

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 03/25/2015
--	---	--	---

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 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00168873.</p> <p>Complaint IN00168873- Unsubstantiated due to lack of evidence</p> <p>Survey Dates: March 16, 17, 18, 19, 20, 23, 24 and 25, 2015</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Survey Team: Maria Pantaleo, RN-TC Rita Mullen, RN (3/17,18,19, 20, 24 ,25, 2015) Bobette Messman, RN:</p> <p>Census bed type: SNF: 37 SNF/NF: 23 Residential: 23 Total: 83</p> <p>Census by Payor Type: Medicare: 21 Medicaid: 22</p>	F 000	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.

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 03/25/2015
--	---	--	---

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 279 SS=D Bldg. 00	<p>Other: 17 Total: 60</p> <p>Sample: Complaint: 3 Residential: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on March 31, 2015.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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>			

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 03/25/2015
--	---	--	---

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 develop individualized care plans to address a resident receiving dialysis and restorative care for 1 of 1 residents reviewed for dialysis and 1 of 3 residents reviewed for rehabilitation services. (Resident #68).</p> <p>Findings include:</p> <p>The clinical record of resident #68 was reviewed on 3/17/2015 at 2:00 p.m. Diagnoses included, but were not limited to, end stage renal disease, dementia, multiple sclerosis, edema and diabetes.</p> <p>1. Resident #68 received dialysis treatments three times a week. A review of the care plans did not include a care plan for dialysis.</p> <p>2. On 1/29/15, Resident #68 was discharged from Physical Therapy with a recommendation for restorative therapy with nursing and a recommendation from Occupational Therapy to allow the resident time to complete tasks before completing them for her. There was no nursing restorative care plan.</p> <p>During an interview with the Director of Nursing, on 3/24/15 at 10:45 a.m., she indicated nursing decided Resident #68 was not a good candidate for the nursing</p>	F 279	<p>1. The care plan of Resident #68 cited in the survey was updated to reflect current status for Dialysis and Restorative Care. 2.A. Care plans of current residents receiving dialysis were reviewed and updated per individual plan. 2.B. Care plans of current residents on a Restorative Nursing Program were reviewed and updated per individual plan. 3.A. Individual care plans will be developed for all new admissions receiving Dialysis. 3.B. Individual care plans will be developed for all residents discharged from therapy on a Restorative Nursing Program. Director of Health Services or designee will monitor Dailysis plan of care and Restorative plan of care to ensure plans reflect residents current status 1x/week x 6 months. 4. Director of Health Services or designee will report any findings to QA Committee monthly until 100% compliance is achieved.</p>	04/24/2015

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 03/25/2015
--	---	--	---

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 309 SS=D Bldg. 00	<p>restorative program since she could not walk and Range of Motion would be Activity's of Daily Living (ADL's).</p> <p>A review of the current Care Plan for ADL's did not include the recommendations from therapy or Range of Motion to be completed by nursing.</p> <p>A Guideline for Dialysis Provider Communication (no date) received from the Administrator, on 3/20/15 at 2:15 p.m., indicated the following:</p> <p>"...Purpose: To provide guidelines for communication and partnership of Dialysis Providers and the campus.</p> <p>Procedure:...</p> <p>6. A care plan shall be developed containing the necessary information for ongoing care interventions and approaches regarding Dialysis services."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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</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 03/25/2015
--	---	--	---

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>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 #68).</p> <p>Findings include:</p> <p>The clinical record of resident #68 was reviewed on 3/17/2015 at 2:00 p.m. Diagnoses included, but were not limited to, end stage renal disease, dementia, high blood pressure, edema and diabetes.</p> <p>Resident #68 received dialysis treatments three days a week on Monday, Wednesday, and Friday.</p> <p>A review of the Nursing notes, dated January 2015 through March 19, 2015, did not indicate a post dialysis assessment was performed.</p> <p>There were no "Communication from campus to dialysis center" forms in the resident's record.</p> <p>During an interview with the Director of Nursing, on 3/24/15 at 10:45 a.m., she indicated the staff should have been doing the assessments and using the dialysis communication forms.</p>	F 309	<p>1. Resident #68 cited in the survey was observed with no adverse effects noted. 2. All residents receiving dialysis have had a post dialysis assessment and the dialysis communication book reviewed for any follow-up requirements. 3. All Licensed Nursing Staff were reeducated to the facility dialysis communication form to include monitoring of the shunt and any follow-up requirements. Director of Health Services or designee will audit the post dialysis assessment and dialysis communication book for any follow-up requirements 3x/week x 6 months. 4. Director of Health Services or designee will report any findings to QA Committee monthly or until 100% compliance is achieved.</p>	04/24/2015

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 03/25/2015
--	---	--	---

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 314 SS=D Bldg. 00	<p>A Guideline for Dialysis Provider Communication (no date) received from the Administrator, on 3/20/15 at 2:15 p.m., indicated the following:</p> <p>"...Purpose: To provide guidelines for communication and partnership of Dialysis Providers and the campus.</p> <p>Procedure:...</p> <p>5. Upon return from the Dialysis Provider the campus shall:</p> <p>a. Provide ongoing monitoring of the shunt site for signs of complication.</p> <p>b. Review the Dialysis Provider paperwork for any necessary follow up requirements...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure</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 03/25/2015
--	---	--	---

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>sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to monitor and treat a potential Suspected Deep Tissue Injury for 1 of 1 residents reviewed for pressure ulcers (Resident #68).</p> <p>Findings include:</p> <p>The clinical record of resident #68 was reviewed on 3/17/2015 at 2:00 p.m. Diagnoses included, but were not limited to, end stage renal disease, dementia, high blood pressure, edema and diabetes.</p> <p>A Care Plan for Skin, dated 1/20/15, indicated "I am at risk for impaired skin integrity...I use a pressure reducing mattress and a pressure relief cushion to my wheelchair to help prevent skin breakdown. My nurse needs to check my skin weekly...If you notice any open areas or persistently reddened areas on my skin, please tell the nurse so she/he can do an assessment and notify the doctor as needed...."</p> <p>A "Skin Impairment Circumstance, Assessment and Intervention," dated 3/3/15, indicated Resident #68 had a painful "Deep Bruise" to the left heel and</p>	F 314	<p>1. For Resident #68 cited in the survey, the area noted had improved and was reidentified during the 7 day skin check and a new treatment was ordered.</p> <p>2. Current residents have been reassessed for proper identification of any suspected deep tissue injuries. 3. All licensed nursing staff were reeducated on the facility policy for General Wound and Skin Care Guidelines with focus on identification of suspected deep tissue injuries versus bruises on pressure points. The Director of Health Services or designee will reassess any identified bruises/suspected deep tissue injury on pressure points 5x/week x 60 days; then 3x/week x 60 days and document to ensure proper identification and treatment orders are accurate. 4. The Director of Health Services or designee will report any findings to the QA Committee monthly x 6 months or until 100% compliance is achieved.</p>	04/24/2015

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 03/25/2015
--	---	--	---

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>a history of skin impairment. The intervention was to float heels.</p> <p>A "Multiple Bruise Monitoring Sheet," dated 3/3/15, indicated a "Deep purple" bruise to the left heel 3 centimeters (cm) x 2 cm. and the area was not present on admission.</p> <p>A Nursing note, dated 3/6/15 at 12:45 p.m., indicated "...Res (Resident) going to (name of hospital) for a fistulagram, this is an outpatient procedure. If Res is not admitted, she will need to go to dialysis tomorrow...."</p> <p>A Nursing note, dated 3/10/15 at 2:30 p.m., indicated "Res Re-admitted from (name of hospital)...."</p> <p>A "Nursing Admission Assessment & Data Collection," dated 3/10/15 at 8:00 p.m., indicated Resident #68 had an area on the left heel. The area on the left heel was not described.</p> <p>A Nursing note, dated 3/10/15 at 9:00 p.m., indicated "Res has 6 bruises that need reassessed [sic]...."</p> <p>A Treatment Administration Record (TAR), dated 3/11/15 to 3/31/15, indicated Weekly Skin Assessments on Mondays. A skin check should have</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 03/25/2015
--	---	--	---

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>been done on 3/16/15. A hand written note on the TAR indicated the skin check was not done due to dialysis. The Resident had dialysis on Monday, Wednesday and Friday.</p> <p>During an observation of Resident #68's left heel with the Director of Nursing, on 3/17/15 at 2:00 p.m., the area measured 1.7 cm x 2 cm and was deep purple in color. The resident complained of the area being painful.</p> <p>A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form, dated 3/17/15, indicated a Suspected Deep Tissue Injury. Length 1.7 cm, Width 2 cm and Depth E (Un-stageable).</p> <p>During an observation of the left heel with the Director of Nursing, on 3/24/15 at 1:50 p.m., the area measured 1.8 cm x 2 cm x E. The area was dark in color.</p> <p>During an interview with the Director of Nursing, on 3/34/15 at 9:00 a.m., she indicated when Resident #68 came back from the hospital on 3/10/15, the left heel was assessed as a bruise. The area had been reassessed as a Suspected Deep Tissue Injury and was being treated with a skin protectant and the heels were still being floated.</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 03/25/2015
--	---	---	---

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 371 SS=F Bldg. 00	<p>A policy for General wound and Skin Care Guidelines, no date, received from the Director of Nursing on 3/25/15 at 10:00 a.m., indicated the following:</p> <p>"Purpose: To provide measures that will promote and maintain good skin integrity.</p> <p>Procedure The following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity....</p> <p>21. Notify wound care nurse/nurse supervisor for all new stage II - IV pressure ulcers or if you have any questions...."</p> <p>3.1-40(a)(1)</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, record review and interview, the facility failed to ensure that kitchen equipment was free from food and debris in 1 of 1 char broiler in 1 of 1</p>	F 371	<p>1. No residents were affected by the deficient practice. 2. All but 1 resident had the potential to be affected with no concerns noted. 3. The char broiler was cleaned</p>	04/24/2015

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 03/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE 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>kitchen in the facility. This deficient practice had the potential to impact 59 of 60 residents who received meals form the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 3/16/2015 at 9:15 a.m., the following observation was made:</p> <p>The char broiler was observed to have food debris on the grill.</p> <p>During an interview on 3/16//2014 at 11:45 a.m. with the Director of Food Services, he indicated the char broiler was last utilized on 3/15/2015 for the evening meal and the char broiler should have been clean and free of food and debris.</p> <p>Record review on 3/18/2014 at 3:00 p.m., the "Policies, Procedures, and Best Practices for Char Broiler", undated, received from the Director of Food Services, indicated "...Keep your grill clean and well-maintained...."</p> <p>3.1-21(i)(3)</p>		<p>prior to any further use. All dietary cooks were reeducated to the facility Policies, Procedures and Best Practices for Char Broiler. The cleaning was added to the Daily Data Sheet (see attached) for both shifts to document daily as to the char broiler being cleaned each shift. The Director of Food Services or designee will monitor 5x/weekly x 60 days to ensure compliance.</p> <p>4. The Director of Food Services or designee will report any findings to the QA Committee until 100% compliance is achieved.</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 03/25/2015
--	---	---	---

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 465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, record review and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 8 of 29 resident rooms (walls, floors, doors, and furniture), Room's # 101, 103, 108, 109, 110, 114, 305, and 308.</p> <p>Findings include:</p> <p>During resident room observations on 3/16, 3/17, and 3/18/2015 the following were observed:</p> <ol style="list-style-type: none"> 1. Room 103 on 3/16/2015 at 2:15 p.m., the bedroom door and furniture were gouged, marred and chipped . 2. Room 108 on 3/16/2015 at 3:45 p.m., the walls were chipped, gouged and marred and the resident dividing curtain was stained with a brown substance. 3. Room 109 on 3/17/2015 at 11:26 a.m., the bathroom and bedroom doors were marred, chipped and gouged. 4. Room 110 on 3/16/2015 at 3:38 p.m., the bedroom walls and door were marred, 	F 465	<ol style="list-style-type: none"> 1. All resident's associated with the identified Room's were observed with no concerns noted. 2. All other resident room's were observed and any identified concerns were added to the preventative maintenance schedule. 3. The Environmental Services employees were reeducated to the facility policy Work Order Procedure to be used throughout their daily cleaning process. The Director of Plant Operations or designee will monitor through daily rounds and monthly room preventative maintenance. 4. The Director or Plant Operations or designee will report any findings to the QA Committee monthly until 100% compliance is achieved. 	04/24/2015

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 03/25/2015
--	---	--	---

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>chipped and gouged.</p> <p>5. Room 114 on 3/16/2015 at 3:15 p.m., the bedroom wall behind the lounge chair had a whole in the wall. The bathroom door, walls and archway were gouged, chipped, marred and peeling.</p> <p>6. Room 305 on 3/18/2015 at 12:31 p.m., the walls in the bathroom had holes and were chipped and peeling.</p> <p>7. Room 308 on 3/18/2015 at 3:07 p.m., the wall behind the bed was gouged, chipped and peeling and paint splatter was on one of the bedroom walls.</p> <p>During the environmental tour, on 3/19/2015 at 1:30 p.m., with the Maintenance Director, the Environmental Services Director, and the Executive Director the following was observed:</p> <p>1. Room 101 the bathroom door and frame were chipped, gouged, and marred.</p> <p>2. Room 114 the bathroom shower stall floor needed repair and the wall needed painting.</p> <p>3. Hallway wall below hand rail between rooms 108 and 106 was gouged, chipped and peeling.</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 03/25/2015
--	---	---	---

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>During an interview on 3/19/2015 at 2:00 p.m., the Maintenance Director indicated a work request system was in place and all staff are aware of how to request repairs in the facility.</p> <p>During an interview on 3/19/2015 at 3:00 p.m., with the Maintenance Director, indicated he was not aware the resident rooms needed repair, and the work request system did not include these rooms.</p> <p>A procedure titled " Work Order Procedures ", not dated, received from the Executive Director on 3/20/32015 at 2:30 p.m. indicated " Purpose of Work Orders... The use of the three-part work order ticket provides a means to track maintenance request by all campus residents and fellow employees. The work order system, when used correctly, allows the Executive Director to monitor productivity of the Plant Operations Department"</p> <p>3.1-19(f)</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 03/25/2015
--	---	--	---

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
R 000 Bldg. 00	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R 000	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.	
R 217 Bldg. 00	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: (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. (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. (3) The agreed upon service plan shall be signed and dated by the resident, and a			

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 03/25/2015
--	---	--	---

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>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 have an initial service plan completed and signed for 1 of 7 residents reviewed for service plans. (Resident # 73).</p> <p>Findings include:</p> <p>The record for Resident # 73 was reviewed on 3/24/2015 at 1:30 p.m. The resident was admitted to the facility on 11/11/2014. Diagnoses included, but were not limited to, arthritis, chronic airway obstruction, depressive disorder, anemia, dementia, osteoporosis, stage 3 chronic kidney disease, hypertension and glaucoma. The residential initial service plan could not be located.</p> <p>During an interview on 3/24/2015 at 2:30 p.m., with the Executive Director she indicated the initial service plan for resident # 73 could not be located.</p> <p>During an interview on 3/25/2015 at</p>	R 217	<p>1. Resident #73 cited in the survey was discharged from the Assisted Living prior to the survey. 2. All resident charts were reviewed for signed Service Plans with no further concerns noted. 3. AL unit manager and nursing administration were reeducated to the facility policy Guidelines for Evaluation and Service Plan. All new admissions will be reviewed for the initial service plan to be completed and signed per policy. Unit Manager will review as needed and report any findings to the Director of Health Services or designee. 4. The Director of Health Services or designee will report any findings to the QA committee x 6 months or until 100% compliance is achieved.</p>	04/24/2015

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 03/25/2015
--	---	---	---

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
R 246 Bldg. 00	<p>10:30 a.m., with the Social Services Director she indicated the initial service plan for resident # 73 was not completed and signed.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure a QMA (Qualified Medication Aide) obtained authorization from a licensed nurse prior to administering PRN (as needed) medications. This deficient practice affected 1 of 7 resident records reviewed for QMA prior authorization of PRN medications in a sample of 7. (Resident #121).</p> <p>Findings include:</p> <p>Record review for Resident #121 was completed on 3/24/15 at 1:30 p.m., PRN Medication Tracking record indicated Resident #121 received</p>	R 246	<p>1. Resident #121 was observed with no adverse effects noted. 2. All other residents were observed with no adverse effects noted. 3. All QMA's and licensed nurses were reeducated to the policy and procedure Administration of PRN Medications Guideline and the Indiana QMA Scope of Practice and appropriate steps taken to ensure continued compliance. AL unit manager will monitor PRN medication administration 5 x weekly and report any concerns to the Director of Health Services or designee. 4. Director of Health Services or designee will report any findings to the QA Committee monthly x 6 months or until 100% compliance is</p>	04/24/2015

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 03/25/2015
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>Hydrocodone-APAP 5/325 mg (a narcotic pain medication) orally and Zofran (nausea medication) orally. PRN Medication Tracking record indicated medication was given by QMA # 2 on the following dates: 12/4/14 at 8:00 p.m. (Hydrocodone-APAP 5/325mg and Zofran) 12/5/14 at no time listed 12/14/14 at 8:20 p.m. 1/2/15 at 8:00 p.m. 1/5/15 at 8:30 p.m. 1/8/15 at 8:00 p.m. PRN Medication Tracking Sheet had no cosignature of licensed nurse on the above dates.</p> <p>During an interview with LPN #1 on 3/24/15 at 1:30 p.m., she indicated a QMA must have a licensed nurse co-sign PRN medications and this is documented on PRN Medication Tracking Sheet in the clinical record.</p> <p>During an interview with QMA #1 on 3/25/15 at 9:25 p.m., he indicated during his training, he was instructed when giving a PRN medication, he must get a licensed nurse to give permission and must co-sign PRN log.</p> <p>Review of document titled "Administration of PRN Medications</p>		achieved.		

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 03/25/2015
--	---	---	---

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
R 273 Bldg. 00	<p>Guideline", indicated "...4. If PRN medication is to be administered by a QMA, the Standards of Practice for PRN medication administration by a Qualified Medication Assistant shall be observed...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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, record review and interview, the facility failed to ensure that kitchen equipment was free from food and debris in 1 of 1 char broiler in 1 of 1 kitchen in the facility. This deficient practice had the potential to impact 22 of 22 residents who receive meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 3/16/2015 at 9:15 a.m., the following observation was made:</p> <p>The char broiler was observed to have food debris on the grill.</p>	R 273	<p>1. No residents were affected by the deficient practice. 2. All residents had the potential to be affected with no concerns noted. 3. The char broiler was cleaned prior to any further use. All dietary cooks were reeducated to the facility Policies, Procedures and Best Practices for Char Broiler. The cleaning was added to the Daily Data Sheet for both shifts to document daily as to the char broiler being cleaned each shift. The Director of Food Services or designee will monitor 5x/week x 60 days then 3x/week 60 days then weekly x 60 days to ensure compliance. 4. The Director of Food Services or designee will report any findings to the QA Committee x 6 months until 100% compliance is</p>	04/24/2015

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 03/25/2015
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>During an interview on 3/16//2014 at 11:45 a.m., with the Director of Food Services, he indicated the char broiler was last utilized on 3/15/2015 for the evening meal and the char broiler should have been clean and free of food and debris.</p> <p>Record review on 3/18/2014 at 3:00 p.m., the "Policies, Procedures, and Best Practices for Char Broiler", undated, received from the Director of Food Services, indicated "...Keep your grill clean and well-maintained...."</p>		achieved.		