

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2023
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NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 602 WOODBIDGE AVE LOGANSPORT, IN 46947
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F 0000 Bldg. 00	<p>This visit was for Investigation of Complaints IN00401394, IN00401863 and IN00402369.</p> <p>Complaint IN00401394 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00401863 - Federal/State deficiencies related to the allegations are cited at F689.</p> <p>Complaint IN00402369 - Federal/State deficiencies related to the allegations are cited at F689.</p> <p>Survey date: May 15, 2023</p> <p>Facility number: 003691 Provider number: 155724 AIM number: 200456230</p> <p>Census bed type: SNF: 18 SNF/NF: 46 Residential: 23 Total: 87</p> <p>Census payor type: Medicare: 18 Medicaid: 26 Other: 43 Total: 87</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on May 22, 2023.</p>	F 0000	<p>The submission of the Plan of Correction does not indicate an admission by Woodbridge Health Campus that the findings and allegations contained herein are accurate, a true representation of the quality of care provided, or the 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 is committed to compliance with its regulatory and legal standards as well as quality of care and alleges that it is in substantial compliance with all state and federal requirements governing the management of this facility. Woodbridge Health Campus submits that the effective date for substantial compliance is June 5, 2023. This Plan of Correction is submitted in accordance with this provider's legal and regulatory requirements, and not as an admission of any wrongdoing. The facility respectfully requests from the Department of Health a desk review of this submission for substantial compliance, which is expressly alleged as part of this submission. As part of this submission, and through a</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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 disclosed 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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F 0689 SS=G Bldg. 00	<p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure staff members followed a resident's plan of care for transfers which resulted in an injury during a transfer with a two-person manual assist and failed to follow post-fall interventions after one resident fell twice sustaining an injury for 2 of 3 residents reviewed for accidents. (Residents B and G) Resident B suffered a left tibial plateau fracture during an incorrect transfer. Resident G suffered a head laceration and two skin tears to her left upper extremity prior to the fall interventions being put into place.</p> <p>Findings include:</p> <p>1. A document, titled "Indiana State Department of Health Survey Report System," dated 5/15/23 at 11:15 a.m., indicated the incident occurred on 5/7/23 at 4:25 p.m. On 5/7/23, Resident B complained of pain to her left knee after being</p>	F 0689	<p>separate submission, this facility is seeking Informal Dispute Resolution with respect to the findings under F689 and the scope and severity of the alleged deficiency in the survey report.</p> <p>1. Residents B and G were affected. Resident B has been assessed and her care plan has been reviewed. The role of a stand-up lift has been clarified so that it is only to be used if a 2-person assist is inadequate. Resident G has been assessed and the corrective measures (i.e., the soft touch call light and the Reacher) described in the findings have been implemented with the resident.</p> <p>2. All residents have the potential to be affected. All residents' plan of care have been reviewed and are correct. Nurses and QMAs educated on care plans and implementation of fall interventions. CRCAs educated on</p>	06/05/2023

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	<p>transferred by staff. The type of injury she sustained was a nondisplaced medial tibial plateau fracture of the left lower extremity. The resident was evaluated in the ER (Emergency Room) on 5/7/23. The resident had a surgical repair of the left lower extremity tibial plateau fracture.</p> <p>An "Investigation Summary" undated, indicated Resident B while being transferred by staff members on 5/7/23, complained of left knee pain. At 10:45 a.m., on 5/7/23, the resident complained of pain to her left knee with swelling. She was sent to the ER and was returned to the facility at 4:25 p.m. The summary of the investigation indicated the resident sustained a fracture during a transfer.</p> <p>A document, titled "Musculoskeletal Events-Trilogy Musculoskeletal Event," dated 5/8/23 at 7:07 a.m., indicated Resident B sustained a nondisplaced medial tibial fracture to her left lower extremity (LLE). Type of injury was a suspected fracture. There was no description of how the injury occurred. The resident had verbal complaints of pain rated as a sharp pain. She had non-pitting edema to the area of injury with pain upon bearing weight. The examiner was unable to do range of motion to the area. The resident was sent to the ER for further evaluation.</p> <p>The record for Resident B was reviewed on 5/15/23 at 2:00 p.m. Diagnoses included, but were not limited to, unspecified fracture of right patella, subsequent encounter for closed fracture with routine healing, displaced fracture of fourth metatarsal bone, right foot, subsequent encounter for fracture with routine healing, unspecified fracture of second metacarpal bone, right hand, subsequent encounter for fracture with routine healing, displaced fracture of proximal phalanx of right lesser toe(s), subsequent encounter for</p>		<p>resident profiles. Resident profiles reviewed, updated, and shared with CRCAs. Implemented new rounding binder that is to be used for walking rounds at shift change containing all resident profiles.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit 5 resident plan of care regarding transfers and fall interventions weekly x 1 month to ensure care plans are correct and followed, then every other week x 2 months, then monthly x 3 months. DHS or designee will complete CCM (Clinical Care Meeting) 5 days a week review of fall review and placement of timely interventions. Preceptors or designee will review resident profiles weekly for accuracy. Assigned leaders will be completing rounding 5 days a week to ensure fall interventions in place.</p> <p>4. As a measure of ongoing compliance, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.</p> <p>5. Date of Completion: June 5, 2023.</p>	

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	<p>fracture with routine healing, age-related osteoporosis without current pathological fracture, protein-calorie malnutrition, unsteadiness on her feet, and adult failure to thrive.</p> <p>Physician's orders, dated 4/8/23 to 5/8/23, included, but were not limited to the following orders:</p> <p>a. 3/18/23, the resident was to be a stand assist lift for transfers three times a day from 6:00 a.m.-2:00 p.m., 2:00 p.m.-10:00 p.m., and 10:00 p.m.-6:00 a.m.</p> <p>b. 5/7/23, send to the ER for left knee pain and swelling STAT (immediately).</p> <p>c. 5/7/23, NWB (non-weight bearing) to the left leg three times a day from 6:00 a.m.-2:00 p.m., 2:00 p.m.-10:00 p.m., and 10:00 p.m.-6:00 a.m.</p> <p>d. 5/7/23, Keep the knee immobilizer in place three times a day from 6:00 a.m.-2:00 p.m., 2:00 p.m.-10:00 p.m. and 10:00 p.m.-6:00 a.m.</p> <p>The progress notes included, but were not limited to, the following notes:</p> <p>On 05/07/2023 at 11:16 a.m., the resident complained of pain and swelling in her left knee. She was sent to the ER for evaluation.</p> <p>On 05/08/2023 at 12:42 p.m., a follow up appointment was made with the orthopedic surgeon for 5/9/23 at 10:45 a.m., by ambulance.</p> <p>On 05/09/2023 at 2:50 a.m., the resident had a non-displaced fracture to medial tibial plateau on LLE and continued to use the knee immobilizer to LLE and remained NWB.</p> <p>On 05/09/2023 at 1:56 p.m., (Recorded as Late Entry on 05/10/2023 at 1:56 p.m.) Rounding Providers Progress Note: Reason for visit: psychotropic medication review and management,</p>			

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	<p>continued evaluation of moods and behaviors. Met with patient today and she was sitting in her recliner. She had fallen since the last time the provider saw her. She currently had a non-displaced fracture to the medial tibial plateau on the LLE. She was supposed to have surgery in the next few days, and she had a little anxiety about the surgery. She indicated her leg did not hurt too bad if she did not move it.</p> <p>On 05/09/2023 at 5:21 p.m., the resident returned from her orthopedic consult appointment for a left tibial plateau fracture. Surgery was scheduled for Thursday (5/11/23). The resident was to remain NWB to her LLE.</p> <p>On 05/11/2023 at 10:55 a.m., the resident was scheduled for surgery for a nondisplaced medial tibial plateau fracture of the LLE at 1:30 p.m.</p> <p>On 05/12/2023 at 5:13 p.m., the resident returned from the hospital after her surgery, via ambulance on a stretcher at approximately 1:00 p.m. The resident's surgery included a metal plate and 5 screws to her LLE. Her incision was covered with an ace bandage and placed in a passive motion device and not to go past 60 degrees.</p> <p>On 05/15/2023 at 12:20 p.m., the resident was NWB to the LLE with a passive immobilizer in place. Lift evaluation was completed, and it was determined the resident was to be a Hoyer lift for transfers.</p> <p>Resident B's care plans were reviewed and included, but were not limited to, the following care plans dated prior to 5/15/23 (survey entrance date):</p> <p>The resident had a care plan with the problem she</p>			

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	<p>had an impairment in functional status related to bed mobility, transfers, toileting and eating related to falls, history of fractures and chronic obstructive pulmonary disease. The start date was 4/27/22, with a revised date of 2/17/23.</p> <p>Approaches included, but were not limited to, the following approaches: start date 3/20/23, stand assist lift for transfers, and start date 2/6/23, Broda chair, she required extensive assist (two-person physical assist) with transfers, bed mobility and toileting. MDS (Minimum Data Set) Annual assessment, dated 2/14/23, indicated the resident had a BIMS (Brief Interview of Mental Status) of 10 (indicated she was moderately cognitively impaired), she required physical two person assists for toileting and transfers.</p> <p>The resident had a care plan with a problem she had a diagnosis of osteoporosis and was at risk for fractures and increased weakness. The start date was 4/27/22, with a revised date of 2/17/23. The approaches included, but were not limited to, the following approaches: start date 4/27/22, assist as needed with mobility.</p> <p>The resident had a care plan with a problem she was at risk for falling related to, she required assistance with her ADL's (Activities of Daily Living), she had a history of falls with fractures, she had cognitive losses and a diagnosis osteoporosis (bones are brittle and fracture easily).</p> <p>The Emergency Room documentation, dated 5/7/23 at 11:30 a.m., indicated the resident complained of pain to her left knee at a level 8 on a pain scale of 0 to 10 with 0 being no pain and 10 being the worst pain. X-ray results of her left knee, dated 5/7/23 at 12:36 p.m., indicated she had a nondisplaced (a fracture in which the bone</p>			

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	<p>cracks or breaks, but maintains the proper alignment of the bone) left medial tibial plateau fracture. Her CT (Computerized Tomography) results, dated 5/7/23 at 1:55 p.m., indicated there was subcutaneous (fatty layer of tissue) edema particularly involving the upper calf. The impression indicated there was a medial tibial plateau fracture.</p> <p>Hospital discharge instructions, dated 5/7/23 at 3:16 p.m., indicated the resident had a visit at the ER (Emergency Room) on 5/7/23 at 11:30 p.m., and was being discharged with a diagnosis of a left medial tibial plateau (a bony surface on the top of the lower shin bone which connects with the thigh bone. It was the surface on the side corresponding to the big toe) fracture (Knee fracture). She was to keep a knee immobilizer (used to support and protect an injured and painful knee) in place until seen by the Orthopedic surgeon the following day.</p> <p>During an interview, on 5/15/23 at 2:02 p.m., CNA 1 indicated when she came in the morning of 5/6/23, the night shift CNA told her Resident B had been complaining of leg pain throughout the night. When she went to greet the resident that morning, she requested to go to the bathroom. She and CNA 2 transferred Resident B from the bed to her Broda chair and from her Broda chair to the toilet by a two-person physical assist manual lift transfer without a gait belt. While transferring the resident, she indicated the word "Ouch" while being transferred from the bed to the Broda chair and the Broda chair to the toilet. She notified the nurse the resident complained of knee pain while being transferred. When she came in the next day on 5/7/23, Resident B's left knee was swollen. She notified the nurse caring for the resident, her left knee was swollen, and she was sent out to the</p>			

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	<p>hospital.</p> <p>During an interview, on 5/15/23 at 2:10 p.m., Resident B was observed lying in bed. She indicated she fractured her lower leg when she was taken to the bathroom by two staff members. They were attempting to lift her onto the toilet from her Broda chair when her top half of her body turned, but the bottom half didn't turn, and she got a sharp pain in her lower left leg.</p> <p>A review of a typed statement, dated 5/7/23, indicated CNA 6 indicated Resident B complained of knee pain while transferring her from the bed to the Broda chair with another staff member. The nurse caring for the resident was notified.</p> <p>During an interview, on 5/15/23 at 2:45 p.m., the DON indicated when Resident B's LLE was fractured the staff was doing a two-person physical assist transfer without a gait belt, instead of using the stand-up lift as ordered by the physician and per her care plan.</p> <p>During an interview, on 5/15/23 at 3:15 p.m., PTA (Physician Therapy Assistant) 7 indicated the resident was a stand up lift instead of a two person physical manual lift because she was twisted at the top of her body from scoliosis, which made it difficult for her to turn her lower body at the same time as her upper body, she was not able to initiate movement to pivot and her body strength was poor. He had to position her so her pelvis was in position where he could ambulate her because her upper body was twisted, and it was pushing one side of her pelvis to the other side making it difficult for her to move.</p> <p>2. The record for Resident G was reviewed on</p>			

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	<p>5/15/23 at 10:30 a.m. Diagnoses included, but were not limited to, Parkinson's disease, peripheral vascular disease, muscle weakness (generalized), age-related osteoporosis without current pathological fracture, unsteadiness on feet, difficulty in walking, lack of coordination, and protein-calorie malnutrition.</p> <p>The progress notes included, but were not limited to, the following notes:</p> <p>a. On 2/9/23 at 8:10 p.m., the resident was found on the floor after yelling for help. She indicated she was pushing her wheelchair out of the bathroom, and she fell. No injuries. Her brief was very wet, so she was assisted to the toilet. Discussed with the resident about toileting every 2 hours while awake and the resident agreed it would be helpful.</p> <p>On 2/10/23 at 10:17 a.m., the Interdisciplinary Team (IDT) identified the root cause of the resident's fall while in the bathroom was her brief was soiled. The intervention for the fall was staff were to offer assistance with PM care.</p> <p>b. On 2/28/23 at 8:50 a.m., LPN 8 was called to Resident G's room by a QMA (Qualified Medication Aide). The resident was observed sitting on the floor in front of her recliner. The resident indicated she did not remember what she was doing prior to her fall, but she remembered falling and hitting her head. She had a large skin tear to the left forearm, left elbow, and a hematoma with a laceration to the back of her head. 911 was called immediately.</p> <p>On 2/28/23 at 3:56 p.m., Resident G was returned to the facility from the hospital with four staples placed to the back of her scalp due to the head laceration and she sustained a skin tear to the left</p>			

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	<p>forearm times two wounds. X-rays at the ER showed a possible fractured left radius (wrist).</p> <p>(Recorded as a late entry on 3/2/23 at 1:43 p.m.) On 3/1/23 at 9:41 p.m., IDT reviewed the resident's fall for 5/7/23, indicating the root cause of the fall was the resident was self-transferring in her room. The new intervention put into place indicated there would be a soft touch call light exchanged for the push button call light.</p> <p>On 3/6/23 at 1:57 a.m., indicated a splint remained to the left upper extremity. The skin tears to the left upper extremity were not able to be visualized due to the splint being in place. The resident continued to have staples intact to the laceration to the back of her head.</p> <p>On 3/7/23 at 1:06 p.m., IDT note indicated the resident was on an antibiotic for left forearm cellulitis with signs and symptoms of redness, swelling, tenderness, drainage, and acute functional decline.</p> <p>On 3/7/23 at 10:01 p.m., the resident continued the antibiotic prescribed by the orthopedic doctor.</p> <p>On 3/8/23 at 12:34 p.m., four staples were removed from the laceration on the back of the resident's head.</p> <p>c. On 3/29/23 at 1:47 p.m., resident was found sitting on her floor on her buttocks. Her bilateral lower extremities were straight out and even. She indicated she was reaching for an object on the floor and slid off the edge of the recliner. The immediate temporary intervention was to place a cushion to her recliner with Dycem on it.</p> <p>On 3/30/23 at 9:38 p.m., the IDT reviewed the</p>			

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	<p>resident's fall from 3/29/23. The root cause was she was reaching for an object. The intervention was to supply her with a Reacher.</p> <p>Resident G's care plans were reviewed, which included, but were not limited to, the following:</p> <p>The resident had a care plan which indicated she was at risk for falling related to she required assistance with transfers, she had diagnoses of hypertension, depression and osteoporosis and she received anxiety medications. Approaches included, but were not limited to, start date was 3/29/23-supplied with a Reacher, start date was 2/28/23-supplied with a soft touch call light, and start date 11/22/19-the staff was to assist the resident with transfers as needed.</p> <p>On 5/15/23 at 1:50 p.m., the Director of Plant Operations and the Housekeeping Supervisor were in attendance when Resident G's room was observed to be missing a soft touch call light and a Reacher. A regular call light was observed attached to the resident's recliner. The Director of Plant Operations indicated he was not told Resident G required a soft touch call light however, he was going to get her one at that time.</p> <p>During an interview, on 5/15/23 at 1:57 p.m., the Housekeeping Supervisor was in attendance during the interview. Resident G indicated she was never given a soft touch call light or a Reacher. She indicated her roommate was given the soft touch call light and the Reacher.</p> <p>During an interview, on 5/15/23 at 2:10 p.m., the DON was in attendance during the interview. When the DON asked Resident G about her Reacher and call light, she indicated to the DON she was never given a soft touch call light or</p>			

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NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
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(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>Reacher. She indicated a different call light and Reacher was given to her roommate, but not to her.</p> <p>A current policy, titled "Fall Management Program Guidelines," dated with a revised date of 3/16/22 and provided by the DON on 5/15/23 at 1:00 p.m., indicated "...Definition: A fall is considered to be: 'an unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor a fall is considered to have occurred...Should the resident experience a fall the attending nurse shall complete the 'Fall Event.' This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions...Any orders received from the physician should be noted and carried out. 5. The resident care plan should be updated to reflect any new or change in interventions...7...communicate interventions during shift report."</p> <p>A current policy, titled "Resident Transfers," with a revised date of 3/21/22 and provided by the DON on 5/15/23 at 3:45 p.m., indicated "OVERVIEW: To ensure the safety of residents and staff when performing mobility/transfer tasks. SOP DETAILS: 1. Upon admission the admitting nurse and/or therapy department shall determine</p>			

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	<p>the type of transfer device, amount of assistance required to assist with safe mobility based on assessments in the area of: a. Cognition-ability to follow simple instructions b. Weight bearing status- full, partial, toe touch, non-weight c. Resident's weight d. Upper and lower body strength. e. Trunk stability f. Skin condition g. Mobility status-supervision, limited, extensive, dependent. 2. Nurse may use Lift Evaluation to assist with determining type of lift needed. 3. Campuses determine the amount of assistance required for transfers and record this on the Admission Observation, the Care Assist profile, and the Resident Care Plan to provide communication to all staff regarding safe transfers. 4. Transfer status will be reviewed at least quarterly with Quarterly Observation and as needed."</p> <p>A current policy, titled "Comprehensive Care Plan Guideline," dated with a revised date of 12/31/22 and provided by the DON on 5/15/23 at 3:45 p.m., indicated "...To ensure appropriateness of services and communication that will meet the resident's needs, severity/satiability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident. c. Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan...Address problems that become ongoing or chronic with a new comprehensive care plan...Pertinent care plan approaches are communicated to the nursing staff per the Care Assist profile dependent on campus preference. 5. If the resident is readmitted to the campus, the previous care plan will be reviewed and updated to meet the resident's current needs...6. Comprehensive care plans need to</p>			

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

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FORM APPROVED
OMB NO. 0938-039

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	<p>remain accurate and current. a. New interventions will be added and updated during or directly following CCM meeting. b. Newly recognized problems will have a care plan developed and added after CCM meeting."</p> <p>This Federal tag relates to Complaints IN00401863 and IN00402369.</p> <p>3.1-45(a)(2)</p>				