

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 02/21/2013
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NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00124579 and IN00124648.</p> <p>Survey dates: February 12,13,14,15, 18, 19, 20, and 21, 2013.</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Survey team: Michelle Carter, RN- TC Rita Mullen, RN Bobbette Messman, RN (2/21/2013)</p> <p>Census bed type: SNF: 39 SNF/NF: 19 Residential: 20 Total: 78</p> <p>Census Payor type: Medicare: 29 Medicaid: 17 Other: 32 Total: 78</p> <p>Residential Sample: 7</p>	F000000	<p>The facility wishes to request desk compliance. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Tammy Alley RN on February 26, 2013.</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure privacy was maintained for 1 of 1 resident randomly observed for privacy and dignity. (Resident #126).</p> <p>Findings include:</p> <p>During a random observation on 2/29/2013 at 9:05 A.M., on the 200 unit, Resident #126's call light was activated. Resident #126's door was closed. CNA #1 answered the call light, promptly. CNA #1 failed to knock and failed to announce herself when she opened and entered Resident #126's room.</p> <p>Interview with DON on 2/19/13 at 2:10 P.M. indicated all staff are expected to knock prior to entering resident's room.</p> <p>3.1-3(t)</p>	F000241	<p>1. Resident #126 cited in the survey was observed and no adverse effects were noted. 2. No Residents were affected. 3. The staff were re-educated on the facility policies and procedures for providing privacy and dignity upon entering a resident room. All staff will monitor through daily tasks and activity within the facility and report any concerns to the Executive Director immediately. 4. The Executive Director will report the findings to the QA monthly x 3 months and then at least quarterly thereafter or until ongoing compliance is assured.</p>	03/15/2013

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to ensure preferred bathing choices were met for 1 of 40 residents reviewed for bathing choices. (Resident #119)</p> <p>Findings include:</p> <p>The clinical record for Resident #119 was reviewed on 2/18/13 at 9:55 A.M.</p> <p>Diagnoses for Resident #119 included, but were not limited to, dementia, cellulitis of the leg, history of deep vein thrombosis (DVT), osteoporosis, arthropathy, depressive disorder, hearing loss, high blood pressure, glaucoma, lumbago, and muscle weakness.</p> <p>During an interview with Resident #119's daughter on 2/14/13 at 11:10 A.M., she indicated Resident #119 did not receive tub baths as requested and according to her past preferences. Resident #119's daughter indicated her mother was an immaculate, well-dressed,</p>	F000312	<p>1. Resident #119 was monitored and no adverse effects were noted.2. All residents were reviewed and no residents were found to be affected.3. The staff were re-educated on the facility policies and procedures as it relates to resident bathing choices. New admissions will be monitored through our first Care Plan conference in regards to bathing preferences. The Director of Health Services or designee will monitor current residents through ADL documentation review and interview 5 residents per week x 3 months. Preferences will be reviewed at least quarterly and PRN with the MDS. Any identified concerns will be corrected immediately and followed through the QA process.4. The Director of Health Services or designee will report any findings to the QA monthly x 3 months then at least quarterly thereafter or until ongoing compliance is assured.</p>	03/22/2013			

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	<p>"put-together" lady. She was not capable of making her own decisions, anymore, and was not capable of taking care of herself due to progressing dementia. Resident #119's daughter was the power of attorney (POA) and requested that her mother receive 2-3 spa tub baths each week. Resident #119's daughter was told by staff that the resident refused to bathe.</p> <p>During an interview with RN #2, at 10:40 A.M., on 2/18/13, she indicated Resident #119 was recently admitted on 2/02/13 and was still being assessed for staff assistance. Thus, actual care plans were not completed yet.</p> <p>A Nursing Admission Assessment and Data Collection form dated 2/02/13 indicated Resident #119 required extensive assistance with bathing. During an interview with the Assistant Director of Nursing (ADON) on 2/18/13 at 10:25 A.M., the ADON stated Resident #119 was scheduled to receive spa tub baths, 3 times per week, on Tuesday's, Thursday's and Saturday's. The Care Tracker system, a computer tracking system used by CNA's, indicated the resident was planned for whirlpool tub baths on Tuesday's, Thursday's and</p>			

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	<p>Saturday's.</p> <p>During an interview with CNA #1, on 2/18/13 at 11:20 A.M., she indicated Resident #119 was scheduled for tub baths on Tuesday's, Thursday's, and Saturday's. CNA #1 stated if a resident did not want to bathe, after the staff offered 3 times, the staff offered a partial bath which included cleansing the back, armpits, and peri area. She indicated if the resident refused the offers to bathe, staff could not "make" the resident bathe. CNA #1 indicated Resident #119 refused the bathing offers, occasionally.</p> <p>During an interview with RN #2 on 2/18/13 at 10:45 A.M., she indicated there was not any documentation of bathing refusal from Resident #119.</p> <p>A Resident Bathing Chart, provided by RN #2, on 2/18/13 at 10:50 A.M., indicated 4 tub baths were given to Resident #119 since admission on 2/02/13. Spa/whirlpool tub baths were given to Resident #119 on 2/6/13, 2/12/13, 2/14/13, and 2/16/13.</p> <p>3.1-38(a)(2)(A)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 11 residents had diagnoses for medications (Resident # 100 and # 118) and failed to monitor the apical pulse for the use of digoxin for 1 of 11 residents (Resident # 122) reviewed for medication monitoring in a sample of 11.</p> <p>Findings include:</p> <p>1. The clinical record of Resident</p>	F000329	<p>1. Diagnoses were obtained prior to survey exit for Residents #100 and #118. 2. All physician orders have been reviewed for diagnosis for all residents. Any identified concerns were immediately communicated to the physician and diagnosis were obtained. All medication administration records were reviewed for all residents receiving medications with parameters. Any identified concerns were immediately communicated to the physician. 3. The licensed nursing staff were re-educated on the facility</p>	03/15/2013	

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	<p>#100 was reviewed on 2/18/13 at 10:00 A.M.</p> <p>A review of the Medication Administration Record (MAR), dated for the month of February 2013, indicated the following:</p> <p>Clonazepam (an anti-anxiety medication), 0.5 mg (milligrams), twice a day. There was not a documented diagnosis for the use of this medication.</p> <p>Alprazolam (an anti-anxiety medication), 0.12 mg, every 6 hours, as needed. There was not a documented diagnosis for the use of this medication.</p> <p>During an Interview with the Director of Nursing (DON), on 2/20/13 at 11:10 A.M., she indicated diagnoses for the use of alprazolam and clonazepam were not identified.</p> <p>2. The clinical record of Resident #122 was reviewed on 2/19/13 at 2:00 P.M.</p> <p>A review of the MAR, dated for the month of February 2013, indicated the resident was receiving Prilosec (an anti-ulcer medication) 20 mg, twice a day. There was not a</p>		<p>policies and procedures as it relates to obtaining diagnoses for medication usage and medication administration relating to parameters. The Director of Health Services or designee will monitor through Medication Administration Record reviews 5 x weekly. Any identified concerns will be documented. 4. The Director of Health Services or designee will report any findings to the QA monthly x 3 months then at least quarterly thereafter or until ongoing compliance is assured.</p>	

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	<p>documented diagnosis for the use of this medication.</p> <p>During an interview with the DON, on 2/20/13 at 11:10 A.M., she indicated a diagnosis was not identified for the use of Prilosec.</p> <p>3. The clinical record of Resident #118 was reviewed on 2/20/13 at 9:45 A.M.</p> <p>Diagnoses included, but were not limited to, atrial fibrillation and high blood pressure.</p> <p>A review of the MAR, dated for the months of January 2013 and February 2013, did not indicate apical pulse checks on January 28, 29, February 3, 6, 7, 8, and 12, 2013.</p> <p>Nursing notes, from January 28, 2013 through February 15, 2013, did not indicate the apical pulse was monitored at the time the digoxin was administered on January 28, 29, February 3, 6, 7, 8, 12, 2013.</p> <p>During an interview with the DON, on 2/20/13 at 11:10 A.M., she indicated the staff should monitor the apical pulse prior to administering the digoxin.</p>			

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	<p>A facility Policy for "Administration Procedures for all Medication," dated 2/1/0 (sic) and received from the DON, on 2/20/13 at 1:40 P.M., indicated the following:</p> <p>"...M. Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration...."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F009999	<p>STATE FINDINGS</p> <p>3.1-14 Personnel</p> <p>(1) At the time of employment, or within one (1) month prior to employment , and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For healthcare workers who have not had a documented negative tuberculin skin test results during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. if the first step is negative, a second should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure TB (Tuberculin) testing was completed timely for 1 of 10 employees reviewed for TB testing. (CNA #3)</p>	F009999	<p>1. CNA #3 has received a two-step Tuberculin testing. 2. All employee records have been reviewed with no concerns noted. 3. The facility policy and procedure for two-step Tuberculin testing was reviewed with the Payroll Specialist and Assistant Director of Health Services. Executive Director or designee will monitor through new employee record review on a weekly basis. Any identified concerns will be documented. 4. The Executive Director or designee will report the findings to the QA monthly x 3 months then quarterly thereafter or until ongoing compliance is assured.</p>	03/15/2013	

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	<p>Findings include:</p> <p>During employee files review, on 2/20/13 at 1:00 P.M., the tuberculin skin test for CNA # 3 was not completed for a start date of 6/7/12. It was indicated CNA #3 received a two step tuberculin (TB) skin test on 6/1/12 and read on 6/4/12. The result was negative. No second step TB test was performed. Further review indicated another two step TB test was initiated on 7/8/12 and read on 7/10/12, with negative results. No second step TB skin test was performed. A third, two step, TB test was initiated on 10/2/12 and read on 10/4/12, results were negative. The second step was performed on 10/16/12 and read on 10/19/12, with negative test results.</p> <p>During an interview with the Human Resources Coordinator, on 2/20/12 at 1:15 P.M., she indicated CNA #3 did not complete two step TB testing until 10/19/12.</p> <p>During an interview with the DON (Director of Nursing), on 2/20/13 at 2:30 P.M., she indicated CNA #3 worked from 6/11/12 through 10/16/12 without two step TB test completion.</p>			

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure 4 of 7 residents, or their responsible party, signed and dated the service plans in a sample of 7. (Residents # 127, #131, C, and D)</p>	R000217	<p>1. Residents #127, #131, C and D were observed and no adverse effects were noted. 2. All Service Plans were reviewed for signature. For any identified concerns, a current Service Plan has been completed and signatures obtained. 3. The licensed nursing staff were re-educated to the facility policy</p>	03/15/2013			

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	<p>Residential findings included :</p> <p>1. The clinical record of Resident #127 was reviewed on 2/21/13 at 9:45 A.M. The resident was admitted to the facility on 10/12/12.</p> <p>A review of the resident service plans, dated 10/10/12 and 11/24/12, were not signed or dated by the resident or their representative.</p> <p>2. The clinical record for Resident C was reviewed on 2/21/13 at 9:45 A.M. The resident was admitted to the facility on 1/8/13.</p> <p>A review of the resident service plan, dated 1/22/13, was not signed or dated by the resident or their representative.</p> <p>3. The clinical record for Resident D was reviewed on 2/21/13 at 10:00 A.M.</p> <p>A document titled "Evaluation and Service Plan" was dated 11/24/12 and had a review date of 12/3/12. The Service Plan document was not signed by Resident D.</p> <p>During an interview the the Executive Director (ED) on 2/21/13 at 3:50 P.M.,</p>		<p>and procedure for Resident Service Plans. The Director of Health Services or designee will ensure ongoing compliance through new admission chart reviews. Any identified concerns will be documented. 4. The Director of Health Services or designee will report any findings to QA monthly x 3 months then quarterly thereafter or until ongoing compliance is assured.</p>	

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 02/21/2013
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NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
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	<p>she indicated the service plan was not signed by the resident or a representative for the resident.</p> <p>4. The clinical record for Resident #131 was reviewed on 2/21/13 at 10:25 A.M.</p> <p>A document titled "Evaluation and Service Plan" was dated 11/19/12 and had a review date of 12/3/12. The Service Plan document was not signed by Resident #131.</p> <p>During an interview the the Executive Director (ED) on 2/21/13 at 3:50 P.M., she indicated the service plan was not signed by the resident or a representative for the resident.</p>			

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R000270	<p>410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.</p> <p>Based on interview and observation, the facility failed to meet resident's personal preferences and requests for food and drink. This deficiency affected 1 of 3 residents interviewed for kitchen and dining services, in a sample of 7. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 2/21/13 at 9:15 A.M.</p> <p>Diagnoses for Resident B included, but were not limited to, irritable bowel syndrome, depression, insomnia, back pain, generalized anxiety disorder, and high blood pressure.</p> <p>During an interview with Resident B on 2/19/13 at 3:35 P.M., she indicated concerns regarding food service, such as not getting the ordered items on meal trays, receiving items on the meal tray that were not ordered (this caused great confusion), no coffee cup but received a pot of coffee, and</p>	R000270	<p>1. Resident B was observed and no adverse effects were noted. 2. All residents were reviewed and no residents were found to be affected. 3. Dietary staff were re-educated to the facility policy and procedure related to meal service. The Director of Food Services or designee will monitor random trays 5 x weekly through daily tasks. Any identified concerns will be documented. 4. The Director of Food Services will report any findings to the QA monthly x 3 months then quarterly thereafter or until ongoing compliance is assured.</p>	03/15/2013

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	<p>missing condiments. She indicated she consistently received food that she did not order and menu choices were consistently not honored. Resident B indicated the disorganization with food service happened at every meal and she had discussed her frustrations with management, in the past.</p> <p>On 2/21/13 at 7:45 A.M., a test breakfast room tray was received for observation and evaluation. Coffee, skim milk, scrambled eggs, and 2 pieces of bacon were ordered at 7:20 A.M. Coffee and a coffee cup were not received or observed on the room tray. Additionally, butter and jelly were served on the breakfast tray, but no bread was served to put it on.</p> <p>During an interview with the Dietary Manager on 2/21/13 at 9:05 A.M., she indicated meal orders should be checked for accuracy before leaving the kitchen and that when the kitchen is out of a certain item, they will attempt to replace it with a similar item. She said the facility ran out of maple syrup one morning. She made her own syrup with maple flavoring and sugar because no one was available to go to the grocery.</p> <p>This State Residential tag relates to</p>				

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	Complaint IN00124648.			