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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155724	A. BUILDING 00 B. WING	06/03/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00454866. Complaint IN00454866-No deficiencies related to the allegations are cited. Survey dates: May 27, 28, 29, 30 and June 2 and 3, 2025 Facility number: 003691 Provider number: 155724 AIM number: 200456230 Census Bed Type: SNF/NF: 33 SNF: 30 Residential: 23 Total: 86 Census Payor Type: Medicare: 18 Medicaid: 26 Other: 19 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 12, 2025.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility	F 0578	**F578 The right to request,**	06/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly	Snay	06/25/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	failed to ensure a resident's advanced directives were updated for 1 of 1 resident reviewed for advanced directives. (Resident 19) Finding Includes: The clinical record for Resident 19 was reviewed on 5/29/25 at 2:04 p.m. The diagnoses included, but were not limited to, right hip fracture, cognitive communication deficit, metabolic encephalopathy, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and atrial fibrillation. A current care plan, dated 3/14/25, indicated Resident 19 had advanced directives. The care plan was not specific on what his advanced directives included. Interventions included, but were not limited to, advanced directives reviewed quarterly and as needed, code status as ordered, and honor durable POA's (Power of Attorney) decision. A current physician's order in Resident 19's electronic medical record, dated 4/9/25, indicated the resident was to be a full code. An out of hospital DNR form, dated 4/9/25 and signed by the resident's POA on 4/9/25, indicated the resident did not want to receive Cardiopulmonary Resuscitation (CPR) and wished to have a code status of DNR. The form was signed by the physician on 4/12/25. During an interview, on 6/3/25 at 10:10 a.m., Registered Nurse (RN) 3 indicated once they had a signed DNR form, they should have changed the code order in the electronic record. During an interview, on 6/3/25 at 11:29 a.m., the		**refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** The submission of this plan of correction does not indicate any admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Resident 19 had the potential to be effect by this deficient practice; no adverse effects were noted. Order immediately updated upon finding All other residents have the	

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	Assistant Director on Nursing (ADON) indicated the nurses should have updated the code status order when they received the DNR form signed by the resident or resident representative, a witness, and the physician. A current facility policy, titled Guidelines for Advanced Directives," dated 12/17/24 and received from the Interim Executive Director on 6/3/25 at 10:42 a.m., indicated "...Advanced Directives will be reviewed with resident and/or resident representative by the Admissions Representative or designee at time of admission...The nursing staff will confirm the desired code status and obtain an order from the physician...Designation of code status and obtainment of physician order will be part of the medical record..." 3.1-4(f)(5)		potential to be affected. A complete review of all resident's code status orders and signed code status directives was completed on 6/10/25 with no additional concerns. As a measure of ongoing compliance, the clinical team will review all admissions daily 5 times a week in the clinical care meeting to ensure code status orders are correct. All clinical staff educated on the importance of ensuring code status orders match the directives that the resident or POA sign. Marketing team educated to notify clinical staff of any new advance directives signed so they may update orders from the physician. Additionally, the DHS or designee will audit admissions to ensure code status orders, face sheet and advance directives form match. Audit will consist of 5 admissions weekly for 4 weeks, then twice monthly for 2 months, then monthly for 3 months. As a quality measure the DHS or designee will review and present any findings or corrective action monthly in the Quality Assurance Performance Improvement meeting as facilitated by the Executive Director. The plan will be revised and updated as needed and audits will be discontinued after 6 months if no further concerns are identified. The systemic changes for this deficiency will be completed by	

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			June 20th, 2025.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments			
	Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when a resident received a new mental health diagnosis and was prescribed an antipsychotic medication for 1 of 1 resident reviewed for PASARR. (Resident 46) Findings include: The clinical record for Resident 46 was reviewed on 6/2/25 at 11:30 a.m. The diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, dementia with psychotic disturbance, psychotic disorder with delusions due to a known physiological condition, and depression. A PASARR level I, dated 9/11/24, indicated the resident had a diagnosis of anxiety disorder and depression and no level II was required. A physician's order, dated 9/14/24, indicated quetiapine (an antipsychotic medication) 25 mg (milligram) twice a day related to a psychotic disorder with delusions due to a known physiological condition. The diagnosis of psychotic disorder with delusions due to a known physiological condition was added on 10/4/24. During an interview, on 6/2/25 at 2:11 p.m., the Social Service Director (SSD) indicated Resident	F 0644	**F644 Coordination of PASARR and Assessments** The submission of this plan of correction does not indicate any admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Resident 46 had the potential to be affected by this deficient practice, no adverse effects were noted. PASARR Level I was reviewed and updated with current	06/20/2025

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	46 did have a PASARR completed without the antipsychotic medication listed and another screen should have been implemented. A current facility policy, titled "Indiana PASARR," undated and received from the Executive Director (ED) on 6/2/25 at 3:10 p.m., indicated "...Preadmission screening and resident review (PASARR) is a federal requirement to help ensure that individuals are appropriately placed in nursing facilities for long term care...A change in status and Level II follow up, SSD to ensure paperwork is submitted, print outcome letter and upload to Matrix file...Applicable supportive documentation is in place, SSD for Level II...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		antipsychotic medication. No level II was indicated. All other residents have the potential to be affected. A complete review of all Level I PASARR paperwork has been completed by the SSD and if indicated a new Level I was completed. As a measure of ongoing compliance education was provided to SSD to review Level I for accuracy within the first 5 days of admission. If discrepancies are found a new Level I will be completed. Audits of 5 Level 1's will be completed weekly for 4 weeks, twice a month for 2 months, then monthly for 3 months by the DSS or designee. As a quality measure the SSD or designee will review and present the findings monthly in the Quality Assurance Performance Improvement meeting as facilitated by the Executive director. The plan will be revised and updated as needed and audits will be discontinued after 6 months if no further concerns are noted. The systemic changes for this deficiency will be completed by June 20th, 2025	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to ensure daily weights	F 0684	**F684 Quality of Care** The submission of this plan of correction does not indicate any	06/20/2025

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	were obtained as ordered and to ensure the physician was notified of weight changes as ordered for 2 of 2 residents reviewed for quality of care. (Resident 9 and 10) Findings include: 1. During an observation, on 5/28/25 at 11:04 a.m., Resident 9 was lying in bed and had audible wheezes. The clinical record for Resident 9 was reviewed on 5/28/25 at 1:30 p.m. The diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disorder, shortness of breath, acute kidney failure, hypertensive, and type 2 diabetes mellitus. A care plan, dated 3/26/25, indicated the resident had congestive heart failure and had the potential for complications. The interventions included, but were not limited to, obtain weights as ordered. A physician's order, dated 5/29/25, indicated to weigh the resident daily and notify the physician of a weight gain of 2 pounds or greater in one day, or for a plus or minus of 5 pounds in one week. A progress note, dated 5/30/25 at 6:56 p.m., indicated Resident 9 was concerned with the increased swelling to her bilateral lower extremities (BLE) and recent weight gain. A progress note, dated 5/31/25 at 12:24 a.m., indicated Resident 9's daughter was concerned about the resident's swelling in her legs. The nurse assessed Resident 9, and the resident had non-pitting edema (swelling) to her BLE. The electronic health record did not have any		admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Residents 9 and 10 had the potential to be affected by this deficient practice, no adverse effects were noted. Physicians were notified of missing weights and missing notification of weights outside of parameters. All other residents with daily weights have the potential to be affected. An audit of residents with daily weights was completed on 6/10/25. As a measure of ongoing compliance education provided to	

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	documentation the resident was weighed on 5/29/25 and 5/31/25. The physician was not notified of the missing weights. During an interview, on 6/3/25 at 11:10 a.m., the Executive Director (ED) indicated the resident had a new daily weight order added on 5/29/25. The weight for 5/29/25 was missed. The nurse inputted the order and did not hit the save button. It was unknown why the resident missed the daily weight on 5/31/25. The resident should have been weighed daily, and the weight should have been documented. During an interview, on 6/3/25 at 11:55 a.m., RN 7 indicated the daily weights with call parameters would be charted in the Medication Administration Record (MAR). A certified nursing assistant (CNA), qualified medical assistant (QMA), or a nurse could obtain a daily weight. 2. During an observation, on 5/29/25 at 12:10 p.m., Resident 10 had both legs elevated on her wheelchair foot pedals. The resident's legs were swollen and purple. The clinical record for Resident 10 was reviewed on 5/28/25 at 1:37 p.m. The diagnoses included, but were not limited to, congestive heart failure, right femur fracture, hypertension, chronic kidney disease, Parkinson's disease, psychotic disorder with hallucinations, depressive disorder, and anxiety disorder. A care plan, dated 11/22/19, indicated the resident had congestive heart failure and had potential for complications. The interventions included, but were not limited to, obtain weights as ordered. A physician's order, dated 4/16/21, indicated daily		all clinical staff on the importance of daily weights and notification if the weight is outside of the parameters the physician has set. Will also monitor daily weights and notifications 5 times a week in daily clinical care meeting by the nurse management team.. The DHS or designed will complete audits of 5 residents with daily weights weekly for 4 weeks, then twice a month for 2 months, then monthly for 3 months. As a quality measure the DHS or designee will present the findings monthly in the Quality Assurance Performance Improvement meeting facilitated by the Executive Director. The plan will be revised and updated as needed and the audits will be discontinued after 6 months if no further concerns are noted. The systemic changes for this deficiency will be completed by June 20, 2025.	

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weights before breakfast and to notify the physician of a weight gain of 2 pounds or greater in one day, or for a plus or minus of 5 pounds in one week.

The resident's weight on 3/12/25 was 116.9 pounds and on 3/13/25 the weight was 119.4 pounds. This was an increase of 2.5 pounds.

The resident's weight on 3/18/25 was 107.5 pounds and on 3/19/25 the weight was 110.1 pounds. This was an increase of 2.6 pounds.

The resident's weight on 4/12/25 was 108.9 pounds and on 4/13/25 the weight was 111.8 pounds. This was an increase of 2.9 pounds.

During an interview, on 6/3/25 at 12:05 p.m., Licensed Practical Nurse (LPN) 6 indicated daily weights were obtained in the morning between 6:00 a.m., and 10:00 a.m. The staff were responsible for making sure the weights were completed, added to the MAR, and recorded in the residents' progress notes.

The clinical record did not have any documentation the physician was notified of the weight gains.

A current facility policy, titled "Clinical Services-Weight Monitoring," dated 12/20/24 and received from the Executive Director on 6/2/25 at 3:33 p.m., indicated "...Weight monitoring is essential to the well-being of the residents we serve and requires a multidisciplinary approach...Daily weights as ordered ...May be delegated to clinical leaders...Re-weigh as needed...Correct weights as needed...."

3.1-37(a)

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F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to ensure medications were prescribed as ordered to prevent significant medication errors for 1 of 1 resident reviewed for medication errors. (Resident 202) Findings include: The clinical record for Resident 202 was reviewed on 5/28/25 at 2:40 p.m. The diagnoses included, but were not limited to, a history of a deep vein thrombosis (a blood clot in a deep vein), peripheral vascular disease, hyperlipidemia, anemia, hypertension. Resident 202 was admitted to the facility from the hospital on 5/23/25. An admission observation and data collection form, dated 5/23/25, indicated that the resident would be free from complications and adverse side effects from any medications and administer anticoagulant medications as ordered. A hospital discharge note, dated 5/23/25, indicated Resident 202 was to continue taking the medication Eliquis (an anticoagulant or a blood thinner used to prevent and treat blood clots in various cardiovascular conditions) twice a day for blood clots. A physician's order, dated 5/28/25, indicated to give Eliquis (apixaban) 5 mg tablet twice a day. The MAR (Medication Administration Record) indicated the first dose of Eliquis was administered on 5/28/25 at 10:18 a.m.	F 0760	**F760 Residents are Free of Significant Med Errors** The submission of this plan of correction does not indicate any admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Resident 202 had the potential to be affected by this practice, no adverse affects noted. NP notified immediately of the error; education given to nurse completing admission orders on the importance of having 2 nurse	06/20/2025

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	This was 5 days after the resident was admitted to the facility. A nursing progress note, dated 5/28/25 at 11:10 a.m., indicated a medication error had occurred. The resident was admitted on 5/23/25 and the hospital discharge orders indicated the resident was to receive Eliquis 5 mg twice a day. The order was not transcribed into the MAR. The nurse practitioner completed a chart review and indicated the Eliquis was needed due to the resident's medical history. An admission checklist, dated 5/23/24, had the admitting nurse's signature, however the second nurse signature on the form was missing. During an interview, on 6/2/25 at 3:55 p.m., the Executive Director (ED) indicated the order for the medication was not found in Resident 202's medical record. The mistake was discovered on 5/27/25 and the medication order was entered on 5/28/25. During an interview, on 6/2/25 at 3:18 p.m., RN 2 indicated the hospital discharge medication orders should be entered into the computer. During an interview, on 6/3/25 at 11:30 a.m., the Assistant Director of Nursing (ADON) indicated when a nurse entered the physician's orders a second nurse was required to review and sign off on the orders within 24 hours. A current Registered Nurse (RN) job description, received by the interim ED on 6/3/25 at 11:49 a.m., indicated "...role and responsibilities...lead a team of direct care providers to ensure appropriate execution of medications and treatments,		check for accuracy in orders. All other residents have the potential to be affected by the deficient practice. Education given to nursing staff with ability to transcribe orders on the importance of having 2 nurses check orders at admission for accuracy. To ensure ongoing compliance all new admissions will be reviewed in clinical care meeting 5 days a week for accuracy and that 2 nurses signed off on orders. Audits will be completed by the DHS or designee of 5 new admissions per week for the first 4 weeks, then twice monthly for 2 months then once a month for 3 months. As a quality measure the DHS or designee will present the findings to the Quality Assurance Performance Improvement meeting monthly facilitated by the Executive Director. Plan will be reviewed and revised as needed and audits will be discontinued after 6 months if there are no further concerns. The systemic changes for this deficiency will be completed by June 20th, 2025.	

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	documentation...in compliance with the Health Campus Policies and Procedures...." A current RN new hire checklist, dated effective 2/21/18 and received by the interim ED on 6/3/25 at 11:49 a.m., indicated "...admissions...admission verification of orders and order entry...." A current facility policy, titled "Guidelines for Medication Orders," dated 12/17/24 and received by the Interim ED on 6/3/25 at 11:49 a.m., indicated "...the admitting nurse shall review the standing order list with the physician when verifying admission orders...standing orders shall be in the medical record with the other physician orders...." 3.1-48(c)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00454866. Complaint IN00454866-No deficiencies related to the allegations are cited. Survey dates: May 27, 28, 29, 30 and June 2 and 3, 2025 Facility number: 003691 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 12, 2025.	R 0000		

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R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on observation, interview and record review, the facility failed to ensure a resident's medication was secured in a locked container for a resident who self-administered medication for 1 of 5 residents reviewed for medication administration. (Resident 4) Findings include: During an observation, on 5/30/25 at 1:42 p.m., Resident 4 was out of the facility for dialysis. The door to her room was open. During an observation, on 6/2/25 at 9:43 a.m., Resident 4 was out of the facility for dialysis. The door to her room was open, and contract workers were on the unit installing carpet in all resident rooms. During an interview, on 6/3/25 at 9:44 a.m., Resident 4 indicated workers had installed a new carpet in her room on 6/2/25 while she was out at dialysis. She stored approximately nine days of medication in a pill organizer inside an unlocked drawer in her nightstand. The remainder of her medications were stored in a shoebox-sized plastic container on her countertop above the mini refrigerator in her room. There was no lock on the door to her room. The clinical record for Resident 4 was reviewed on 5/29/25 at 9:44 a.m. The diagnoses included, but were not limited to, arthritis, atrial fibrillation, chronic kidney disease, diabetes mellitus, congestive heart failure, and cardiomegaly. A service plan, dated 3/17/25, indicated Resident 4	R 0295	**R295 Pharmaceutical Services Noncompliance** The submission of this plan of correction does not indicate and admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care, and living environment provided to the residents of 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Resident 4 had the potential to be affected by this practice, no adverse effects were noted. Resident given a lock box for her medication with a key for her and a key for the nurse or QMA to keep.	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155724	A. BUILDING 00 B. WING	06/03/2025

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	self-administered medications. A physician's order, dated 5/21/25, indicated Resident 4 self-administered medications. During an interview, on 6/3/25 at 12:44 p.m., the Interim Executive Director (ED) indicated the medications should have been secured and locked up. A current facility policy, titled "AL Self Administration of Medications Guidelines," dated 12/17/24 and received from the Interim ED on 6/3/25 at 12:44 p.m., indicated "...The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key and a second key will be maintained by the licensed nurse and or QMA...."		All other residents who self administer medication and store them in their rooms have the potential to be affected. Audit done of residents who self administer and store medication in their room and those residents were given a lock box with a key for them to keep and a key for the nurse or QMA to keep. Education given to the nursing staff and director of assisted living on the importance of keeping medication in a locked box if they store it in their room. As a measure of ongoing compliance, the Director of Assisted living or designee will, upon completing a self administration of medication assessment and deeming it appropriate for a resident to store medication will give them a lock box with a key and keep a key for the nurse or QMA. Audits will be conducted on 5 residents who self administer and store medication by the director of assisted living or designee weekly for 4 weeks, twice a month for 2 months, then monthly for 3 months. As a quality measure the director of assisted living or designee will present the findings of the audits to the Quality Assurance Performance Improvement committee as facilitated by the Executive Director. The plan will be revised and updated as needed and audits will be discontinued	

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			after 6 months if no further concerns are noted. The systemic changes for this deficiency will be completed by June 20th 2025.	