DEPARTMENT OF HEALTH AND HUN	MAN SERVICES			FORM APPE
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 09
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	COMPLETED
	155724	B. WI	NG	05/20/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	

602 WOODBRIDGE AVE WOODBRIDGE HEALTH CAMPUS LOGANSPORT. IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 The submission of this plan of conducted by the Indiana Department of Health in correction does not indicate an accordance with 42 CFR 483.73. admission by Woodbridge Health

Facility Number: 003691 the quality of care provided, and the living environment provided to AIM Number: 200456230 the residents by Woodbridge Health Campus. The facility recognizes its obligation to provide Woodbridge Health Campus was found in substantial compliance with Emergency care and services to its residents

substantial 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 05/22/24

E 0004 SS=C Bldg. --

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)

Survey Date: 05/20/24

Develop EP Plan, Review and Update

Annually

§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).

The [facility] must comply with all applicable

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

TITLE

Campus that the findings and

in an economic and efficient

manner. The facility hereby

maintains it is in substantial compliance with all state and

statute only.

federal requirements governing the

management of this facility. It is thus submitted as a matter of

allegations contained herein are accurate, true representation of

(X6) DATE

Alma Nieves Executive Director 06/07/2024

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: Z93X21 Facility ID: 003691 If continuation sheet Page 1 of 17

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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/20/2024	
	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 R LSC 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
	Federal, State and preparedness req must develop esta comprehensive er program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness planand updated at leamust do all of the * [For hospitals at §485.625(a):] Emergency Planat develop and main preparedness req CAH] must develoc comprehensive er program that mee section, utilizing a * [For LTC Facilitie Emergency Planat develop and main preparedness planand updated at least testing and updated at lea	d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, rents:  an. The [facility] must tain an emergency that must be [reviewed], rest every 2 years. The plan following:  §482.15 and CAHs at regency Plan. The [hospital reply with all applicable d local emergency uirements. The [hospital or rep and maintain a mergency preparedness ts the requirements of this n all-hazards approach.  res at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, rest annually.  rities at §494.62(a):] The ESRD facility must tain an emergency that must be [evaluated], rest every 2 years.	FO		The Executive Director has		
		view and interview, the facility and maintain an emergency	E 0	004	The Executive Director has reviewed the Emergency		06/04/2024

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 2 of 17

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 0/2024
	PROVIDER OR SUPPLIER		602 W	ADDRESS, CITY, STATE, ZIP ( OODBRIDGE AVE NSPORT, IN 46947	COD	
(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 COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	at least annually in 483.73(a). This definition occupants.  Findings include:  Based on review of Preparedness Planton Disaster Preparedness 10:15 a.m. with the (DPO) present, doe preparedness prograwithin the most reconstruction available for review available has not be months with the las 01/03/2023. Based record review, the I had its entire emerginess and the same previewed by the face	the facility's Emergency entitled "Emergency and ess Manual" on 05/20/24 at Director of Plant Operations umentation for an emergency am reviewed by the facility ent twelve-month period was view. The emergency plan en reviewed within the past 12 t documented update listed as on interview at the time of DPO said the facility has not ency preparedness program ility within the most recent d because the Administrator the annual review.		Operations Plan in its During this review the Director made all nece revisions and updates Emergency Operation The Executive Director educated by the Facili Management Support Develop EP, Review a Annually. The LTC fact develop and maintain emergency prepared must be reviewed and least annually. The Executive Director the Emergency Opera and the contents withi Month X 3 Months and per quarter X 2 to ensupdates have been ap Emergency Operation Results of this review presented by the Executive Director to the QAPI of further recommendation continue until the Quant Assurance Team determines achieved. This deficient practice all occupants.	Executive essary to to the as Plan. or was ities to on E004, and Update cility must an aness plan that d updated at or will review ations Plan in 1 X Per d then once ture proper oplied to the as Plan. will be cutive committee for ons and ality ermines e has been	
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),				

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 3 of 17

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

	OF CORRECTION	IDENTIFICATION NUMBER  155724	 UILDING	NSTRUCTION	COMPI 05/20	ETED
	PROVIDER OR SUPPLIER		602 WO	DODRESS, CITY, STATE, ZIP COD OODBRIDGE AVE SPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	§485.68(b), §485.	475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b),				
	develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) c communication pla section. The policy	ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2				
	and procedures. To develop and imples preparedness police on the emergency (a) of this section, paragraph (a)(1) communication plasection. The police	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.				
	*[For PACE at §46 procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The police	60.84(b):] Policies and PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and				

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet Page 4 of 17

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPLETED
		155724	B. W	ING		05/20/2024
NAME OF F	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD	-
					OODBRIDGE AVE	
MOODB	RIDGE HEALTH C	AIVIPUS		LUGAN	NSPORT, IN 46947	
(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 APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY	DATE
		gencies, including, but not				
		quipment, power, or water ed emergencies; and natural				
		threaten the health or				
	-	cipants, staff, or the public.				
		procedures must be				
		dated at least every 2 years.				
	. stielled and apo	at loads of dry 2 yours.				
	*[For ESRD Facil	ities at §494.62(b):] Policies				
		The dialysis facility must				
		ement emergency				
	preparedness pol	licies and procedures, based				
	on the emergency	y plan set forth in paragraph				
	(a) of this section	, risk assessment at				
	paragraph (a)(1)	of this section, and the				
	communication p	lan at paragraph (c) of this				
	-	cies and procedures must				
		updated at least every 2				
	I -	ergencies include, but are				
		, equipment or power				
		ted emergencies, water				
		n, and natural disasters				
	I	he facility's geographic				
	area.	view and interview 4- 6-11kg	FA	012	The Everythus Directors	06/04/2024
		view and interview, the facility nd implement emergency	E 0	U13	The Executive Director has	06/04/2024
	•	ies and procedures. The			reviewed the Emergency	
		lures must be reviewed and			Operations Plan and its polici	
		nually in accordance with 42			and procedures in its entirety.  During this review the Execut	•
	_	his deficient practice could affect			Director made all necessary	IVE
	all residents in the	-			revisions and updates to the	
	an residents in the				policies and procedures for the	e
	Findings include:				Emergency Operations Plan.	
					The Executive Director was	
	Based on review of	f the facility's Emergency			educated by the Facilities	
		entitled "Emergency and			Management Support, on E0	13,
		ess Manual" on 05/20/24 at			Development of EP Policies a	
	10:15 a.m. with the	e Director of Plant Operations			Procedures. The LTC facility	•
	(DPO) present, doo	cumentation of facility policies			develop and implement emer	gency
	and procedures rev	iewed by the facility within the			preparedness policies and	

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 5 of 17

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

		IDENTIFICATION NUMBER  155724	r í	UILDING	INSTRUCTION	COMPL 05/20/	ETED
	PROVIDER OR SUPPLIER			602 WC	ADDRESS, CITY, STATE, ZIP COD DODBRIDGE AVE SPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	available for review available did not have past 12-month periodocumented update Based on interview the DPO said the face emergency prepared facility within the management of the property of	month period was not  The emergency plan  we a review date during the d with the most recent being listed as 01/03/23.  at the time of record review, cility has not had its entire lness program reviewed by the nost recent twelve-month Administrator had not al review.			procedures, based on the emergency plan set forth in paragraph (a) of this section, r assessment at paragraph (a) of this section, and the communication plan at paragra (c) of this section. The policies and procedures must be review and updated at least annually.  The Executive Director will review the Emergency Operations Plan and the policies & procedures within 1 X Per Month X 3 Montand then once per quarter X 2 ensure proper updates have be applied to the Emergency Operations Plan.  Results of this review will be presented by the Executive Director to the QAPI committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  This deficient practice could af all the residents in the facility.	i) of aph wed iew in to een	
E 0029 SS=C Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62( Development of Co §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.6	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 6 of 17

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

	N OF CORRECTION	IDENTIFICATION NUMBER  155724	A. BUILDING B. WING		JNSTRUCTION	COMPLETED 05/20/2024	
	PROVIDER OR SUPPLIEI			602 W	ADDRESS, CITY, STATE, ZIP COD DODBRIDGE AVE ISPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC 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
	an emergency preplan that complies local laws and must least every 2 ye facilities]. Based on record refailed to develop ar preparedness comm with Federal, State, with 42 CFR 483.7 could affect all occ Findings include:  Based on review of Preparedness Plan Obisaster Preparedness P	Ethe facility's Emergency entitled "Emergency and ess Manual" on 05/20/24 at Director of Plant Operations umentation of the facility in reviewed by the facility ent twelve-month period was view. The emergency plan eve a review date within the od with the most recent ebeing listed as 01/03/23. The time of record review, incility has not had its entire diness program reviewed by the most recent twelve-month Administrator had not	EO	029	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 develor and maintain an Emergency Preparedness Communication Plan that complies with Federa State, and Local laws in accordance with 42 CFR 483.73(c). The Executive Director will revisible the Emergency Preparedness Communication Plan and the contents within 1 X Per Month Months and then once per quax 2 to ensure proper updates been applied to the Emergency Preparedness Plan. Results of this review will be presented by the Executive Director to the QAPI committed further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.	on op n al, view a X 3 arter have cy ee for	06/04/2024

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 7 of 17

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY TPLETED 20/2024
	PROVIDER OR SUPPLIER RIDGE HEALTH CA		602 W	ADDRESS, CITY, STATE, ZIP CO OODBRIDGE AVE NSPORT, IN 46947	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §485. §485.68(d), §485. §485.920(d), §486 §494.62(d).  *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness train that is based on the in paragraph (a) of assessment at paragraph training and testin that is based on the paragraph of the paragraph training and testin reviewed and upd  *[For LTC facilities and testing. The land maintain an extraining and testin the emergency place.	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 485.68(d), 20(d), 486.360(d), (d) resting 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 5.360(d), §491.12(d), 5.360(d), §491.12(d), 5.360(d), §491.12(d), 5.360(d),		all occupants.		

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 8 of 17

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/18/2024 FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. I		A. BU	(2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  05/20/2024		
	PROVIDER OR SUPPLIER			602 WC	ADDRESS, CITY, STATE, ZIP COD DODBRIDGE AVE ISPORT, IN 46947	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
	at paragraph (b) c communication pl section. The train	on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least					
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk at (a)(1) of this section at paragraph (b) communication placetion. The train must be reviewed 2 years. The ICF/	D must develop and gency preparedness training am that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every and updated at least every evacuation drills and training					
	Training, testing, a dialysis facility mu emergency prepa and patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at par and the community of this section.	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based replan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and					
	Based on record rev failed to develop ar preparedness training	view and interview, the facility and maintain an emergency and testing program that updated at least annually in	E 00	)36	The Executive Director has provided "All Staff" training on Emergency Preparedness Communication Plan.	the	06/04/2024

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

accordance with 42 CFR 483.73(d). This deficient

Event ID:

Z93X21

Facility ID: 003691

The Executive Director was

If continuation sheet

Page 9 of 17

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

	OF CORRECTION	IDENTIFICATION NUMBER  155724		ILDING	INSTRUCTION	COMPL 05/20/	ETED
	ROVIDER OR SUPPLIER			602 WC	ADDRESS, CITY, STATE, ZIP COD DODBRIDGE AVE ISPORT, IN 46947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	practice could affect Findings include:  Based on review of Preparedness Plan et Disaster Preparedne 10:15 a.m. with the (DPO) present, document available for review available did not hat past 12-month period documented update Based on interview the DPO said the face emergency prepared facility within the most recent available did not hat the past 12-month period documented update.	the facility's Emergency entitled "Emergency and ess Manual" on 05/20/24 at Director of Plant Operations ementation of a facility testing ent reviewed by the facility ent twelve-month period was riew. The emergency plan entitle we are review date within the end with the most recent being listed as 01/03/23. The time of record review, cility has not had its entire entitle		IAG	educated by the Facilities Management Support on The facility must develop and main an emergency preparedness training and testing program th is based on the emergency pla set forth in paragraph (a) of thi section, risk assessment at paragraph (a)(1) of this section policies and procedures at paragraph of this section, and communication plan at paragra (c) of this section. The training testing program must be review and updated at least annually.  The Executive Director will rev the Emergency Preparedness Training and testing documentation of all staff, including newly hired employe X Per Month X 3 Months then Per Quarter X 3.  Results of this review will be presented by the Executive Director to the QAPI committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. This deficient practice could af all occupants.	tain eat ean s n, the eaph and wed iew es 1 1 X	DATE
K 0000							
Bldg. 01	_	Recertification and State as conducted by the Indiana	K 00	000	The submission of this plan of correction does not indicate ar		

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

Page 10 of 17

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155724	r í	UILDING	onstruction 01	(X3) DATE COMPI <b>05/20</b>	LETED
	PROVIDER OR SUPPLIER			602 WC	ADDRESS, CITY, STATE, ZIP COD DODBRIDGE AVE ISPORT, IN 46947		
			1		- ,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	Department of Hea 483.90(a).	Ith in accordance with 42 CFR			admission by Woodbridge He Campus that the findings and allegations contained herein a		
	Survey Date: 05/20	0/24			accurate, true representation the quality of care provided, a	of	
	Facility Number: 0	003691			the living environment provide	ed to	
	Provider Number:	155724			the residents by Woodbridge		
	AIM Number: 200	456230			Health Campus. The facility recognizes its obligation to pro	ovide	
	At this Life Safety	Code survey, Woodbridge			legally and medically necessa		
		s found not in compliance with			care and services to its reside	-	
	Requirements for P	-			in an economic and efficient		
	Medicare/Medicaid	l, 42 CFR Subpart 483.90(a),			manner. The facility hereby		
	Life Safety from Fi	re and the 2012 edition of the			maintains it is in substantial		
	National Fire Prote	ction Association (NFPA) 101,			compliance with all state and		
	Life Safety Code (I	LSC), Chapter 19, Existing			federal requirements governir	ig the	
	Health Care Occup	ancies, and 410 IAC 16.2.			management of this facility. It thus submitted as a matter of	-	
	This one-story facil	lity was determined to be of			statute only.		
		truction and was fully					
		cility has a fire alarm system					
		on in the corridors, spaces					
		rs and hard-wired smoke					
		t rooms. The facility has a					
		had a census of 61 at the time					
	of this survey.						
	All areas where the	residents have customary					
	access were sprinkl	ered. All areas which provide					
	facility services wa	s sprinklered.					
	Quality Review con	mpleted on 05/22/24					
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
<b>O</b> -		the transmission of a fire					
		simulation of emergency fire					
	_	rills are held at expected					
		imes under varying					

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet Page 11 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/20/2024 155724 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 602 WOODBRIDGE AVE WOODBRIDGE HEALTH CAMPUS LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility K 0712 Immediate Intervention 06/07/2024 failed to conduct quarterly fire drills for 2 of 4 The Director of Plant Operations quarters. LSC 19.7.1.6 requires drills to be has conducted a Fire Drill on each conducted quarterly on each shift under varied shift, with documentation. conditions. This deficient practice affects all staff The Director of Plant Operations and residents. was educated by the Executive Director on K712, Fire Drills. Fire Findings include: drills are held at expected and unexpected times under varying Based on record review on 05/20/24 at 9:15 a.m., conditions, at least quarterly on the "Direct Supply - TELS" fire drill forms with each shift. The staff is familiar with Director of Plant Operations (DPO) the following procedures and is aware that drills was noted: are part of established routine. a) There was no documentation of a third shift fire Where drills are conducted drill conducted in the first quarter (January, between 9:00 PM and 6:00 AM, a February, and March) of 2024. coded announcement may be b) There was no documentation of a second shift used instead of audible alarms. fire drill conducted in the fourth quarter 19.7.1.4 through 19.7.1.7 (October, November, and December) of 2023 Based on interview at the time of record review. The Executive Director and the the DPO acknowledged the aforementioned fire Director of Plant Operations will drills and stated that he was not yet in the DPO review the Fire Drills 1 X Per role at the time of the aforementioned fire drills. Month X 6 Months for complete and accurate documentation in This item was discussed again at the exit accordance with NFPA 101. conference with the DPO and the Facilities 19.7.1.4 through 19.7.1.7. Maintenance Support Manager on 05/20/24 at 2:10 Results of this review will be p.m. presented by the Executive 3.1-19(b) Director to the QAPI committee for 3.1-51(c)further recommendations and continue until the Quality

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 CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  05/20/2024				
	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	(X5) COMPLETION DATE				
				Assurance Team determines substantial compliance has be achieved. This deficient practice could at all the residents in the facility.				
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade records and when anesthesia is adminitial installation, Additional testing defined by docume Receptacles not list these locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visually LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99)	oom or area tested, and						
	interview, the facili nonhospital-grade of resident room locat	on, record review and ty failed to ensure all electrical receptacles at ions were tested at least , Health Care Facilities Code	K 0914	The Director of Plant Operatio completed testing of all non-hospital grade electrical receptacles at resident room locations.	ns 06/04/2024			

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

2012 Edition, Section 6.3.4.1.3 states receptacles

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet

The Director of Plant Operations

Page 13 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/20/2024 155724 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 602 WOODBRIDGE AVE WOODBRIDGE HEALTH CAMPUS LOGANSPORT, IN 46947 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE not listed as hospital-grade, at patient bed was educated by the Executive locations and in locations where deep sedation or Director on NFPA 99, Health Care general anesthesia is administered, shall be tested Facilities Code 2012 Edition, at intervals not exceeding 12 months. Section 6.3.4.1.3 states Additionally, Section 6.3.3.2, Receptacle Testing receptacles not listed as in Patient Care Rooms requires the physical hospital-grade, at patient bed integrity of each receptacle shall be confirmed by locations and in locations where visual inspection. The continuity of the deep sedation or general grounding circuit in each electrical receptacle shall anesthesia is administered, shall be verified. Correct polarity of the hot and neutral be tested at intervals not connections in each electrical receptacle shall be exceeding 12 months. confirmed; and retention force of the grounding Additionally, Section 6.3.3.2, blade of each electrical receptacle (except Receptacle Testing in Patient locking-type receptacles) shall be not less than Care Rooms requires the physical 115 grams (4 ounces). This deficient practice integrity of each receptacle shall could affect all residents. be confirmed by visual inspection. The continuity of the grounding Findings include: circuit in each electrical Based on record review with the Director of Plant receptacle shall be verified. Operations (DPO) and the Facilities Maintenance Correct polarity of the hot and Support Manager (FMSM) at 9:50 a.m. on neutral connections in each 05/20/24, the DPO was asked to provide a copy of electrical receptacle shall be the annual receptacle retention documentation. confirmed; and retention force of Based on an interview at the time of record review. the grounding blade of each the DPO advised that he had not had time to electrical receptacle (except complete the testing and that documentation was locking-type receptacles) shall be not available at the present time. Based on not less than 115 grams (4 observations made during a tour of the facility ounces). from 12:00 p.m. to 2:02 p.m., the resident rooms had approximately six receptacles in each of the The Director of Plant Operations resident rooms and none of them were hospital we audit each resident rooms 1 X grade and would require an annual inspection. quarterly X 4 in accordance with Based on interview at the time of the observation. NFPA 99, Health Care Facilities the Maintenance Director indicated all of the Code 2012 Edition. Section electrical receptacles in the resident rooms were 6.3.4.1.3 and Section 6.3.3.2. non hospital-grade and also indicated there was Results of this audit will be no documentation of annual testing per NFPA 99, presented by the Executive Receptacle Testing requirements. Director to the QAPI committee for further recommendations and This item was discussed again at the exit continue until the Quality

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 155724			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/20/2024		
NAME OF PROVIDER OR SUPPLIER WOODBRIDGE 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	FIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		DPO and the Facilities rt Manager on 05/20/24 at 2:10			Assurance Team determines substantial compliance has be achieved. This deficient practice could af all residents, as well as the stand visitors in the facility.	fect	
K 0916 SS=F Bldg. 01	Electrical Systems System Alarm Ann A remote annuncia powered is provide generating room in observed by opera annunciator is har conditions of the e centralized compu- information system for the alarm annu- 6.4.1.1.17, 6.4.1.1 Based on observatio failed to ensure 1 of annunciator panel w condition. This defi- the residents, as wel- facility.  Findings include:  Based on observatio facility on 05/20/24 of Plant Operations Maintenance Suppo- generator's annuncia nurse's station of the illuminated. The lig the "Bat Chrg AC F the time of the obse	ator that is storage battery ed to operate outside of the n a location readily ating personnel. The d-wired to indicate alarm emergency power source. A atter system (e.g., building n) is not to be substituted unciator.	K 0'	916	The Director of Plant Operation has contacted the Generator Contractor for repairs to the Generator Battery Charger. The Director of Plant Operation was educated by the Executive Director on NFPA 99, 6.4.1.1.16.4.1.1.17.5 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 general testing, and routine checks the Director of Plant Operations winclude a visual (audit) inspect of the annunciator panel of the	ns e 17, s tor e iill ion	06/04/2024

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet Page 15 of 17

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
155724		155724	B. WING			05/20/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				602 WC	OODBRIDGE AVE		
WOODBRIDGE HEALTH CAMPUS			LOGANSPORT, IN 46947				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE DATE	
	•	ould contact his vendor to		generator and address any aud alarms with repairs 1 X per wed 8 weeks.			
	assess the issue imn	nediately.				ек х	
	This item was disau	and again at the arrit					
		ssed again at the exit DPO and the Facilities			Results of this review will be		
		ort Manager on 05/20/24 at 2:10			presented by the Executive Director to the QAPI committe	o for	
	p.m.	It Manager on 03/20/24 at 2.10			further recommendations and	5 IOI	
	р.ш.				continue until the Quality		
	3.1-19(b)				Assurance Team determines		
	3.1 17(0)				substantial compliance has be	en	
					achieved.	CII	
					This deficient practice could at	fect	
					residents, as well as staff and		
					visitors in the facility.		
					,		
K 0927	NFPA 101						
SS=E		Transfilling Cylinders					
Bldg. 01	Gas Equipment -	Transfilling Cylinders					
	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						
		nt care rooms. Transfilling					
		ontainers or to portable					
		) psi comply with conditions					
	· ·	NFPA 99). Transfilling to					
		ainers or to portable					
	containers under 5	· · · · · · · · · · · · · · · · · · ·					
		1.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99	on and interview, the facility	K 09	027	The Director of Plant Operation	ne	06/04/2024
		2 oxygen storage rooms	K 0	741	The Director of Plant Operation has repaired the ventilation in	113	06/04/2024
		ferring takes place, was			oxygen storage room.		
					The Director of Plant Operatio	ns	
	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				was educated by the Executive Director on NFPA 99, Healthcare facilities , 2012 edition 11.5.2.3.1 requires mechanical exhaust to		
		pressure in the space			maintain a negative pressure i		

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

Event ID:

Z93X21

Facility ID: 003691

If continuation sheet Page 16 of 17

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 WOODBRIDGE 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		PREI	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				the space continuously. In addition, we will audit full function of ventilation fan in oxygen room monthly for 3 months to remain in compliant Results of this review will be presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved. This deficient practice could a residents, as well as staff and visitors in the facility	e for een		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Z93X21 Facility ID: 003691 If continuation sheet Page 17 of 17