STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE HEALTH CAMPUS	602 WOODBRIDGE AVE LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/02/11. Survey Dates: January 17, 18, and 19, 2012 Facility number: 003691 Provider number: 155724 AIM number: 200456230 Survey team: Tim Long, RN, TC Julie Wagoner, RN Christine Fodrea, RN (01/17/2012) Census bed type: SNF: 43 SNF/NF: 19 Residential: 19 Total: 81 Census payor type: Medicare: 27 Medicaid: 17 Other: 37 Total: 81 Sample: 08 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute an admission by WoodBridge Health Campus of any wrong-doing or failure to comply with the Federal or State Regulations. WoodBridge Health Campus submits this plan of correction as its letter of credible allegation and respectfully requests a desk review.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	Quality review 1/26/12 by Suzanne Williams, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, record review, and interview, the facility failed to ensure the physician was notified timely of a change in condition for 1 of 8 residents reviewed for physician notification in a sample of 8. (Resident #1)	F0157	**F157 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident 1 had an oral cavity assessment on 1.19.12 which revealed pink rough patches on the the residents tongue. Res denied any	02/18/2012

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	Finding includes: During the initial tour of the facility, conducted on 01/17/12 at 10:15 A.M., the medical records nurse, LPN #2, indicated Resident #1 had recently been treated for an oral thrush infection. She indicated she thought the infection was possibly due to the resident's desire to frequently suck on hard candy. The clinical record for Resident #1 was reviewed on 01/18/12 at 10:00 A.M. Review of the physician's orders, dated 01/04/12, indicated an order for Nystatin Lozenges 200,000 units, one lozenge four times a day for 7 days. A subsequent physician's order, dated 01/05/12, indicated the Nystatin lozenges were to be discontinued and the medication Mycelex (Cloinmazole) troche 10 mg by mouth 5 times a day for 14 days was ordered. Nursing notes for Resident #1, dated 01/04/12, indicated the physician's order for the Nystatin lozenges was received but there was no assessment of the resident's mouth. The order changes were again documented on 01/05/12 but there was no assessment of the resident's mouth. There were no nursing notes on 01/06/12 and 01/07/12. An undated note, written at 12:30 A.M.,		pain in mouth or throat. Resident 1 chart reviewed and the faxed documentation of oral assessment which notified the physician requesting orders for treatment added to resident 1 chart. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Current residents have had an oral assessment to ensure their oral cavity is without signs and symptoms of infection. No further residents noted to have signs and symptoms of infection of the oral cavity. **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** New admissions/readmissions will have their oral cavity assessed during time of admission to ensure the resident is without an oral infection. If infection noted then physician will be notified timely for treatment orders and follow up of resident infection. Licensed nursing staff will receive a directed inservice prior to February 16, 2012 to identify any resident with a change in condition has a complete and thorough assessment with notification to the physician timely for treatment of the change on condition. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS/designee will review change	

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	indicated the following: "at 1910 (7:10 P.M.) daughter (daughter's name) voices concern regarding father's condition at this time resident was in his w/c (wheelchair) with eyes closed head forward. daughter states 'he holds his arm with his hand et shakes.' Further states his words are slurred et he is 'more confused than usual.' Resident arouses does speak with difficulty. Recognized daughter but not staff. Upon inspection resident's tongue is swollen et has large white plaques. Smaller plaques noted to inner lips accounting for cautious speech. Resident's mental status has changed as he attempts to chew his medication rather than swallow whole. further, he chokes on water. Offered Nectar thick apple juice et drinks without incident. Resident is on Mycelex... Daughter request Dr be called." At 19:20 (7:20 P.M.) "Attempts x3 to page (physician's name) on call for (physician's name) each time recording line no longer in service." 19:35 (7:35 P.M.) "resident assisted to floor by staff CNA. no open areas abrasions, bruising or bumps noted. Bilateral lower extremities equal in length. no inward/outward rotation. 20:50 (10:50 P.M.) daughter notified of lowering to floor et inability to contact physician call...."		of condition form and physician orders during clinical meeting Mon –Fri to ensure residents are treated timely for a change in condition and follow up occurs until condition is resolved. Results will be followed monthly times six motnhs during the Quality assurance meeting and any recommendations noted. Addendum: F0157- Oral sweep was completed on all skilled units on January 27, 2011 with no ill effects noted. DHS/DESIGNEE to audit all new admissions for documentation on any and all noted oral concerns and pain within 24-hours of admission. Audit to include physician and family notification of documented concerns within 24-hours of admission. New admission audits to be completed daily for 6 months then weekly for 3 months until compliance is met as determined by QAA. Monthly assessment audits will be completed on 30 residents for one month then 15 residents thereafter monthly until compliance is met as determined by QAA. **Date: February 18, 2012**	

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	Interview with the Interim Director of Nursing, on 01/19/11 at 10:00 A.M., indicated the nurse who made the undated entry was requested, on 01/09/12, to make an entry for events which occurred on the evening of 01/07/12. The Interim Director of Nursing indicated RN #4, who had not documented any of the events of 01/07/12 and had failed to contact the physician due to Resident #1's change of condition, was no longer employed by the facility. The physician was notified, on 01/08/12, of the first shift nurse's assessment, but it was not clear if the events occurring on 01/07/12 in the evening were relayed to the physician on 01/08/12 as the events were not documented until 01/09/12 after the physician was notified. The physician gave an order for Nystatin oral solution to be given for 10 days. Observation of the resident's mouth, on 01/19/11 at 2:10 P.M., indicated there were pink rough patches noted on the resident's tongue. The resident was unable to recall any recent discomfort with his mouth and indicated his mouth did not hurt. The resident's tongue and oral mucosa did not appear swollen and his speech was not noted to be slurred. He was noted to display some confusion.			

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	This deficiency was cited on 12/02/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review, and interview, the facility failed to ensure an oral skin infection was thoroughly and consistently assessed and treated for 1 of 8 residents reviewed for assessments in a sample of 8. (Resident #1) Finding includes: During the initial tour of the facility, conducted on 01/17/12 at 10:15 A.M., the medical records nurse, LPN #2, indicated Resident #1 had recently been treated for an oral thrush infection. She indicated she thought the infection was possibly due to the resident's desire to frequently suck on hard candy. The clinical record for Resident #1 was reviewed on 01/18/12 at 10:00 A.M. Review of the physician's orders, dated 01/04/12, indicated an order for Nystatin Lozenges 200,000 units, one lozenge four times a day for 7 days. A subsequent physician's order, dated 01/05/12, indicated the Nystatin lozenges were to be discontinued and the medication Mycelex (Cloinmazole) troche 10 mg by mouth 5	F0309	**F309 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident 1 had an oral cavity assessment on 1.19.12 which revealed pink rough patches on the the residents tongue. Res denied any pain in mouth or throat. Resident 1 chart reviewed and the faxed documentation of oral assessment which notified the physician requesting orders for treatment added to resident 1 chart. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Current residents have had an oral assessment to ensure their oral cavity is without signs and symptoms of infection. No further residents noted to have signs and symptoms of infection of the oral cavity. **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** New admissions/readmissions will have their oral cavity assessed during time of admission to ensure the resident is without an	02/18/2012

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	times a day for 14 days was ordered. Another physician's order, dated 01/08/12, indicated Nystatin 100,000 units per milliliter 2 ml by mouth on each side of the mouth QID (four times a day) was ordered. Finally, an order, dated 01/09/12, discontinued the Nystatin because the resident was already receiving the Mycelex medication. Nursing notes for Resident #1, dated 01/04/12, indicated the physician's order for the Nystatin lozenges was received, but there was no assessment of the resident's mouth. The order changes were again documented on 01/05/12, but there was no assessment of the resident's mouth. There were no nursing notes on 01/06/12 and 01/07/12. On 01/08/12 at 8:30 A.M., there was a nursing note indicating the following: "Res daughter called et wanted res. totally assessed. Neuro check done, PEARL (pupils equal and reactive to light), grips equal ...Oral cavity tongue etc has some patchy areas.. Mycelex cont (continues) for thrush. (physician's name) on call at this time. Beeped." A subsequent nursing note, dated 01/08/12 at 9:10 A.M., indicated the physician returned the call and gave an order for Nystatin 2 ml to each side of mouth four times a day.		oral infection. If infection noted then physician will be notified timely for treatment orders and follow up of resident infection. Licensed nursing staff will receive a directed inservice prior to February 16, 2012 to identify any resident with a change in condition has a complete and thorough assessment with notification to the physician timely for treatment of the change on condition. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS/designee will review change of condition form and physician orders during clinical meeting Mon –Fri to ensure residents are treated timely for a change in condition and follow up occurs until condition is resolved. Results will be followed monthly times six motnhs during the Quality assurance meeting and any recommendations noted. Addendum: F309-Oral sweep was completed on all skilled units on January 27, 2012 with no ill effects noted. DHS/DESIGNEE to audit all new admissions for proper documentation and initiation of infection circumstance forms for accuracy, physician notification, family notification and timely completion 5 times weekly for 3 months then 1 time weekly thereafter until compliance is met by QAA. DHS/DESIGNEE to audit 5	

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	Another undated note, written at 12:30 A.M., indicated the following: "at 1910 (7:10 P.M.) daughter (daughter's name) voices concern regarding father's condition at this time resident was in his w/c (wheelchair) with eyes closed head forward. daughter states 'he holds his arm with his hand et shakes.' Further states his words are slurred et he is 'more confused than usual.' Resident arouses does speak with difficulty. Recognized daughter but not staff. Upon inspection resident's tongue is swollen et has large white plaques. Smaller plaques noted to inner lips accounting for cautious speech. Resident's mental status has changed as he attempts to chew his medication rather than swallow whole. further, he chokes on water. Offered Nectar thick apple juice et drinks without incident. Resident is on Mycelex... Daughter request Dr be called." At 19:20 (7:20 P.M.) "Attempts x3 to page (physician's name) on call for (physician's name) each time recording line no longer in service." 19:35 (7:35 P.M.) "resident assisted to floor by staff CNA. no open areas abrasions, bruising or bumps noted. Bilateral lower extremities equal in length. no inward/outward rotation. 20:50 (10:50 P.M.) daughter notified of lowering to floor et inability to contact		times weekly for 6-months for any new orders for antibiotics, physician notification and the start of the infection circumstance form. QAA to determine if compliance is met after 6 months or further action it needed. **Date: February 18, 2012**	

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	physician call...." Interview with the Interim Director of Nursing, on 01/19/11 at 10:00 A.M., indicated the nurse who made the undated entry was requested, on 01/09/12, to make an entry for events which occurred on the evening of 01/07/12. The Interim Director of Nursing indicated RN #4, who had not documented any of the events of 01/07/12 and had failed to contact the physician due to Resident #1's change of condition, was no longer employed by the facility. However, nursing notes, after 01/08/12 again failed to assess the resident's oral thrush infection, even though a note, dated 01/09/12 at 18:10 (6:10 P.M.), indicated there were still orders obtained to treat the resident's infection. There was also no care plan initiated regarding the resident's oral skin infection. Interview with the Interim Director of Nursing (DON), and a Corporate Director of Nursing, RN #6, on 01/19/12 at 2:00 P.M., indicated the facility policy was to document all types of acute issues, including skin issues, on a "circumstance" form which then had assessments documented on the back for at least 72 hours. The DON indicated she could not locate a circumstance form for Resident			

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	#1. In addition, staff were to utilize a "team leader follow up form" daily by unit, completed by the unit manager, to review all new orders, and new occurrences to ensure the proper documentation and follow-up occurred. Review of the "team leader follow up forms" for 01/04/12 for all units, indicated the order for the medication for Resident #1 was not listed on the form. The only documentation of any type of assessment presented, was a 24 hour nursing report form, dated 01/04/12, which indicated the resident had complained of a sore throat and had white spots and a fax had been sent out to the physician. A copy of the fax was also presented which did include an assessment of the resident's oral cavity but both documents were not routinely kept as part of the medical record. Observation of the resident's mouth, on 01/19/11 at 2:10 P.M. indicated there were pink rough patches noted on the resident's tongue. The resident was unable to recall any recent discomfort with his mouth and indicated his mouth did not hurt. The resident's tongue and oral mucosa did not appear swollen and his speech was not noted to be slurred. He was noted to display some confusion.			

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	This deficiency was cited on 12/02/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			