

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2011
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NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN46947
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/29/11</p> <p>Facility Number: 003691 Provider Number: 155724 AIM Number: 200456230</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Woodbridge Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. and with 410 IAC 16.2</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 69 and had a census of</p>	K0000	Submission of this plan of correction does not constitute an admisson byWoodbridge Health Campus of any wrong-doing or failure to comply withthe Federal or State Regulations.Woodbridge Health Campus submits this plan of correction as its letter of credible allegation.	

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

TITLE

(X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficiency 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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K0051 SS=E	<p>61 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 184 smoke detectors in the facility was installed in a location which would allow the smoke detector to function to its fullest</p>	K0051	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: No residents have been affected by the smoke detector being installed in a location which would not allow</p>	01/13/2012	

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K0130 SS=E	<p>capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 10 residents on Center east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/29/11 at 1:20 p.m. with the Maintenance Supervisor, the smoke detector just east of the dining room on Center east hall was within three feet of an air diffuser. Based on interview on 12/29/11 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed within three feet of an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 nonflammable gas cylinders was properly chained or supported in a cylinder stand</p>	K0130	<p>smoke detector to function to its fullest capability. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected, therefore 19 smoke detectors were moved by Koorsen's Fire and Safety Company. DPO will monitor smoke detectors monthly and Koorsens will perform quarterly fire alarm testing as required. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Smoke detectors have been moved at least 36" from air supply vents by Koorsens. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DPO will monitor detectors monthly and Koorsens will perform fire alarm test quarterly as required. Executive Director will review the documentation of monthly checks and review in QA/Safety</p> <p>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice: No residents have been affected by a</p>	01/13/2012	

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	<p>or cart while in storage. LSC 2.1.1 references NFPA 99, Health Care Facilities. NFPA 99, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 9 residents in the Activities room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 12/29/11 at 1:20 p.m. with the Maintenance Supervisor, the helium cylinder located in the Activities room closet was free standing without being chained or supported in a cylinder stand or cart. Based on interview on 12/29/11 at 1:22 p.m. with the Maintenance Supervisor, it was acknowledged the helium cylinder should have been in a rack or properly secured with the chain provided.</p> <p>3.1-19(b)</p>		<p>nonflammable gas cylinder not being properly chained. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected, therefore the DPO has removed helium tank from building, chain was installed in Activity room closet so that if helium tanks are used in the future they can be secured properly per code. How the corrective measures will be monitored to ensure the alleged deficient practice will not recur: DPO will inspect activity room closet for properly secured helium tank weekly. Executive Director will review documented checks.</p>		