

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  08/12/2015
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00179478.</p> <p>Complaint #IN00179478- Substantiated. Federal/State deficiencies related to the allegations are cited at F241 &amp; F246.</p> <p>Survey dates: August 11 &amp; 12, 2015</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Census bed type: SNF- 39 SNF/NF- 18 Residential- 21 Total- 78</p> <p>Census payor type: Medicare- 20 Medicaid- 18 Other- 19 Total- 57</p> <p>Sample- 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	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.	

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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F 0241 SS=D Bldg. 00	<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 observations and interviews, the facility failed to ensure residents were treated with respect, dignity, and failed to ensure staff maintained full recognition of a resident's cognitive level during 1 of 11 observations made of staff to resident care and treatment. (Resident F)</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 8/12/15 at 1:30 p.m. Diagnoses for Resident F included, but were not limited to, leukocystosis, chronic respiratory failure with hypoxia, history of sepsis secondary to urinary tract infection, chronic obstructive pulmonary disorder, congestive heart failure, generalized weakness and general anxiety disorder.</p> <p>During an observation and interview on 8/12/15 at 10:35 a.m., Resident F was sitting in a wheelchair, in her room and crying out for the nurse and for help.</p>	F 0241	<p>1. Resident F was observed with no adverse effects noted. 2. All residents have the potential to be affected by the deficient practice and were observed with no concerns noted. 3. All staff were reeducated to conversing with residents and dignity. All leaders will monitor through daily tasks and report any concerns per facility guidelines. 4. Social Services Director will report any concerns to QA Committee monthly x 3 months or until 100% compliance is achieved.</p>	08/31/2015

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	<p>Resident F indicated she could not find her call light and needed to use the bathroom. The Assistant Director of Nursing (ADON) was notified of the resident's need. The ADON and LPN #1 entered Resident F's room. Resident F indicated she needed assistance to use the bathroom. The ADON found Resident F's call light on the roommate's bed and indicated Resident F was unable to reach it. The ADON, then, checked her portable oxygen tank and determined the oxygen level was low. The ADON left Resident F's room with the portable oxygen tank and indicated she would return with a full tank.</p> <p>While waiting for the ADON to return, Resident F indicated to LPN #1, her oxygen tank was empty on the previous day and didn't work. Resident F continued to indicate a reminder note was on the oxygen tank that did not work. During this time, LPN #1 indicated to Resident F that she understood that she (Resident F) was confused, often, especially about her oxygen. Resident F said, "Well, when I don't have oxygen, I get confused!" Resident F insisted there was a "do not use" note on an oxygen tank that she used and that she told the nurse she was experiencing shortness of breath, on the previous day. LPN#1 was at Resident F's eye level, attempting to</p>			

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F 0246 SS=D Bldg. 00	<p>ensure her of properly working oxygen tanks, then, indicated, "You understand that she's not an interviewable person, don't you?" Resident F replied, "I know when I need oxygen! I'm not stupid and I'm not confused! Just because I'm 91 years old doesn't mean I'm confused!"</p> <p>An undated care plan for Activities of Daily Life (ADL's) indicated Resident F was "alert and oriented with some confusion, at times."</p> <p>This Federal tag relates to complaint #IN00179478.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observations and interviews, the facility failed to ensure resident's needs were met and individual call lights were within reach and within sight of each individual resident, for 2 of 8 residents reviewed for call light placement, in a sample of 8. (Resident F</p>	F 0246	<p>1. Resident F and I were observed with no adverse effects noted. 2. All residents have the potential to be affected by the deficient practice and were observed with no concerns noted and care plans updated as needed. 3. All staff were reeducated to call light placement</p>	08/31/2015

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	<p>&amp; I)</p> <p>Findings include:</p> <p>1. The clinical record for Resident F was reviewed on 8/12/15 at 1:30 p.m. Diagnoses for Resident F included, but were not limited to, leukocystosis, chronic respiratory failure with hypoxia, history of sepsis secondary to urinary tract infection, chronic obstructive pulmonary disorder, congestive heart failure, generalized weakness and general anxiety disorder.</p> <p>During an observation and interview on 8/12/15 at 10:35 a.m., Resident F was sitting in a wheelchair, in her room and crying out for the nurse and for help. Resident F indicated she could not find her call light and needed to use the bathroom. The Assistant Director of Nursing (ADON) was notified of the resident's need. The ADON and LPN #1 entered Resident F's room. Resident F indicated she needed assistance to use the bathroom. The ADON found Resident F's call light on the roommate's bed and indicated Resident F was unable to reach it.</p> <p>An undated care plan for Activities of Daily Life (ADL's) indicated Resident F was "alert and oriented with some</p>		<p>and availability. All leaders will monitor through daily tasks and report any concerns per facility guidelines. 4. Social Services Director will report any concerns to QA Committee monthly x 3 months or until 100% compliance is achieved.</p>		

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	<p>confusion, at times." The care plan indicated Resident F was at an increased risk for injury related to falls and used a wheelchair. Care plan documentation continued with "Please place my call light within reach and where I can see it."</p> <p>Another, undated care plan, for Moods and Behaviors indicated Resident F's goal for herself was to be assured staff would tend to her needs, by using/putting on her call light, therefore, not feeling the need to call out for the nurse.</p> <p>2. The clinical record for Resident I was reviewed on 8/12/15 at 2:10 p.m. Diagnoses for Resident I included, but were not limited to, depression, macular degeneration, dementia, Alzheimer's Disease, right eye blindness, diabetes, anxiety, cardiomegaly, emphysema, osteopenia, osteoarthritis, hard of hearing, chronic kidney disease, and generalized discomfort.</p> <p>On 8/12/15 at 10:55 a.m., Resident I was observed laying in bed. The call light was noted inside a basket of stuffed animals, on a bedside table that was set up at the foot of the bed.</p> <p>At 10:58 a.m., on 8/12/15, during an observation and interview, LPN #1 indicated the call light was not in</p>			

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	<p>Resident I's sight. LPN #1 found the call light at the foot of the bed, in a basket and indicated Resident I was legally blind. LPN #1 placed the call light in Resident I's hands.</p> <p>An undated care plan for Activities of Daily Life (ADL's) indicated the following: "I have impaired vision. I am legally blind in both eyes and have macular degeneration in both eyes... Please place my call light where I can see it."</p> <p>This Federal tag relates to complaint #IN00179478.</p> <p>3.1-3(v)(1)</p>						