STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155724	A. BUILDING -- B. WING	02/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/13/23 Facility Number: 003691 Provider Number: 155724 AIM Number: 200456230 At this Emergency Preparedness survey, Woodbridge Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 69 certified beds. At the time of the survey, the census was 61. Quality Review completed on 02/15/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/13/23 Facility Number: 003691 Provider Number: 155724 AIM Number: 200456230 At this Life Safety Code survey, Woodbridge	K 0000	The submission of this plan of correction does not indicate any admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Woodbridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alma Nieves	Executive Director	02/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155724	A. BUILDING 01 B. WING	02/13/2023

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	Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 69 and had a census of 61 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services was sprinklered. Quality Review completed on 02/15/23		care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observations and interview, the facility failed to ensure 1 of 1 ceiling barriers in the	K 0311	1. No residents were directly affected. Fire caulking has been	02/22/2023

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	Director of Plant Operations (D.P.O.) in accordance with 19.3.1. LSC 19.3.1 requires protection of a vertical opening. LSC 19.3.1 requires a vertical opening shall be enclosed or protected in accordance with section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire rating. This deficient practice could affect approximately 3 employees in the facility. Findings include: Based on observations made with the Director of Plant Operations (D.P.O.) on 02/13/23 at 1:45 p.m., the D.P.O.'s office had two four inch in diameter conduits extending up through the ceiling and into the attic space. These pipes had approximately 40 blue data cables routed up through each of them and had annular space measuring approximately one-half of an inch around them that needed to be filled in to be made smoke tight. Based on interview at the time of the observation, the D.P.O. acknowledged the ceiling penetration and agreed that the ceiling was not smoke tight. On 02/13/23 at 2:33 p.m., during the exit conference with the facility Administrator, the D.P.O. and the Facilities Support Director, no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		placed to conduits to make smoke tight. 2. All residents have the potential to be affected. Director of Plant Operations has been educated on NFPA 101 vertical openings. An audit of all vertical openings in facility has been completed. 3. All vertical openings will be audited after any kind of maintenance has been completed. As a measure of ongoing compliance, DPO will review vertical openings 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	