

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 04/11/2016
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 5, 6, 7, 8 and 11, 2016</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Census bed type: SNF/NF: 22 SNF: 39 Residential: 19 Total: 80</p> <p>Census payor type: Medicare: 18 Medicaid: 21 Other: 41 Total: 80</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on April 12, 2016.</p>	F 0000	<p>This 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>	
------------------------	--	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2016
--	---	---	---

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

(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
F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</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 04/11/2016
--	---	--	---

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

(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
	<p>Based on record review, and interview, the facility failed to correctly identify and accurately assess the residents status regarding Hospice for 1 out of 1 resident reviewed for Hospice (Resident # 89).</p> <p>Findings include:</p> <p>1. The Clinical record for Resident # 89 was reviewed on 4/7/2016 at 11:15 a.m. Diagnoses included, but were not limited to, bipolar disorder, obesity, hypertension, chronic ischemic heart disease, other pulmonary embolism, atrial fibrillation, congestive heart failure, chronic embolism and thrombosis, chronic obstructive pulmonary disease, and coronary atherosclerosis.</p> <p>A Physician's order, dated 8/20/2015, indicated, admission to Hospice with diagnosis of coronary atherosclerosis, and resident had prognosis of six months or less.</p> <p>A Physician's order, dated 2/4/2016, indicated, admission to Hospice with diagnosis of coronary atherosclerosis, and resident had prognosis of six months or less.</p> <p>A Physician's order, dated 3/31/2016, indicated, admission to Hospice with diagnosis of coronary atherosclerosis, and</p>	F 0278	<p>1. The MDS assessment for Resident #89 cited in the survey was modified and resubmitted.</p> <p>2. MDS Assessments of current residents receiving Hospice have been reviewed for accuracy and prognosis of six months or less with changes made accordingly.</p> <p>3. MDS Coordinator was reeducated, by the MDS Support, on RAI guidelines related to coding of Hospice.</p> <p>4. DHS/designee will review 3 residents per week for accurate coding of Hospice on MDS Assessment. Any findings will be reported to QA Committee monthly x 6 months or until 100% of substantial compliance is achieved. QA will monitor for any trends and make recommendations as needed.</p>	05/11/2016

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 04/11/2016
--	---	--	---

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

(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
	<p>resident had prognosis of six months or less.</p> <p>A Quarterly Review Minimum Data Set Assessment (MDS), dated 11/28/2015, indicated Resident #89 was on hospice and did not have a prognosis of six months or less.</p> <p>A Quarterly Review Minimum Data Set Assessment (MDS), dated 12/10/2015, indicated Resident #89 was on hospice and did not have a prognosis of six months or less.</p> <p>A Quarterly Review Minimum Data Set Assessment (MDS), dated 3/11/2016, did not indicate Resident #89 was on hospice and did not have a prognosis of six months or less.</p> <p>During an interview with the MDS coordinator on 4/7/2016 at 11:45 a.m., regarding the hospice status of Resident #89, she indicated that hospice was noted on the MDS, but that Resident #89 did not have a prognosis of less than six months indicated on the MDS and on the Quarterly Review on 3/11/2016, she did not indicate resident #89 was on hospice or had a prognosis of six months or less.</p> <p>3.1-31(a) 3.1-31(d)(3)</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 04/11/2016
--	---	--	---

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

(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
F 0279 SS=E Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure antidepressant medications, antianxiety medications, and psychotropic medications side effects and monitoring were included in care plans for 4 of 5 residents reviewed for unnecessary medications. (Residents #1, #68, #16, #93)</p>	F 0279	<p>1. The care plans for Residents #1, #68, #16 and #93 cited in the survey were updated to reflect the Psychotropic medication regimen and adverse reactions.</p> <p>2. Care plans of current residents receiving Psychotropic medications were reviewed and updated per individual care plan.</p> <p>3. MDS Coordinator and nursing</p>	05/11/2016

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 04/11/2016
--	---	--	---

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

(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
	<p>Findings include:</p> <p>1. During a record review on 4/10/16 at 10:00 a.m. Resident #1 diagnoses included, but were not limited to, hypertension, glaucoma, hyperlipidemia, chronic obstructive pulmonary disease, diabetes mellitus, peripheral vascular disease, dementia with behavioral disturbance and unspecified symbolic dysfunction.</p> <p>Medications included, but were not limited to, Celexa (an antidepressant) 10 mg (milligrams) every night ordered by the physician on 1/20/16.</p> <p>A review of the care plan on 4/10/16 did not include antidepressant medication or monitoring for side effects of antidepressant medication.</p> <p>2. During a record record review on 4/07/16 at 9:05 a.m., Resident #68's diagnoses included, but were not limited to, pneumonia, sepsis, atrial fibrillation, acute kidney failure, heart failure and anemia.</p> <p>Resident #68's medications included, but were not limited to Mirtazapine (an anti-depressant) 15 mg every bedtime.</p> <p>During review of Resident #68's care</p>		<p>admin team have been reeducated, by the MDS Support and/or Director of Health Services, on care plan guidelines. 4. DHS/designee will audit 5 residents care plans per week to ensure care plans are reflective of Psychotropic medication regimen and adverse reactions. DHS/designee will report findings to QA Committee for 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.</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 04/11/2016
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(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	
F 0280 SS=D Bldg. 00	<p>plan, there were no care plans located for an anti-depressant medication.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review, observation and interview, the facility failed to revise a Plan of Care related to dental status for 1 out of 2 residents reviewed for dental services (Resident #32).</p> <p>Findings include:</p> <p>The record for Resident #32 was reviewed on 4/07/2016 at 10:56 a.m. Diagnoses included, but were not limited to , unspecified dementia without behavioral disturbance, dysphagia, and</p>	F 0280	<p>1. Resident #32 care plan was reviewed and updated to reflect her current dental status. 2. Current residents have been assessed and care plans updated to reflect their current dental status. 3. MDS Coordinator, Director of Social Services and Nursing Admin Team have been reeducated, by the MDS Support, on care planning dental status. Licensed Nurses have been reeducated on assessment of dental status. 4. DHS/designee will audit 5 residents care plans per week to</p>	05/11/2016	

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 04/11/2016
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(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	
F 0309 SS=D Bldg. 00	<p>type 2 diabetes mellitus. The review included a dental exam completed on 8/13/15 which indicated Resident #32 had 5 lower teeth. The care plan did not include that Resident #32 had problems with losing teeth.</p> <p>During an observation on 4/07/2016 at 9:12 a.m., the resident had two bottom teeth visible.</p> <p>During an interview on 4/08/2016 at 11:28 a.m., with CRCA (Certified Resident Care Assistant) #1 she indicated Resident #32 used to have 5 lower teeth and now only has 2 lower teeth.</p> <p>During an interview on 4/11/2016 at 11:10a.m., with the Social Services Director she indicated the resident's issues with continued tooth loss and the family's request for resident to be seen by the dentist were not updated on the care care.</p> <p>3.1-35(a) 3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>		ensure care plans are reflective of residents current dental status. DHS/designee will report findings to QA Committee for 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.		

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 04/11/2016
--	---	--	---

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

(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
	<p>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.</p> <p>Based on record review and interview, the facility failed to appropriately assess and monitor a resident who received dialysis treatments for 1 of 1 residents reviewed for dialysis (Resident #80).</p> <p>Findings include:</p> <p>The clinical record of resident #80 was reviewed on 4/11/16 at 9:00 a.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus uncomplicated, atrial fibrillation, hypertension, depressive disorder, ischemic heart disease, and obstructive sleep apnea.</p> <p>Resident #80 received dialysis treatments three days a week on Tuesday, Thursday and Saturday.</p> <p>A review of the Nursing notes, dated 3/1/16 and 4/7/16, did not indicate a post dialysis assessment was performed.</p> <p>The "Communication from campus to dialysis center" forms in the resident's record were not completed.</p>	F 0309	<p>1. Resident #80 cited in the survey was assessed with no adverse effects noted. 2. There are no other residents currently on dialysis. 3. Licensed Nurses were reeducated, by the DHS/designee to the facility dialysis communication form to include assessing and monitoring of the shunt site and any follow-up requirements. 4. DHS/designee will audit the post dialysis assessment and dialysis communication book 3x/week to ensure assessment and monitoring or any follow-up requirements. DHS/designee will report any findings to the QA Committee x 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.</p>	05/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2016
--	---	---	---

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

(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
--------------------	--	---------------	---	----------------------

F 0323 SS=D Bldg. 00	<p>During an interview with the Director of Health Services (DHS) on 4/8/16 at 10:45 a.m., she indicated the staff should have been doing the assessments and using the dialysis communication forms.</p> <p>A "Guideline for Dialysis Provider Communication" (no date) received from the Executive Director and DHS on 4/8/16 at 10:45 a.m., indicated the following: "...Purpose: To provide guidelines for communication and partnership of Dialysis Providers and the campus. Procedure:... 5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication. b. Review the Dialysis Provider paperwork for any necessary follow up requirements...."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</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 04/11/2016	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947			
(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			
	<p>Based on record review, observation, and interview, the facility failed to follow new interventions put into place after a fall for 1 of 3 residents reviewed for falls. (Resident #16)</p> <p>Findings include:</p> <p>During record review on 4/7/16 at 8:44 a.m., Resident #16's diagnoses included, but were not limited to, muscle weakness, repeated falls, hyperlipidemia, dementia without behavioral disturbance, major depressive disorder, anxiety, hypertension, and atherosclerotic heart disease.</p> <p>A fall report, dated 3/13/16, indicated resident had a fall in her room. Resident #16 was not using her alarm devices and did not ask for assistance. Both the resident's bed and chair alarms were found on a chair. Resident #16 indicated she placed them there and did not want to use them.</p> <p>Interdisciplinary team (IDT) review notes, dated 3/14/16, indicated the bed and chair alarms were to be discontinued and to add a floor mat alarm.</p> <p>The Care Plan for ADL's (Activities of Daily Living), updated 3/13/16, indicated to remove bed and chair alarm and add a</p>	F 0323	<p>1. Resident #16 cited in the survey was assessed with no adverse effects noted. 2. Current residents have been reviewed to ensure appropriate fall interventions are in place with any updates/changes made accordingly. 3. Licensed Nurse will implement an intervention immediately following a fall and communicate the intervention to the direct care staff. After reviewing a fall during daily Clinical Care Meeting Monday through Friday, DHS/designee will verify the new fall interventions are appropriate and in place. Care plan will be updated at that time. 4. DHS/designee will audit 5 residents per week to ensure new interventions are in place. DHS/designee will report findings to QA Committee for 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.</p>	05/11/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2016
--	---	---	---

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

(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
	<p>floor mat alarm.</p> <p>During room observation for Resident #16, on 4/5/16 at 10:40 a.m., the resident was noted to be in her room, in her bed, with a bed alarm on and functioning.</p> <p>During an interview with the Director of Health Services, on 4/7/16 at 1:20 p.m., she indicated after Resident #16's fall on 3/13/16, the Interdisciplinary Team's intervention was to discontinue the residents bed and chair alarm due to non-compliance and add a floor mat. She indicated the fall intervention was not followed, a floor mat was not started and the bed and chair alarm was never discontinued.</p> <p>Review of facility policy, dated 6/15, received from the Director of Health Services on 4/8/16 at 3:43 p.m., titled "Falls Management Program Guidelines" indicated "...3. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form" The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2016
--	---	---	---

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

(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
F 0371 SS=F Bldg. 00	<p>investigation and appropriateness of the interventions...."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure food was labeled, dated and discarded when expired. This deficient practice had the potential to affect 60 out of 61 residents who received food from this kitchen and 10 out of 61 residents who received thickened liquids.</p> <p>Findings include:</p> <p>During a tour of the kitchen on 4/05/2016 at 8:47 a.m., the following were observed:</p> <p>1. The freezer had opened and not dated: one box of cauliflower, one box of brussel sprouts, one box of sausage, and one box of potatoes. 2. The walk in cooler had 6 pies on a tray not dated and not covered.</p>	F 0371	<p>1. No residents were affected by the deficient practice cited in the survey. 2. All but 1 resident had the potential to be affected with no concerns noted. 3. The Dining Services staff were reeducated, by the Director of Food Services, to the Food Labeling and Dating Policy. 4. Director of Food Services/designee will audit 3 x per week to ensure proper labeling and dating. Director of Food Services/designee will report to QA Committee x 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.</p>	05/11/2016

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 04/11/2016
--	---	--	---

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

(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
	<p>3. The reach in cooler had one container of nectar thickened cranberry juice cocktail dated 2/4/16.</p> <p>During an interview with the Director of Food Services on 4/05/2016 at 8:55 a.m., he indicated items should have date on them and the nectar thickened cranberry juice should have been be thrown away.</p> <p>The policy titled "Trilogy Health Services Food Labeling and Dating Policy", received from the Director of Food Services on 4/5/16 at 11:15 a.m., indicated " Food Labeling: Any food product: Removed from its original container, has the seal broken, that has been processed or prepared in any way MUST have a label that contains the following: Item date, Date and Time(that the food was labeled), Use by date, Initials of the person labeling the item, Securely cover food item, Use the same label at all times and in all areas...Food Dating Guide... Foods to be expired within 7 days after opened...juices...."</p> <p>3.1-21(i)(3)</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 04/11/2016
--	---	--	---

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

(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
F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to discard expired medications, failed to label medications and failed to follow</p>	F 0431	1. Medications for Resident #93 cited in the survey, the unlabeled Lantus Solostar pen, unlabeled Humalog Quik pen and the Lantus 100 unit vial	05/11/2016

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 04/11/2016
--	---	--	---

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

(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
	<p>guidelines for medications brought to campus by a resident. (Resident #93).</p> <p>Findings include:</p> <p>During a medication storage observation with the Director of Health Services (DHS) on 4/8/16 at 9:00 am the following were observed:</p> <p>Hall 100/200: unlabeled Lantus Solostar pen in the refrigerator, unlabeled Humalog Quik pen in the refrigerator A Lantus 100units vial for a resident who had been discharged within the last 30 days. On a shelf in the medication preparation room, a large bag with medications for Resident #93 was found. The medications were from an outside pharmacy. Medications included Aspirin 81 mg (milligrams), Carvedilol 6.25 mg, Clopidogrel 75 mg, Lisinopril 5 mg, Simvastatin 40 mg, Donepezil 10 mg, Seroquel 25 mg. No indications of destruction were located in the resident's record.</p> <p>During an interview with the DHS on 4/8/16 at 10:30 a.m., she indicated the medications should have been returned at the time of admission, medications in the</p>		<p>were destroyed per facility guidelines. 2. All residents have the potential for this deficient practice; however, there are no expired meds, unlabeled meds or any medications brought into the facility by a resident, in the 100/200 medication room. 3. Licensed Nurses were reeducated, by the DHS/designee, on our Guidelines for Acceptance of Outside Medications, proper medication destruction including expired medications and labeling of medications. 4. DHS/designee will audit the medication room 2 x's per week to ensure proper destruction of medications. DHS/designee will report findings to QA Committee x 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed.</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 04/11/2016
--	---	--	---

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

(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
	<p>refrigerator should be labeled and medications should have been returned to the resident's representative.</p> <p>A policy titled "Guidelines for Acceptance of Outside Medications" dated 6/2015, received from the DHS on 4/8/16 at 12:00 p.m., indicated "Purpose: To establish uniform guidelines for medications brought to the campus by a resident or responsible party. Procedure: 1. Medications (such as prescription medications, medicated lotions, ointments, over the counter medications) brought by or with a resident upon admission to the campus from home or another facility may not be used after admission unless the contents have been examined and positively identified by the pharmacists, attending physician, nurse practitioner or Director of Health Services... 5. Medications not accepted by the campus shall be returned to the resident's representative or destroyed in accordance with established procedures governing the destruction of medications. 6. The charge nurse or nursing supervisor shall be responsible documenting the results of the facilities decision to accept or reject medications brought by or with the resident. 7. The following information shall be documented in the resident's medical record: a. Name ,strength and quantity of the medications</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 04/11/2016
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(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	
R 0000 Bldg. 00	<p>brought. b. If medication was accepted, returned to responsible party, destroyed or provided to a clinic under Karon's Law (OH)...f. Signature of the person recording the data...."</p> <p>3.1-25(o)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 19</p> <p>Sample: 8</p> <p>This State findings are/is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on April12, 2016.</p>	R 0000	This 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.		
R 0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency				

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 04/11/2016
--	---	--	---

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

(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
Bldg. 00	<p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review the facility failed to ensure food was labeled and dated. This deficient practice had the potential to affect 19 out of 19 residents who received food from this kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen on 4/05/2016 at 8:47 a.m., the following were observed:</p> <ol style="list-style-type: none"> 1. The freezer had opened and not dated: one box of cauliflower, one box of brussel sprouts, one box of sausage, and one box of potatoes. 2. The walk in cooler had 6 pies on a tray not dated and not covered. <p>During an interview with the Director of Food Services on 4/05/2016 at 8:55 a.m., he indicated items should have date on them.</p> <p>The policy titled "Trilogy Health Services Food Labeling and Dating Policy", received from the Director of Food Services on 4/5/16 at 11:15 a.m., indicated " Food Labeling: Any food</p>	R 0273	<ol style="list-style-type: none"> 1. No residents were affected by the deficient practice cited in the survey. 2. All but 1 resident had the potential to be affected with no concerns noted. 3. The Dining Services staff were reeducated, by the Director of Food Services, to the Food Labeling and Dating Policy. 4. Director of Food Services/designee will audit 3 x per week to ensure proper labeling and dating. Director of Food Services/designee will report to QA Committee x 6 months or until 100% substantial compliance is achieved. QA Committee will monitor for any trends and make recommendations as needed. 	05/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/11/2016
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(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	
	product: Removed from its original container, has the seal broken, that has been processed or prepared in any way MUST have a label that contains the following: Item date, Date and Time(that the food was labeled), Use by date, Initials of the person labeling the item, Securely cover food item, Use the same label at all times and in all areas...."				