

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000000	<p>This visit was for an Investigation of Complaints IN00150201 and IN00150256.</p> <p>Complaint IN00150201 - Substantiated. State residential deficiencies related to the allegations are cited at R214 and R216.</p> <p>Complaint IN00150256 - Substantiated. State residential deficiencies related to the allegations are cited at R064, R214 and R216.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: June 9 and 10, 2014</p> <p>Facility number: 001148 Provider number: 001148 AIM number: N/A</p> <p>Survey team: Shelly Miller- Vice, RN</p> <p>Census bed type: Residential: 69 Total: 69</p> <p>Census payor type: Other: 69</p>	R000000		

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000064	<p>Total: 69</p> <p>Sample: 4</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on June 18, 2014, by Brenda Meredith, R.N.</p> <p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on record review and interview, the facility failed to investigate the reported loss of hearing aides of a resident. (Resident B.) This affected 1 of 4 Residents sampled.</p> <p>Finding includes:</p> <p>A confidential interview was conducted with a family member indicating a reported loss of a hearing aide that had not been investigated, replaced or reimbursed. The family indicated the hearing aid was with the resident upon admission and could not be located when</p>	R000064	R064 It is the practice of this facility to exercise reasonable care for the protection of residents' property from loss and theft. Resident B no longer resides at the community. The Administrator will remind residents during the next resident council on July 21, 2014, and throughout the month of June, that any items that are lost should be reported to the Administrator and or another department head. A missing items form will be completed. The forms can be located in the Administrator's office as well as in all department head offices. This information is also located in the resident	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>discharged from the facility. The family also indicated the Administrator and Ombudsman were aware of the loss.</p> <p>An interview was conducted with the Ombudsman on 6/10/14 at 9:00 a.m., indicating the hearing aid for Resident B had been reported and a conversation had occurred with the Administrator about the loss.</p> <p>A record review was conducted, on 6/10/14 at 9:30 a.m., of Resident B's Clinical Medical Record (CMR). There was no documentation of a lost hearing aid.</p> <p>A record review of the "Resident Handbook," on 6/10/14 at 10:00 a.m., indicating, "Lost and Found.... If an item is lost, the resident should complete a Missing Items form, and submit it to the administrator so a search and investigation may be started. The forms are available in the Administrator's Office. All results of an investigation will be reported to the resident."</p> <p>An interview with the Regional Director was conducted on 6/10/14 at 10:10 a.m. The Regional Director indicated a report of loss would be recognized, and investigated according to protocol. There was not a 'Missing Items' form on file in</p>		<p>handbook. If a resident has a lost or stolen item reported to the administrator or a department head. A missing items form will be completed. The administrator will then conduct an investigation and document the findings. The findings will be shared with the resident and/or the responsible party. The documentation will be place in the resident file for review. Completion date June 30, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000145	<p>the Administrators office of a loss of a hearing aide. It was also noted a belongings inventory sheet was not required or used at this facility.</p> <p>On 6/10/14 at 10:30 a.m., a record review was conducted of the facility's "Harassment, Abuse & Neglect Policy" provided by the Regional Director. The Policy did not include Misappropriation of Property/ Funds as a definition of Abuse and Neglect. The procedure did not include the act of reporting, responding, training, identifying or protection from misappropriation.</p> <p>This State Residential tag relates to Complaint IN00150256.</p> <p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>of the residents.</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure the safety of the residents requiring a blood glucose test by not completing a quality control test as recommended by the manufacture on the multi-use glucometer prior to use. This affected 7 of 8 sampled of the 18 residents receiving blood sugar testing by the facility. (Resident A, B, C, D, F, G, and H.)</p> <p>Findings include:</p> <p>On 6/9/2014 at 1:50 p.m., LPN #8 provided a record review of the listing of resident currently receiving blood glucose monitoring by the facility.</p> <p>On 6/10/14 at 7:00 a.m., a record review was conducted of the "Medication Skills Checklist. Training element for Blood Glucose.... 4. matches strip to strip number on machine...."</p> <p>On 6/10/14 from 7:02 a.m. till 8:15 a.m., observations were conducted of LPN #8 using the multi-use glucometer by performing a finger stick on Resident's A, B, C, D, F, G, and H.</p> <p>An interview was conducted on 6/10/14 with LPN#8 at 7:35 a.m., indicating a</p>	R000145	<p>R145 It is the practice of this facility to maintain equipment and supplies in a safe and operable condition. Effective 6/16/2014, the Health Care Coordinator trained the nurses on performing the control test for the blood glucose monitor. All employees understand the procedure and documentation completed for the training. The blood glucose monitor will have a control test performed nightly and recorded on the monitoring log. The log will be kept on a clip board and stored with the blood glucose monitor. The Health Services Coordinator will monitor the log on a weekly basis for the month of June 2014, and then will review the log once a month and periodic monitoring of the nurses who use the blood glucose monitor. In addition, all new staff will be given a skills validation training to indicate that they know how to follow this procedure. The training documentation will be placed in their file for review. Completion date 6/16/2014.</p>	06/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>quality control was not conducted on the glucometer because, "... we don't have to do that" and the same glucometer unit was used on all of the residents.</p> <p>On 6/10/14 at 8:10 a.m., Resident G was finger stuck, and the glucometer reading was "350." The LPN #8 indicated to Resident G, "...that's high, are you eating... ya know, we'd better re-do that before I call the doctor...." A re-stick was conducted with a 2nd (second) reading of "375." A fast-acting insulin was administered according to Physician orders and a call was made to the prescribing medical doctor for further orders. A change in insulin was ordered by the prescribing medical doctor in response to the blood glucose test results.</p> <p>An interview was conducted with the HSC (Health Services Coordinator) on 6/10/14 at 8:20 a.m. The HSC indicated a quality control was not being performed on the glucose monitoring system. The HSC indicated the Regional Director advised, a quality control was not required because there was not a regulation for that in residential care.</p> <p>A record review was conducted of the "User Instruction Manual. [manufacture name]. Read this User Instruction manual carefully before you start testing....Using</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000214	<p>[manufacturer name] Control Solution....It is important that you carry out this simple check regularly...." The instructions for quality control of the glucometer, indicated "Note: if your control solution result continues to fall outside the required range, the system may not be working correctly. DO NOT USE [sic] system to test your blood...."</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record reviews and interviews, the facility failed to assess residents conditions as directed in the facility policy. This affected 4 of 4 resident. (Resident, B, C, D and E.)</p> <p>Findings included: A record review of the 'Admission Policy' was conducted on 6/9/14 at 1:30 p.m..</p>	R000214	R214 It is the practice of this facility to assess residents upon admission and upon a decline in condition. All residents shall be assessed upon admission, 30 days after admission, then quarterly for the length of their stay according to the procedure of the facility. The resident will also be assessed if there is a decline or improvement in their condition. Effective 6-26-14 a full audit of all resident medical	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014	
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>The policy indicated an assessment of the resident's medical need is completed upon admission and with medical changes yet not limited to this.</p> <p>A record review of the [facility name] Rental Agreement was conducted on 6/9/14 at 1:32 p.m. The agreement indicated, "... Resident's care level will be assessed at admission and thirty days(30) after admission and quarterly thereafter. Resident's care level may be re-assessed sooner if deemed necessary by the Manager, due to improvement or decline in condition...."</p> <p>An interview was conducted with the Director of Nursing/ Health Services Coordinator (HSC) on 6/10/14 at 10:41 a.m. The HSC indicated all residents and or Power of Attorneys (POA) sign the Rental Agreement upon admission to the facility and are provided an Admissions Policy for their records in the admission packet.</p> <p>On 6/10/14 at 11:00 a.m., a record review was conducted of the clinical medical records of Resident B, C, D and E alongside of the HSC for assessments. The following were indicated:</p> <p>Resident B was admitted "8/8/2011" with a diagnosis of "spinal stenosis,</p>		<p>charts was performed by the Health Services Coordinator and an LPN. Any resident found out of compliance, will be assessed to meet the procedure of the facility. The Wellness Coordinator made a schedule of resident assessments to be completed. All resident charts will be brought up to date by 6-30-14. The Wellness coordinator put a system in place to notify her on monthly basis residents who will need an assessment. Assessments are performed upon move in, and the Health Services Coordinator will add to a designated calendar, the 30 day, and quarterly assessments. The first of each month the calendar is referenced and assessments are scheduled. The administrator will also have the noted scheduled calendar and will perform periodic audits to ensure compliance. In addition, the facility has a records and documentation audit performed quarterly, and the resident assessment will become part of the audit. Completion date 6/30/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>kyphoplasty, L-1 compression Fx [fracture], GERD [gastric-esophageal-reflux- disease], macular degeneration, mild aortic vascular disease w [with] pacemaker" and discharged "3/14/14." It was indicated the quarterly assessments/ service plans were not completed.</p> <p>Resident C was admitted "8/19/09" with a diagnosis of " Depression, venous thrombosis & [sic] Embolism, hypothyroidism syncope," and discharged, "4/20/14." There was no documentation to indicate the quarterly assessments/ service plans were completed.</p> <p>Resident D was admitted "2/7/14" with diagnosis of " History of cholecystectomy, uncontrolled DM [Diabetes Mellitus]," and discharged, "5/30/14." An initial resident evaluation was completed on, "1/19/14." The Regional Director indicated this was the only assessment/evaluation completed. It was indicated the 30 day assessments/ service plans was not completed.</p> <p>Resident E was admitted "9/17/10." There were no diagnosis available on the face sheet, nor evaluation/ assessments. There was no documentation the quarterly assessments/ service plans were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014	
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
R000216	<p>completed.</p> <p>This State Residential tag relates to Complaints IN00150256 and IN00150201.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview the facility did not document weights of residents on assessments. This included</p>	R000216	R216 It is the practice of this facility to obtain a weight upon admission to the facility. Effective 6/26/2014,a full chart audit was	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014	
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>3 of 4 residents (Resident B, C and E).</p> <p>Findings included:</p> <p>On 6/10/14 at 11:00 a.m., a record review was conducted for Residents B,C and E with the HSC (Health Services Coordinator). The following was noted:</p> <p>Resident B was admitted with a diagnosis of spinal stenosis, kyphoplasty, L-1 compression Fx (fracture), GERD (gastric-esophageal-reflux- disease), macular degeneration, mild aortic vascular disease w (with) pacemaker and discharged 3/14/14. There were no weights documented on the evaluation/ assessments.</p> <p>Resident C was admitted with a diagnosis of depression, venous thrombosis & (sic) embolism, hypothyroidism syncope, and discharged on 4/20/14. There were no weights documented on the evaluation/ assessments.</p> <p>Resident E did not have a diagnosis available on the face sheet, nor evaluation/ assessments. There were no weights documented on the evaluation/ assessments.</p> <p>During the review, the HSC indicated</p>		<p>conducted by the Health Services Coordinator to determine if any other residents were without current weights. Any resident found out of compliance will have their weight taken and recorded in their record. The weight record is kept in a separate binder along with the vital signs. Resident's weight and vitals are recorded in this log on a monthly basis. A review of the policy and procedure covering Resident evaluations and documentation was completed on 6/10/2014 with all nurse staff and the Health Services Coordinator. The procedure includes; upon evaluation and assessment, a weight will be documented on the assessment. If the resident moves into the facility, a weight will be taken and documented on the "Initial Admission form", monthly weights are then completed and documented on the resident's weight and vitals record. The facility has records and documentation audits performed quarterly, and the resident evaluation and assessment, along with weight and vitals record will become part of the audit. Completion date 6/30/2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000406	<p>there were no weights recorded on the assessments.</p> <p>This State Residential tag related to Complaints IN00150256 and IN00150201.</p> <p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observations, record reviews and interviews the facility did not use a disinfectant according to the manufacturers directives on the multi-use glucometer. This affected 7 of 8 sampled of the 18 residents receiving blood sugar testing by the facility. (Resident A, B, C, D, F, G , and H.)</p> <p>Findings included:</p> <p>On 6/9/2014 at 1:50 p.m., LPN #8 provided a record review of the listing of resident currently receiving blood glucose monitoring by the facility. There were 18 residents identified by LPN #8 to be receiving blood glucose monitoring by the facility.</p> <p>On 6/10/14 at 7:00 a.m., a record review</p>	R000406	<p>R406 It is the practice of this facility to establish and maintain infection control practices. Effective 6/16/14 all nurses were trained on the proper disinfecting process for the glucometer by the Health Services Coordinator. The Process includes; monitor must be wrapped in the sani-cloth and placed on apiece of paper for three minutes. This is done immediately after doing the BS level and remains wrapped while insulin is given to assure the three minutes pass. To ensure the three minutes is met, another glucometer is used while the first one is wrapped. The nurse taking the BS alternates glucometers so one is disinfecting while the other is in use. The training was documented and placed in employee training records for review. The Health Services Coordinator will monitor and</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014	
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>was conducted of the "Medication Skills Checklist" and did not include a skill validation for cleaning the glucometer between uses.</p> <p>On 6/10/14 from 7:02 a.m. till 8:15 a.m., observations were conducted of LPN #8 performing the procedure/ skill of blood glucose monitoring using the multi-use glucometer. Resident's A, B, C, D, F, G and H were provided a blood glucose finger stick using the same glucometer. LPN#8 used a germicidal disposable wipe, "Sani-Cloth Plus," to cleanse the multi-use glucometer between each resident. A blood glucose test was provided to the resident by the LPN, the glucometer was wiped with a germicidal wipe and used on the next resident. During the observation, the following was noted:</p> <p>Resident A was glucose tested, and the glucometer was wiped with a germicidal wipe for 5 seconds, and laid to rest on the shelf for 2.23 minutes.</p> <p>Resident B was glucose tested, and the glucometer was wiped with a germicidal wipe for 10 seconds, and laid to rest on the shelf for 2:05 minutes.</p> <p>Resident D was glucose tested. The glucometer was wiped with a germicidal</p>		<p>documentthe nurses who will be using the glucometer on a weekly basis over the month of June. Any nurse found not complying with the appropriate practice, will be retrained. In addition, skills validation will be provided for all new nurses working with a glucometer to indicate they know how to properly disinfect the glucometer following the directions located on the container. Periodic monitoring will be completed and documented by the Health Services Coordinator to ensure the practice noted is being completed. An infection control practices in-service will also be provided on an annual basis. Completion date June 30, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/10/2014	
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>wipe for 5 seconds, and allowed to dry for 1 minute.</p> <p>Resident H was glucose tested. The glucometer was wiped with a germicidal wipe for 21 seconds, and allowed to dry for 2 minutes.</p> <p>Resident F was glucose tested. The glucometer was wiped with a germicidal wipe for 1:00 minute, and allowed to dry for 30 seconds.</p> <p>Resident G was glucose tested. The glucometer was wiped with a germicidal wipe for 30 seconds, and allowed to dry for 45 seconds.</p> <p>Resident C was glucose tested. The glucometer was then laid on the shelf.</p> <p>A record review was conducted alongside of LPN#8 at 8:16 a.m., of the disinfecting germicidal property directives located on the "Sani-Cloth Plus Germicidal Disposable Cloth" wipes. The following was noted: "...DEODORIZING AND DISINFECTING [sic]: To disinfectthoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipes(s) if needed to assure continuous three (3) minute wet contact time. Let air dry...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>An interview was conducted with the HSC (Health Services Coordinator) on 6/10/14 at 8:20 a.m.. The HSC indicated she was not aware of the directions for the germicidal property of the wipes being used for the glucometer.</p> <p>An interview was conducted with Regional Director on 6/10/14 at 2:45 p.m., in regards to the directions located on the germicidal wipes. The Regional Director indicated, "... the directions are right there on the container, the nurses have them with them all the time... they know what the directions are."</p>			