage noted.7/16/25 1.5 cm x 1.5 cm (depth could not be measured), no exudate present, and well-defined wound edges. Stage: unstageable -slough and/or eschar.7/22/25 2.3 cm x 2.6 cm x 0. 00 cm (The wound observations were not completed. Stage: suspected deep tissue)7/29/25 0.90 cm x 1.30 cm x 0.00 cm (The wound observations were not completed. Stage: suspected deep tissue)8/5/25 1.4 cm x 1.0 cm x 0.00 cm (The wound observations were not completed. Stage: suspected deep tissue)8/12/25 1.52 cm x 1.48 cm x 0.00 cm (The wound observations were not completed. Stage: suspected deep tissue)8/19/25 1.86 cm x 1.69 cm x 0.00 cm (The wound observations were not completed. Stage: suspected deep tissue)8/26/25 1.8 cm x 1.8 cm x 0.3 cm (The wound observations were not completed. Stage: suspected deep tissue)Wound 2 Left Heel: 8/19/25 5.41 cm x 6.39 cm x 0 cm (The wound observations were not completed. Stage: Unspecified Ulcer Suspected deep tissue)8/26/25 1.84 cm x 1.9 cm x 0.1 cm (The wound observations were not completed. Stage: Unspecified Ulcer Suspected deep tissue)wound 3: left foot lateral first metatarsal 8/26/25 1.0 cm x 0.74 cm x 0 cm. The wound observations were not completed, but had the comment, Area is dark purple and intact, redness noted to peri wound, being seen by PT [physical therapy] and WCC [Wound Care Certified Nurse], treatment in place. Stage: Unspecified Suspected deep tissueThe clinical record lacked documentation of a new event or a skin occurrence for wounds 2 and 3.During an interview on 8/28/25 at 12:21 P.M., the Assistant Director of Nursing (ADON)/WCC indicated the resident was being treated for her right lateral foot wound, then developed the left heel wound, and now has the wound starting on her left first metatarsal. The skin on her left first metatarsal was still intact, and they were hoping to keep it intact. Therapy is doing debridement on the other wounds Monday through Friday because they have some slough on both of them, and then our nurses do it on weekends and holidays. The weekly skin assessments were in the clinical record under the resident's documents and filled out by the nurses once a week. They would to in when therapy did her treatment so it's only done once. They will check off in the medication or treatment record that the assessment was completed. If there are new wounds, there should be an event or a skin occurrence put in the clinical record. The incoming Infection Preventionist (IP) and I make wound rounds every Tuesday. So we would go in, observe the wound, take the pictures, and then PT 1 actually did the debridement.On 8/29/25 at 1:00 P.M., Physical Therapist (PT) 1 indicated she did the wound care for Resident 6 during the week when she was here, but nursing staff would do it otherwise, and they got measurements on Tuesdays. She indicated she would not do the debridement procedure of the wounds on her right lateral foot and the left heel if the resident didn't tolerate it. Yesterday, the resident did not tolerate it, so she did not do it. Resident 6 was in the therapy room behind a privacy curtain, sitting in her wheelchair with her legs up on a therapy wedge with a towel covering it. PT 1 sat on the floor on the resident's right side. PT 1 applied Anti-Bacterial Hand Rub (ABHR) and put on gloves, but did not put on a gown to perform the wound care. First, PT 1 performed care on the right lateral foot. She removed the dressing from her right foot, dated 8/28/25. There was no drainage on the dressing. The wound did not have signs of infection, the edges of the wound were white, and it had white slough in the wound bed. The wound was not measured at that time. She sprayed the wound bed with wound cleanser, not normal saline as ordered. Then, she put Lidocaine 5% ointment on a gauze pad and taped it over the wound on her foot. She removed her gloves, applied ABHR, and put her gloves back on. Next, PT 1 performed care on the resident's left heel. She removed the foam dressing and kerlix gauze, dated 8/28/25. The wound did not have signs of infection, the edges of the wound were white, and it had white slough in the wound bed. The wound was not measured at that time. She sprayed the wound bed with wound cleanser, not normal saline as ordered. Then, she put Lidocaine 5% ointment on a gauze pad and taped it over the wound on her foot. She removed her gloves, applied ABHR, and put her gloves back on. Lastly, PT 1 performed care on the resident's left foot first metatarsophalangeal (MTP) joint (the joint that connects the base of your big toe to the rest of the foot). The wound did not have a dressing over it. It was purple in the middle with redness around it. The skin was intact. She wiped the area with skin prep. PT 1 did not apply an Allevyn LIFE (continued on next page)

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	09/02/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(bandage with foam center to cover wound) dressing to the wound. She took off her gloves, applied ABHR, and put her gloves back on. After 10 minutes, PT 1 started again with the wound on Resident 6's right lateral foot. She removed the lidocaine and gauze. She sprayed the wound bed with wound cleanser again. She took a debriding tool and scraped a scant amount of slough from the wound bed. The resident pulled her foot away, and she said it hurt. PT stopped the debridement procedure. With the same gloves she was using, she cut the calcium alginate pad, put Santyl ointment on it. She wiped with a skin prep pad around the wound and covered it with a bandage dated 8/29. She took off her gloves, applied ABHR, and put her gloves on. Next, she took off the lidocaine and gauze pad from the left heel wound, sprayed it with wound cleanser, and debrided it a scant amount. PT 1 requested that another staff member come over to hold the resident's left foot up. She applied ABHR and put on gloves, but did not have a gown on. She held the left foot with her left hand fingers over the purplish colored wound on the first metatarsal. With the same gloves she used to try to debride the wound, PT 1 put Santyl ointment on a foam heel pad and placed that on the left heel, wrapped with kerlix gauze, taped it in place, and dated it 8/29. With the same gloves on, she put on the resident's socks. During an interview on 9/2/25 at 10:15 A.M., the ADON/WCC indicated the treatments on pressure ulcers should be done as ordered, normal saline was not the same as wound cleanser, and EBP should be used when performing wound care. At that time, a current EBP policy was requested but not provided during the duration of the survey.On 9/2/25 at 11:41 A.M., a current Wound Guidelines Policy, revised 4/9/25, was provided by Clinical Support 1 and indicated, . to provide weekly documentation guidelines of wound measurements and condition. If skin alteration occurs post-admission, follow the steps below:a. Appropriate wound incident is completed by an RN/LPN [Registered Nurse/Licensed Practical Nurse] in EHR [electronic health record] b. Complete the incident for each impaired area and assessment of the wound. Document description of wound using: a. Length (12 o'clock to 6 o'clock) b. Width (3 o'clock to 9 o'clock) c. Depth ^ deepest area of wound bedd. Exudates e. Color f. Odor g. Wound margins h. Surrounding tissue i. Tunneling and/or undermining if applicable . Re^assessment/measurement weekly or with significant change in wound, noting the current treatment, medical interventions provided, and comments as needed in progress notes and wound management or with a follow-up encounter weekly in [wound software name] . On 9/2/25 at 11:41 A.M., Clinical Support 1 indicated they do not have a policy to follow orders, but it would be their policy to do so.3.1-40(a)

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	09/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision and prevent falls for 1 of 3 residents reviewed for accidents. Fall interventions were not in place for a resident with multiple falls and neurological (neuro) checks were not fully completed after unwitnessed falls. (Resident 5)Findings include:During an observation on 8/27/25 at 12:55 P.M., Resident 5 was in the recliner with regular white socks on.On 8/27/25 at 8:56 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but was not limited to, fracture of right pubis, hypertension, anxiety disorder, and depression.The most recent quarterly Minimum Data Set (MDS) assessment, dated 8/6/25, indicated Resident 5 was cognitively intact and substantial to maximal assistance of staff (staff performs more than half the effort) for transfers and toileting, and Resident 6 had a fall with fracture in the last 6 months.Resident 5's Physician's Orders included, but was not limited to the following:Call don't fall sign in the bathroom, dated 8/25/25Non-skid strips on the bathroom floor, dated 8/25/25Resident 5's care plan included, but was not limited to, Resident is at risk for falls, dated 1/25/25. Current interventions included, but were not limited to the following:Non-skid strips to the bathroom floor, dated 7/5/25Call don't fall sign in the bathroom, dated 8/15/24Provide non-skid footwear, dated 1/25/24Resident 5's fall history for the last 3 months included the following:Fall 17/3/25 at 12:25 A.M., Staff responded to call light. Resident noted on bathroom floor, incont of urine, bare foot and no assistive device.The facility failed to complete the following neuro checks related to that fall:-every hour times 4 hours neuro check on 7/3/25 at 6:30 A.M.-every 4 hours times 5 on 7/3/25 at 10:30 A.M. and 2:30 P.M.Fall 27/24/25 at 1:12 A.M., This nurse heard someone yelling for help. Upon opening the door to the room, resident was found on floor between her bed and roommate's bed. Roommate was yelling for help. Full body assessment done. Shortening of RLE (right lower extremity). No ROM (range of motion) at this time RLE.Fall 38/26/25 at 2:50 P.M., Responded to CNA (certified nursing aide) claiming resident was found sitting on the floor in their bathroom. Found resident sitting on the floor in front of toilet facing the door.The facility failed to complete the following neuro checks related to that fall:-every 30 minutes times 4 hours on 8/26/25 at 5:00 P.M.-every 1 hour times 4 hours on 8/26/25 at 8:00 P.M.During an interview on 8/27/25 at 1:00 P.M., CNA 15 indicated current fall interventions included to lock the wheelchair in front of the resident and provide the call light.During an interview on 8/27/25 at 1:02 P.M., Licensed Practical Nurse (LPN) 11 looked on the clinical record and indicated current fall interventions include a call don't fall sign in the bathroom, non-skid strips to the bathroom floor, and ensure that the wheelchair is next to the bed. She further indicated neuro checks should be completed after an unwitnessed fall every 15 minutes times 4, then every 30 minutes times 4, followed by every hour times 4, then every 4 hours times 4. At that time, LPN 11 was unable to locate a call don't fall sign in the bathroom.On 8/29/25 at 8:52 A.M., Qualified Medication Aide (QMA) 7 and CNA 15 assisted Resident 5 to the bathroom. Resident 5 was barefoot during the transfer. At that time, QMA 7 asked if Resident 5 had been wearing non-skid socks throughout the day, and CNA 15 indicated that she had not.During an interview on 8/29/25 at 10:00 A.M., Clinical Support 1 indicated neuro checks should be completed, and care plan interventions should be implemented at all times.On 8/29/25 at 11:56 A.M., Clinical Support 1 provided a current Fall Management Program Guidelines policy, reviewed 12/17/24, indicated, .4. Any order received from the physician should be noted and carried out. 5. The resident care plan should be updated to reflect any new or change in interventions. At that time, a current Guidelines for Neurological Checks policy, reviewed 12/17/24, indicated, .Neuro-checks for 24 hours should be completed.3.1-45(a)

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	09/02/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 1 of 5 residents (Resident 31) observed during the medication pass. There were 25 opportunities for error observed with 3 medication errors, resulting in a medication error rate of 12 percent.Finding includes:On 8/28/25 at 7:27 A.M., Licensed Practical Nurse (LPN) 43 was while they prepared and administered medications to Resident 31. They used Anti-bacterial Hand Rub (ABHR) prior to setting up medications. They measured out 10 milliliters (mL) of Docusate Sodium into a medication cup. They put the Tradjenta and Levothyroxine into another medication cup and the Metoprolol Succinate Extended Release (ER) in another. They crushed all the medications, keeping the Metoprolol separated. They labeled that medication cup with BP. They proceeded to mix the crushed medications in both cups with a spoonful of pudding. They took the medications and vitals machine into the resident's room, took her blood pressure (126/55) with the machine, washed their hands, and then administered the medications to the resident using seperate spoons. On 8/28/25 at 8:00 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, hypothyroidism, constipation, and hypertension. Current Physician's Orders included, but were not limited to, the following medications:May crush meds or open capsules as needed unless contraindicated, refer to Do not crush list, ordered 4/20/22docusate sodium 50 milligram (mg)/5 mL (for constipation), give 10 mL once by mouth (po) daily, ordered 8/6/25Tradjenta 5 mg tablet (for blood sugars), give one po once daily, ordered 8/21/25Metoprolol Succinate Extended Release (ER) 24 hr 25 mg tablet (for blood pressure), give one po once daily. Hold if systolic blood pressure is less than 110., ordered 8/8/25levothyroxine 50 microgram (mcg) tablet (for thyroid hormone replacement), give one po once daily from 6:00 A.M. to 10:00 A.M. at least 30-60 minutes before food or other medications, ordered 8/19/25During an interview on 8/28/25 at 8:25 A.M., the pharmacist at (facility pharmacy) was contacted and indicated these medications (Tradjenta, levothyroxine, and Metoprolol) should not be crushed and in addition, the levothyroxine should not be given with food or other medications. He indicated crushing the medications could disrupt the mechanism, the absorption, and how well the medications worked. On 8/28/25 at 12:15 P.M., the Director of Nursing (DON) and Clinical Support 1 indicated residents should have an order to crush medications. Clinical Support 1 indicated nurses should refer to the Do Not Crush list in the narcotic book on each medication cart for reference. They were to provide a copy of Do Not Crush list and indicated they would have to refer to the list to see if the medications could be crushed. For the levothyroxine, they usually have documentation that the resident doesn't want it administered early and the doctor confirming it would be ok to have with food and other medications instead of not taking at all. They were to provide the documentation. On 8/28/25 at 12:55 P.M., Registered Nurse (RN) 48 indicated she was not sure about a Do Not Crush medication list. At that time, she indicated it was usually in the order not to crush the ones that can't be.On 8/28/25 at 12:59 P.M., the 100 Hall Cart 1, 100 Hall Cart 2, and the 200 Hall Cart 2 narcotic books were observed and did not have a Do Not Crush list in the book or on the cart itself.On 8/29/25 at 8:52 A.M., the DON indicated they misspoke yesterday during the interview and they don't have a Do Not Crush list. The policy was what said they should not crush Metoprolol. They did not have documentation from the physician indicating it was ok to give levothyroxine with other medications and food. They had notified the physician and were waiting on clarification for all medications regarding the crushing and administration of levothyroxine with other medications and food.On 8/29/25 at 9:04 A.M., a current Medication Administration Policy, revised November 2018, was provided by Clinical Support 1 and indicated, . Medications are administered as prescribed in accordance with good nursing principles and practices . Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient personnel and a medication distribution system to ensure safe administration of (continued on next page)

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	09/02/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines. a. Long-acting or enteric coated medications should not be crushed; an alternative should be sought . For residents able to swallow or who have difficulty swallowing, tablets which can be appropriately crushed may be ground coarsely and mixed with the appropriate vehicle so that the resident receives the entire dose ordered. Please consult with the product literature or Do Not Crush lists which the facility may have or with the pharmacist if there is a question about medications to be crushed . The need for crushing medications is indicated on the resident's orders and the MAR so that all personnel administering medications are aware of this need and the Consultant Pharmacist can advise on safety issues and -alternatives, if appropriate, during medication regimen reviews . 3.1-48(c)(1)

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	09/02/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure antibiotic use protocols were followed to monitor antibiotic use. Residents received an antibiotic prior to obtaining culture results, and received an antibiotic without an indication for 2 of 2 residents reviewed for urinary tract infections (UTI). (Resident 45, Resident 1)Findings include:1. On 8/27/25 at 9:27 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and neurogenic bladder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/30/25, indicated a moderate cognitive impairment, and an indwelling urinary catheter. Physician orders included, but were not limited to:Macrobid (nitrofurantoin monohyd/m-cryst) (an antibiotic) capsule; 100 mg; amt: 100 mg; oral for UTI, dated 6/25/25 through 6/27/25. levofloxacin (an antibiotic) tablet; 500 mg; amt: 500mg; oral for UTI, dated 6/27/25 through 7/4/25. Macrobid (nitrofurantoin monohyd/m-cryst) capsule; 100 mg; amt: 100 mg; oral twice A Day, dated 8/20/25 through 8/27/25. A current care plan for urinary tract infection (UTI) was initiated and last reviewed 8/4/25. Interventions included, but were not limited to, administer medications and treatments as ordered. A progress note, dated 6/25/25, indicated a new order for Macrobid was given for Resident 45, however the urine culture we still pending. The note indicated would wait for the culture result to see if the antibiotic prescribed would be resistive or not to the organism indicated. A progress note, dated 6/25/25, indicated a new order was received to start Resident 45 on Cipro (an antibiotic) for seven days for UTI. Physician was updated that an order had already been received for Macrobid. Received order to continue with Macrobid until culture was back. A progress note on 6/27/25 indicated a new order for a different antibiotic and the Macrobid was stopped for UTI. A urine culture report, dated 6/27/25, indicated the organism pseudomonas aeruginosa in the urine. The report did not list Macrobid as resistant or susceptible to the organism, and Cipro was listed as resistant. A progress note, dated 8/20/25, indicated a new order to repeat a UA (urinalysis) and C&S (culture and sensitivity). A progress note, dated 8/20/25, indicated a new order was received for Macrobid 100mg twice a day for seven days for UTI with culture pending. A urine culture report, dated 8/22/25, indicated the culture was completed on 8/22/25. On 8/29/25 at 3:01 P.M., the Infection Preventionist (IP) indicated waiting for a urine culture to come back prior to starting on an antibiotic was hit or miss with the physicians. 2. On 8/27/25 at 9:21 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and renal failure. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/31/25, indicated a moderate cognitive impairment, and an indwelling urinary catheter.Physician orders included, but were not limited to:Urinalysis w/ Microscopic, Culture if Indicated, dated 6/17/25Urine culture, dated 6/17/25.Macrobid (nitrofurantoin monohyd/m-cryst) (an antibiotic) capsule; 100mg; amt: 100mg; oral, twice a day, dated 6/21/25 through 6/27/25. A urine culture, dated 6/18/25, indicated no uropathogens isolated. No organism was found. On 8/29/25 at 3:01 P.M., the Infection Preventionist (IP) indicated that on 6/17/25, Resident 1 had symptoms, and a positive urinalysis, but the culture did not grow anything. She indicated the resident was treated based on symptoms and UA results. At that time, the urinalysis and symptom form was provided. The form indicated the date of infection as 6/17/25, and date of review 7/1/25. The only symptom listed was increased lethargy related to yeast infection. The form also indicated UTI criteria was not met. On 8/28/25 at 10:45 A.M., the Administrator provided a current Antibiotic Stewardship policy, dated 11/10/17, that indicated Optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use

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	09/02/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing forms were accurate for 4 of 6 days during the survey. Census information was not correct on the forms. Finding includes:On 8/27/25 at 12:43 P.M., a posted nurse staffing form was observed at the nurses station. The facility census was listed as 46. At that time, the Administrator indicated the current census was 54.On 8/28/25 at 1:02 P.M., a posted nurse staffing form was observed at the nurses station. The facility census was listed as 46. At that time, the Administrator indicated the current census was 55.On 8/29/25 at 9:10 A.M., a posted nurse staffing form was observed at the nurses station. The facility census was listed as 46. At that time, the Administrator indicated the current census was 55.On 9/2/25 at 8:40 A.M., a posted nurse staffing form was observed at the nurses station. The facility census was listed as 46. At that time, the Administrator indicated the current census was 56. On 9/2/25 at 8:45 A.M., the Administrator indicated the scheduler was responsible for posting the staffing form, and the nurses on the floor were responsible for verifying its accuracy daily. On 9/2/25 at 10:00 A.M., a posted nurse staffing policy was requested and not provided.