| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724 | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SU COMPLET 04/26/2 | | IPLETED | | |
|---|--|---|--|---------------------|---|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WOODBRIDGE HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL 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 | Licensure Survey and IN00429159. This State Licensure survey and IN00429159. This State Licensure survey dates: April Facility number: 00 Provider number: 1. AIM number: 2004. Census Bed Type: SNF: 21 SNF/NF: 31 Total: 52 Census Payor Type Medicare: 12 Medicaid: 30 Other: 10 Total: 52 These deficiencies is accordance with 410 are survey and incomplete in the control of the con | 2159: No deficiencies related to ited. 22, 23, 24, 25, and 26, 2024. 3691 55724 56230 | F 00 | 000 | The submission of the Plan of Correction does not indicate a admission by Woodbridge Heat Campus that the findings and allegations contained herein a accurate, a true representation the quality of care provided, or living environment provided to residents of Woodbridge Healt Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manne. The facility is committed to compliance with its regulatory legal standards as well as qua of care, and alleges that it is in substantial compliance with all state and federal requirements governing the management of facility. Woodbridge Health Campus submits that the effect date for substantial compliance with a submission of any wrongdoing. In the Department of Health a dereview of this submission for substantial compliance, which expressly alleged as part of the submission. As part of this submission, and through a | n alth re n of the the th es and lity n l s this stive e is this The om sk is | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Alma Nieves Executive Director 05/09/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 1 of 9

| JENTERS FOR | R MEDICARE & MEDIC | AID SERVICES | | | | OM | B NO. 0938-039 | |
|---|---|--|-------------------------------|--|--|------------------|----------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155724 | | A. BU | A. BUILDING <u>00</u> B. WING | | | ETED | | |
| | | B. WI | | | | 04/26/2024 | | |
| NAME OF PROVIDER OR SUPPLIER WOODBRIDGE HEALTH CAMPUS | | | | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | | | | separate submission, this facil is seeking Informal Dispute Resolution with respect to the findings under R273. | ity | | |
| F 0812 | 483.60(i)(1)(2) | | | | | | | |
| SS=E | Food | | | | | | | |
| Bldg. 00 | | re/Prepare/Serve-Sanitary | | | | | | |
| | ` ` ` ` | afety requirements. | | | | | | |
| | The facility must - | | | | | | | |
| | §483.60(i)(1) - Procure food from sources | | | | | | | |
| | approved or considered satisfactory by | | | | | | | |
| | federal, state or local authorities. | | | | | | | |
| | (i) This may include food items obtained | | | | | | | |
| | | producers, subject to | | | | | | |
| | applicable State a | | | | | | | |
| | regulations. | | | | | | | |
| | | does not prohibit or prevent | | | | | | |
| | | ng produce grown in facility | | | | | | |
| | | to compliance with | | | | | | |
| | | owing and food-handling | | | | | | |
| | practices. | d | | | | | | |
| | | does not preclude residents oods not procured by the | | | | | | |
| | facility. | oods not procured by the | | | | | | |
| | lacility. | | | | | | | |
| | \$483.60(i)(2) - Sto | ore, prepare, distribute and | | | | | | |
| | | ordance with professional | | | | | | |
| | standards for food service safety. | | | | | | | |
| | Based on observation | on and interview, the facility | F 08 | 12 | Deficiency Tag: F-812 Food | | 05/09/2024 | |
| | | d was handled to maintain food | | | Procurement, | | | |
| | | scarding and thawing. 52 of 52 | | | Store/Prepare/Serve-Sanitary | ` ' | | |
| | | n the facility ate food prepared | | | All food preparation and serving | ng | | |
| | in the kitchen. | | | | areas (excluding areas in | | | |
| | F' 1' ' 1 1 | | | | residents' units) are maintaine | | | |
| | Findings include: | | | | accordance with state and loc | | | |
| | Daning of | 4: | | | sanitation and safe food handl | U | | |
| | During an Observat | tion of the kitchen on 4/22/24 | | | standards, including 410 IAC | / - 24. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

at 9:10 AM with Dietary Staff 3, on the bottom of

Z93X11

Facility ID: 003691

273

If continuation sheet

Page 2 of 9

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|---------------------------|--|----------------------------------|---------|----------------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155724 | B. WING | | | 04/26/2024 | |
| | | <u> </u> | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | OODBRIDGE AVE | | |
| WOODB | RIDGE HEALTH C | AMPUS | | | ISPORT, IN 46947 | | |
| | Т | | | | I | | T |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | _ | ted in the walk in cooler, there | | | Deficiency's Cited Below: | | |
| | | s with of poultry stacked on top | | | Based on observation, intervi | | |
| | | top one was a mid-size | | | and record review, on 4/22/24 | _ | |
| | | bel: prep on 4/19/24 at 12:54 PM | | | 9:12 A.M. the facility failed to | | |
| | I - | end of day. The bottom one | | | store food properly. This had | | |
| | _ | ntainer with a label: prep pan | | | potential to affect all resident | | |
| | | M and use by 4/21/24 end of | | | were served their meal from t | ine | |
| | day. | | | | kitchen. | | |
| | At 9:12 AM right a | above the two large containers | | | Findings include – On the both | ttom | |
| | _ | e silver sheet pan, was a | | | of the large rack, located in the | | |
| | | derneath the package turkey | | walk-in cooler, there was two | | | |
| | | n, brown liquid. The turkey nor | | containers of poultry stacked on | | | |
| | | to indicate when the thurkey | | | top of each other. The top on | | |
| | had been thawed | ž | | | a mid-size container with a la | | |
| | | | | | prep on 4/19/24 @ 12:54 PM | | |
| | At 9:15 AM, on the | e shelf there was a large clear | | | use by 4/21/24 end of day. At | | |
| | | oughs inside. The prepared date | | | AM right above the two large | | |
| | indicated 4/12/24 a | | | | containers in a large silver sh | | |
| | | | | | pan, was packaged turkey. | | |
| | At 9:17 AM, on the | e shelf there was a small jar of | | | Underneath the packaged tur | key | |
| | base-ham with a pr | repared date of 3/18/24 and use | | | there was reddish brown liqui | id. | |
| | by date of 4/17/24. | | | | The turkey nor the pan was d | lated | |
| | | | | | to indicate when the turkey ha | | |
| | | the walk-in freezer at 9:19 AM | | | been thawed. | | |
| | there was a bag of | french fries with a prepared | | | | | |
| | date 3/17/24 and us | se by 4/16/24. | | | At 9:15 AM, on the shelf there | | |
| | | | | | was a large clear bag with 2 | | |
| | | 9:30 AM Dietary Staff 3 and | | | doughs inside. The prepared | | |
| | 1 | icated they were going to use | | | indicated 4/12/24 and use by | | |
| | | two containers with a use by | | | 4/19/24. At 9:7 AM, on the sh | | |
| | | ney were aware the current date | | | there was a small jar of base | | |
| | | ere prepared to use the chicken. | | | with a prepared date of 3/18/ | 24 | |
| | 1 | icated the kitchen served both | | | and use by 4/17/24. An | | |
| | the Health Care and | d Residential from the kitchen. | | | observation of the walk-in fre | | |
| | | | | | at 9:19 AM there was a bag o | | |
| | | 11:17 AM, the Dietary Manager | | | French fries with a prepared | | |
| | | s were misprinted. The manager | | | of 3/17/24 and use by 4/16/24 | | |
| | | e "a bunch of young kids" and | | | an interview at 9:30 AM Dieta | ary | |
| | they put the wrong label on the chicken. The | | | | staff "3" and Dietary staff "4" | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | SURVEY | | | |
|--|-----------------------|--|--------------------|--|---|-------|------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BUILDING 00 COMPLETED | | | | | | |
| | | 155724 | B. WING 04/26/2024 | | | | /2024 | |
| | PROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | I | | (X5) | |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | IE | DATE | |
| | other items, the staf | f should have discarded. The | | | indicated they were going to u | se | | |
| | staff should have no | ot thawed the turkey that way. | | | the chicken in the two contains | ers | | |
| | | | | | with a use by date of 4/21/24. | | | |
| | | olicy, Food labeling and dating | | | They were aware the current of | date | | |
| | | 2, was provided by the | | | was 4/22/24 but were prepare | | | |
| | - | and Executive Director on, | | | use the chicken. Dietary staff ' | | | |
| | | M. The policy indicated" to | | | indicated the kitchen served b | | | |
| | | and direction on how to | | | Health Care and Residential fr | | | |
| | | late all food items and food | | | the kitchen. In a interview with | | | |
| | products" | | | | 11:17 AM, the dietary manage |)r | | |
| | 3.1-21(i)(1) and (3) | | | | indicated the labels were misprinted. The manager indic | rated | | |
| | 3.1-21(1)(1) and (3) | | | | staff were "a bunch of young k | | | |
| | | | | | and they put the wrong label of | | | |
| | | | | | the chicken. The other items, t | | | |
| | | | | | staff should have discarded. T | | | |
| | | | | | staff should not have thawed t | he | | |
| | | | | | turkey that way. | | | |
| | | | | | | | | |
| | | | | | A current facility policy, Food I | abel | | |
| | | | | | and dating policy, dated 4/26/2 | | | |
| | | | | | was provided by the Director of | | | |
| | | | | | Nursing and Executive Director | | | |
| | | | | | 4/25/24 at 11:00 AM. The poli | - | | |
| | | | | | indicated"to provide knowled | • | | |
| | | | | | and direction on how to prope | - | | |
| | | | | | label and date II food items an | a | | |
| | | | | | food products" | | | |
| | | | | | | | | |
| | | | | | POC: | | | |
| | | | | | The Director of Food Service | will | | |
| | | | | | hold a Formal In-Service with | | | |
| | | | | | entire Dietary Staff to ensure t | hat | | |
| | | | | | the team knows and understa | | | |
| | | | | | the importance of storing food | | | |
| | | | | | safely and sanitary for the | | | |
| | | | | | residents. Once these in-serv | ices | | |
| | | | | | are complete, all team membe | ers | | |
| | | | | | will sign a document stating th | е | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Z93X11

Facility ID: 003691

If continuation sheet Page 4 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155724 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 04/26/2024 | | | | |
|--|---|---|--------------------------|--|--|--|--|--|
| | PROVIDER OR SUPPLIER | | 602 W | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | | | |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | TAG | training has taken place. | DATE | | | |
| | | | | The Director of Food Service and/or Designee will verify & document that the facility will store food as indicated on the the campus in-service policy. Director of Food Service and/Designee will verify that the fawill store food properly and allabels and dates are complying x per week for 4 weeks (2 of audits will be by non-dietary supervision). Followed by 3 x week for 4 weeks (1 of these audits will be by non-dietary supervisor). This will be follow by 2 audits per week for 3 week (1 by DFS and 1 by ED). Find an audit will occur 2 x per ween 1 week (1 by DFS and 1 by ED). Please reference the campus audit sheets that will be used during this POC. | The dor do de la company de la | | | |
| R 0000 | | | | | | | | |
| Bldg. 00 | Survey. This surve and State Licensure Nursing Home Con | | R 0000 | The submission of the Plan of Correction does not indicate a admission by Woodbridge Her Campus that the findings and allegations contained herein a accurate, a true representation the quality of care provided, of living environment provided to residents of Woodbridge Hear Campus. The facility recognizits obligation to provide legall | ean ealth eare on of or the o the lth | | | |

State Form Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 5 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155724 | | A. BUILDING B. WING | 00 | COMPLETED 04/26/2024 | | | |
|---|--|--|--|--|---|--|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | |
| | | | medically necessary care and services to its residents in an economic and efficient manner. The facility is committed to compliance with its regulatory and legal standards as well as quality of care, and alleges that it is in substantial compliance with all state and federal requirements governing the management of this facility. Woodbridge Health Campus submits that the effective date for substantial compliance is 5/9/24. This Plan of Correction is submitted in accordance with this provider's legal and regulatory requirements, and not as an admission of any wrongdoing. The facility respectfully requests from the Department of Health a desk review of this submission for substantial compliance, which is expressly alleged as part of this submission. As part of this submission, and through a separate submission, this facility is seeking Informal Dispute Resolution with respect to the findings under R273. | | and lity this this The om sk is is | | |
| R 0273 Bldg. 00 | (f) All food prepara (excluding areas in maintained in acco- local sanitation an standards, includir | nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling | R 0273 | Deficiency Tag : R 273 Food a | and 05/09/2024 | | |
| | | was handled to maintain food | | nutritional services- deficiency | | | |

State Form Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 6 of 9

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|---------------------------|---|----------------------------------|----------------------------|-----------------------|--|------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | | ETED |
| | | 155724 | B. W | B. WING | | 04/26/2024 | |
| | | | | CTREET | ADDRESS SITE STATE SID COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| WOODD | | AMPLIC | | | OODBRIDGE AVE | | |
| WOODB | RIDGE HEALTH C | AMPUS | | LOGAN | ISPORT, IN 46947 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | safety related to dis | scarding and thawing. 20 of 20 | | | All food preparation and servir | ng | |
| | residents residing in | n the facility ate food prepared | | | areas (excluding areas in | | |
| | in the kitchen. | | | | residents' units) are maintaine | d in | |
| | | | | | accordance with state and loca | al | |
| | Findings include: | | | | sanitation and safe food handl | ing | |
| | | | | | standards, including 410 IAC 7 | 7-24. | |
| | _ | tion of the kitchen on 4/22/24 | | | 273 | | |
| | | ietary Staff 3, on the bottom of | | | Deficiency's Cited Below: | | |
| | 1 | ed in the walk in cooler, there | | | Based on observation, intervie | | |
| | | with of poultry stacked on top | | | and record review, on 4/22/24 | @ | |
| | | top one was a mid-size | | | 9:12 A.M. the facility failed to | | |
| | | pel: prep on 4/19/24 at 12:54 PM | | | store food properly. This had t | | |
| | | end of day. The bottom one | | | potential to affect all residents | | |
| | _ | ntainer with a label: prep pan | | | were served their meal from th | ie | |
| | | M and use by 4/21/24 end of | | | kitchen. | | |
| | day. | | | | | | |
| | 4.010.435.11. | | | | Findings include – On the bott | | |
| | _ | bove the two large containers | | | of the large rack, located in the | 9 | |
| | | e silver sheet pan, was a | | | walk-in cooler, there was two | | |
| | | derneath the package turkey | | | containers of poultry stacked of | | |
| | | , brown liquid. The turkey nor | | | top of each other. The top one | | |
| | had been thawed | o indicate when the thurkey | | | a mid-size container with a lab | | |
| | nad been thawed | | | | prep on 4/19/24 @ 12:54 PM a | | |
| | At 9.15 AM on the | e shelf there was a large clear | | | use by 4/21/24 end of day. At AM right above the two large | IJ. I∠ | |
| | | oughs inside. The prepared date | | | , , | ot | |
| | indicated 4/12/24 a | | | | containers in a large silver she pan, was packaged turkey. | ·Uι | |
| | marcaica 7/12/24 a | na abe by 7/1//27. | | | Underneath the packaged turk | ·ev | |
| | At 9.17 AM on the | e shelf there was a small jar of | | | there was reddish brown liquid | - | |
| | | epared date of 3/18/24 and use | | | The turkey nor the pan was da | | |
| | by date of 4/17/24. | - | | | to indicate when the turkey ha | | |
| | | | | | been thawed. | - | |
| | An observation of t | he walk-in freezer at 9:19 AM | | | Boon mawou. | | |
| | | french fries with a prepared | | | At 9:15 AM, on the shelf there | | |
| | date 3/17/24 and us | | | | was a large clear bag with 2 pi | zza | |
| | | - | | | doughs inside. The prepared of | | |
| | In an interview at 9 | :30 AM Dietary Staff 3 and | | | indicated 4/12/24 and use by | | |
| | | cated they were going to use | | | 4/19/24. At 9:7 AM, on the she | elf | |
| | | wo containers with a use by | | | there was a small jar of base-h | | |
| | | ey were aware the current date | | | with a prepared date of 3/18/2 | | |
| | dute of W21/211 They were aware the cultivit dute | | | | 1 | | |

State Form Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 7 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155724 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/26/2024 | | | |
|--------------------------|--|--|--|---|---------------------------------------|--|--|--|
| | PROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION re prepared to use the chicken. | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) and use by 4/17/24. An | (X5) COMPLETION DATE | | | |
| | Dietary Staff 3 indi- the Health Care and | cated the kitchen served both Residential from the kitchen. 1:17 AM, the Dietary Manager | | observation of the walk-in free at 9:19 AM there was a bag o French fries with a prepared of of 3/17/24 and use by 4/16/24 | f late | | | |
| | indicated the labels indicated staff were they put the wrong | were misprinted. The manager "a bunch of young kids" and label on the chicken. The | | an interview at 9:30 AM Dieta staff "3" and Dietary staff "4" indicated they were going to u | ry use | | | |
| | staff should have no | f should have discarded. The of thawed the turkey that way. olicy, Food labeling and dating | | the chicken in the two contain with a use by date of 4/21/24. They were aware the current was 4/22/24 but were prepare | date | | | |
| | Director of Nursing 4/25/24 at 11:00 AM | 2, was provided by the and Executive Director on, M. The policy indicated" to and direction on how to | | use the chicken. Dietary staff indicated the kitchen served be Health Care and Residential f the kitchen. In a interview with | ooth rom | | | |
| | properly label and oppoducts" | late all food items and food | | 11:17 AM, the dietary manage indicated the labels were misprinted. The manager indi- staff were "a bunch of young l | cated | | | |
| | | | | and they put the wrong label of the chicken. The other items, staff should have discarded. I staff should not have thawed | the The | | | |
| | | | | A current facility policy, Food and dating policy, dated 4/26/ was provided by the Director of | 22, | | | |
| | | | | Nursing and Executive Director 4/25/24 at 11:00 AM. The poli indicated"to provide knowle and direction on how to prope | or on, cy dge rly | | | |
| | | | | label and date II food items ar food products" POC: | ia | | | |
| | | | | The Director of Food Service hold a Formal In-Service with | | | | |

State Form Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 8 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-039

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | _ | | | | IB NO. 0936-039 |
|---|----------------------|---|---|---------------------|---|-------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | |
| 155724 | | B. WING | | | 04/26/2024 | | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBRIDGE AVE LOGANSPORT, IN 46947 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | | | | entire Dietary Staff to ensure to the team knows and understand the importance of storing food safely and sanitary for the residents. Once these in-servare complete, all team member will sign a document stating the training has taken place. The Director of Food Service and/or Designee will verify & document that the facility will store food as indicated on the the campus in-service policy. Director of Food Service and/or Designee will verify that the fawill store food properly and all labels and dates are complyin x per week for 4 weeks (2 of the audits will be by non-dietary supervision). Followed by 3 x week for 4 weeks (1 of these audits will be by non-dietary supervisor). This will be follow by 2 audits per week for 3 week (1 by DFS and 1 by ED). Final an audit will occur 2 x per week 1 week (1 by DFS and 1 by DS Please reference the campus audit sheets that will be used during this POC. | on The or cility g 4 hese per | |

State Form Event ID: Z93X11 Facility ID: 003691 If continuation sheet Page 9 of 9