

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

PRINTED: 06/18/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/20/24</p> <p>Facility Number: 003691 Provider Number: 155724 AIM Number: 200456230</p> <p>At this Emergency Preparedness survey, Woodbridge Health Campus was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 69 certified beds. At the time of the survey, the census was 61.</p> <p>Quality Review completed on 05/22/24</p>			E 0000	<p>The submission of this plan of correction does not indicate an 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 by Woodbridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary 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.</p>		
E 0004 SS=C Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable</p>						

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

TITLE

(X6) DATE

Alma Nieves

Executive Director

06/07/2024

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 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 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.

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

PRINTED: 06/18/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 05/20/2024	
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 DEFICIENCY (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>Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency</p>			E 0004	The Executive Director has reviewed the Emergency		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 0013 SS=C Bldg. --	<p>preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan entitled "Emergency and Disaster Preparedness Manual" on 05/20/24 at 10:15 a.m. with the Director of Plant Operations (DPO) present, documentation for an emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with the last documented update listed as 01/03/2023. Based on interview at the time of record review, the DPO said the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period because the Administrator had not completed the annual review.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b),</p>		<p>Operations Plan in its entirety. During this review the Executive Director made all necessary revisions and updates to the Emergency Operations Plan. The Executive Director was educated by the Facilities Management Support on E004, Develop EP, Review and Update Annually. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>The Executive Director will review the Emergency Operations Plan and the contents within 1 X Per Month X 3 Months and then once per quarter X 2 to ensure proper updates have been applied to the Emergency Operations Plan. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect all occupants.</p>		

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSPOUT, 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
	<p>§483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and</p>						

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 05/20/2024	
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 DEFICIENCY (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>nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan entitled "Emergency and Disaster Preparedness Manual" on 05/20/24 at 10:15 a.m. with the Director of Plant Operations (DPO) present, documentation of facility policies and procedures reviewed by the facility within the</p>			E 0013	<p>The Executive Director has reviewed the Emergency Operations Plan and its policies and procedures in its entirety. During this review the Executive Director made all necessary revisions and updates to the policies and procedures for the Emergency Operations Plan. The Executive Director was educated by the Facilities Management Support, on E013, Development of EP Policies and Procedures. The LTC facility must develop and implement emergency preparedness policies and</p>		06/04/2024

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

PRINTED: 06/18/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSPOUT, 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 0029 SS=C Bldg. --	<p>most recent twelve-month period was not available for review. The emergency plan available did not have a review date during the past 12-month period with the most recent documented update being listed as 01/03/23. Based on interview at the time of record review, the DPO said the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period because the Administrator had not completed the annual review.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c),</p>				<p>procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>The Executive Director will review the Emergency Operations Plan and the policies & procedures within 1 X Per Month X 3 Months and then once per quarter X 2 to ensure proper updates have been applied to the Emergency Operations Plan.</p> <p>Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect all the residents in the facility.</p>		

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
	<p>§494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan entitled "Emergency and Disaster Preparedness Manual" on 05/20/24 at 10:15 a.m. with the Director of Plant Operations (DPO) present, documentation of the facility communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available did not have a review date within the past 12-month period with the most recent documented update being listed as 01/03/23. Based on interview at the time of record review, the DPO said the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period because the Administrator had not completed the annual review.</p>			E 0029	<p>The Executive Director has reviewed and revised the Communication Plan for the Emergency Operations Plan. The Executive Director was educated by the Facilities Management Support on E029, Development of Communication Plan. The Facility must develop and maintain an Emergency Preparedness Communication Plan that complies with Federal, State, and Local laws in accordance with 42 CFR 483.73(c).</p> <p>The Executive Director will review the Emergency Preparedness Communication Plan and the contents within 1 X Per Month X 3 Months and then once per quarter X 2 to ensure proper updates have been applied to the Emergency Preparedness Plan.</p> <p>Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect</p>		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPOUT, IN 46947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0036 SS=C Bldg. --	<p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph</p>				all occupants.		

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
	<p>(a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient</p>			E 0036	The Executive Director has provided "All Staff" training on the Emergency Preparedness Communication Plan. The Executive Director was		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
K 0000 Bldg. 01	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan entitled "Emergency and Disaster Preparedness Manual" on 05/20/24 at 10:15 a.m. with the Director of Plant Operations (DPO) present, documentation of a facility testing and training program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available did not have a review date within the past 12-month period with the most recent documented update being listed as 01/03/23. Based on interview at the time of record review, the DPO said the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period because the Administrator had not completed the annual review.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana</p>			K 0000	<p>educated by the Facilities Management Support on The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>The Executive Director will review the Emergency Preparedness Training and testing documentation of all staff, including newly hired employees 1 X Per Month X 3 Months then 1 X Per Quarter X 3.</p> <p>Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect all occupants.</p> <p>The submission of this plan of correction does not indicate an</p>		

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSPOUT, 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
K 0712 SS=F Bldg. 01	<p>Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 05/20/24</p> <p>Facility Number: 003691 Provider Number: 155724 AIM Number: 200456230</p> <p>At this Life Safety Code survey, Woodbridge 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.</p> <p>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.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services was sprinklered.</p> <p>Quality Review completed on 05/22/24</p> <p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying</p>				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 by Woodbridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary 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.		

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

PRINTED: 06/18/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSFORT, 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
	<p>conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review on 05/20/24 at 9:15 a.m., the "Direct Supply - TELS" fire drill forms with Director of Plant Operations (DPO) the following was noted:</p> <p>a) There was no documentation of a third shift fire drill conducted in the first quarter (January, February, and March) of 2024.</p> <p>b) There was no documentation of a second shift fire drill conducted in the fourth quarter (October, November, and December) of 2023</p> <p>Based on interview at the time of record review, the DPO acknowledged the aforementioned fire drills and stated that he was not yet in the DPO role at the time of the aforementioned fire drills.</p> <p>This item was discussed again at the exit conference with the DPO and the Facilities Maintenance Support Manager on 05/20/24 at 2:10 p.m.</p> <p>3.1-19(b) 3.1-51(c)</p>			K 0712	<p>Immediate Intervention</p> <p>The Director of Plant Operations has conducted a Fire Drill on each shift, with documentation.</p> <p>The Director of Plant Operations was educated by the Executive Director on K712, Fire Drills. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>The Executive Director and the Director of Plant Operations will review the Fire Drills 1 X Per Month X 6 Months for complete and accurate documentation in accordance with NFPA 101, 19.7.1.4 through 19.7.1.7.</p> <p>Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality</p>		06/07/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSPOUT, 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
K 0914 SS=F Bldg. 01	<p>NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles</p>			K 0914	<p>Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all the residents in the facility.</p> <p>The Director of Plant Operations completed testing of all non-hospital grade electrical receptacles at resident room locations. The Director of Plant Operations</p>		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
	<p>not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents.</p> <p>Findings include: Based on record review with the Director of Plant Operations (DPO) and the Facilities Maintenance Support Manager (FMSM) at 9:50 a.m. on 05/20/24, the DPO was asked to provide a copy of the annual receptacle retention documentation. Based on an interview at the time of record review, the DPO advised that he had not had time to complete the testing and that documentation was not available at the present time. Based on observations made during a tour of the facility from 12:00 p.m. to 2:02 p.m., the resident rooms had approximately six receptacles in each of the resident rooms and none of them were hospital grade and would require an annual inspection. Based on interview at the time of the observation, the Maintenance Director indicated all of the electrical receptacles in the resident rooms were non hospital-grade and also indicated there was no documentation of annual testing per NFPA 99, Receptacle Testing requirements.</p> <p>This item was discussed again at the exit</p>				<p>was educated by the Executive Director on NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces).</p> <p>The Director of Plant Operations we audit each resident rooms 1 X quarterly X 4 in accordance with NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 and Section 6.3.3.2. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality</p>		

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
K 0916 SS=F Bldg. 01	<p>conference with the DPO and the Facilities Maintenance Support Manager on 05/20/24 at 2:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator and annunciator panel were in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the facility on 05/20/24 at 12:59 p.m. with the Director of Plant Operations (DPO) and the Facilities Maintenance Support Manager, (FMSM) the generator's annunciator panel located at the nurse's station of the 100 Hall had a (red) light illuminated. The light on the panel coincided with the "Bat Chrg AC Fail". Based on an interview at the time of the observation, the DPO stated that he had no idea the light was lit on the annunciator</p>			K 0916	<p>Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, as well as the staff and visitors in the facility.</p> <p>The Director of Plant Operations has contacted the Generator Contractor for repairs to the Generator Battery Charger. The Director of Plant Operations was educated by the Executive Director on NFPA 99, 6.4.1.1.17, 6.4.1.1.17.5 The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system is not to be substituted for the alarm annunciator. In addition, the weekly generator testing, and routine checks the Director of Plant Operations will include a visual (audit) inspection of the annunciator panel of the</p>		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
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 DEFICIENCY (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
K 0927 SS=E Bldg. 01	<p>panel and that he would contact his vendor to assess the issue immediately.</p> <p>This item was discussed again at the exit conference with the DPO and the Facilities Maintenance Support Manager on 05/20/24 at 2:10 p.m.</p> <p>3.1-19(b)</p>				<p>generator and address any audible alarms with repairs 1 X per week X 8 weeks.</p> <p>Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect residents, as well as staff and visitors in the facility.</p>		
	<p>NFPA 101</p> <p>Gas Equipment - Transfilling Cylinders</p> <p>Gas Equipment - Transfilling Cylinders</p> <p>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space</p>			K 0927	<p>The Director of Plant Operations has repaired the ventilation in oxygen storage room.</p> <p>The Director of Plant Operations was educated by the Executive Director on NFPA 99, Healthcare facilities, 2012 edition 11.5.2.3.1 requires mechanical exhaust to maintain a negative pressure in</p>		06/04/2024

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

PRINTED: 06/18/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE 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
	<p>continuously. This deficient practice could affect as many as 14 residents, 6 staff, and 2 visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the facility on 05/20/24 at 12:50 p.m. with the Director of Plant Operations (DPO) and the Facilities Maintenance Support Manager, (FMSM) the exhaust fan located on the 100 Hall oxygen storage and transfilling room had a mechanically ventilated exhaust fan in the ceiling of this room, however, it was not working. Based on an interview at the time of the observation, the DPO acknowledged the exhaust fan was not working and stated that he would have the fan replaced as soon as possible.</p> <p>This item was discussed again at the exit conference with the DPO and the Facilities Maintenance Support Manager on 05/20/24 at 2:10 p.m.</p> <p>3.1-19(b)</p>				<p>the space continuously.</p> <p>In addition, we will audit full function of ventilation fan in oxygen room monthly for 3 months to remain in compliance. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect residents, as well as staff and visitors in the facility</p>		