

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 07/30/2014
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NAME OF PROVIDER OR SUPPLIER  WOOD RIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: July 29 and 30, 2014.</p> <p>Facility Number: 001148 Provider Number: 001148 AIM Number: N/A</p> <p>Survey Team: Julie Baumgartner, RN-TC Shauna Carlson, RN Sharon Ewing, RN Pam Williams, RN</p> <p>Census bed type: Residential: 68 Total: 68</p> <p>Census payor type: Other: 68 Total: 68</p> <p>Residential sample: 7</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 5, 2014, by Brenda Meredith, R.N.</p>	R000000		
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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 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.

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R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on record review and interview, the facility failed to provide written documentation of resident rights and responsibilities acknowledgement for 2 of 7 residents reviewed for resident rights acknowledgement. (Resident #3 and Resident #4)</p> <p>Findings include:  On 7/30/14 at 11:45 A.M., the clinical</p>	R000026	<p>It is the practice of this facility to provide Resident Rights to each resident. 1. A copy of Resident rights will be given to all current residents no later than August 30,2014 in the event that this process was missed with any other residents not identified during the survey. Acknowledgment of receipt will also be given to each resident. 2. Residentrights are provided to each resident in the resident handbook. Acknowledgment of</p>	08/30/2014

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R000092	<p>record for Resident #3 was reviewed. The clinical record indicated Resident # 3 was admitted on 5-12-14 and lacked written documentation of Resident Right's Acknowledgement.</p> <p>On 7/30/14 at 12:00 P.M., the clinical record for Resident #4 was reviewed. The clinical record indicated that Resident #4 was admitted on 6-2-14 and lacked written documentation of Resident Right's Acknowledgement.</p> <p>On 7/30/14 at 2:15 P.M., an interview was conducted with the Administrator. The Administrator indicated she was unable to locate a signed acknowledgement of Resident's Rights for Resident #3 and Resident #4. She further indicated she did not know what the policy was for Resident Right's Acknowledgement or where it was located.</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p>				<p>receipt is signed by each resident that is given a resident handbook, in addition, acknowledgment is also received in the rental agreement signed by each resident upon moving into the facility 3. The Administrator or designee will check the final move in paperwork that includes resident rights. In addition, a quarterly record review is completed by an outside agency, and a request to monitor resident rights acknowledgement will be added to the list to ensure that resident rights acknowledgment is completed for each resident moving into the facility. 4. Completion date: August 30, 2014.</p>		

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	<p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on observation, interview, and record review, the facility failed to document completion of fire drills. This has the potential to affect 68 out of 68 residents.</p> <p>Findings include:</p> <p>On 7/30/14 at 9:45 A.M., review of the fire drills documentation indicated that quarterly fire drills were not performed during October 2013, November 2013, December 2013, January 2014, and February 2014. Record review further indicated that the facility failed to document coordination of fire and disaster drills with the local fire department over the last year.</p>	R000092	It is the practice of this facility to conduct fire drills monthly. 1. A fire drill with the local fire department will be completed by 9/10/2014. This is the earliest the fire department could schedule an appointment with the facility. 2. Fire drills will be completed and documented for each shift each month by the maintenance director. 3. The regional director will review the maintenance records monthly with the administrator to ensure that fire drills are being completed each month and documented. 4. Completion date: August 30, 2014.	08/30/2014

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R000147	<p>An interview with the maintenance supervisor on 7/30/14 at 10:00 A.M., indicated that fire drills are conducted monthly, "...The Administrator was responsible for documenting the fire drills until March of this year, then I began documenting them...."</p> <p>On 7/30/14 at 1:20 P.M., review of the current undated policy "Training and Fire Drills" provided by the Administrator, "... indicated that fire drills should be done quarterly on all shifts...."</p> <p>410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on observation, interview and record review, the facility failed to comply with fire and safety standards regarding storage room sprinkler clearance. This affected 2 of 3 storage areas. (Spa room and Employee Lounge).</p>	R000147	It is the practice of this facility to comply with fire and safety standards regarding storage areas. 1. The four boxes noted in the employee lounge have been removed from the floor, and the absorbent pads noted on the shelves have been removed to meet the regulations. 2. The	08/30/2014

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	<p>Findings include:</p> <p>During the Environmental tour conducted on 7/30/14 from 10:00 A.M. to 10:35 A.M., with the Maintenance Supervisor the following was observed:</p> <p>The employee lounge (also used as clean storage room) was observed having four boxes of adult diapers on floor and absorbent pads on shelves stacked up to and touching ceiling.</p> <p>The Spa room (which is used as a storage room) was observed to have a tote in the back corner 8 inches from the ceiling. The room was full, from wall to wall, with totes, boxes, mattresses, headboard, leaving no open pathway across the floor.</p> <p>During an interview with the Maintenance Supervisor at this time, the Maintenance Supervisor indicated that items should be at least 18 inches from the ceiling and 6 inches off the floor "...Everything in the spa room belongs to activities...."</p> <p>An interview with the Activities Director on 7/30/14 at 10:37 A.M., indicated that items should be off the floor and 6 inches from the ceiling.</p> <p>An interview with the Administrator on</p>		<p>sparoom – the tote noted in the back corner was removed to meet the regulations. The spa room is in the process of being cleaned out by the maintenance director so that an open pathway across the floor will be provided to meet the regulations. 3. All other areas of the facility that contain storage will be looked over to ensure compliance. Any areas found out of compliance will be cleaned and organized to meet the standards. 3. A safety review will be conducted each month by the maintenance director and this review will be given to the administrator for review. Any trends or patterns of deficient practice will be monitored by the administrator and corrective action designated by the administrator. 4.Completion date: August 30, 2014.</p>				

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R000154	<p>7/30/14 at 2:00 P.M., indicated she did not have a policy for proper storage of supplies.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure serving area were kept clean and sanitary. This deficient practice had the potential to affect all resident's of the facility.</p> <p>Findings include:</p> <p>On 7/29/14 at 10:45 A.M., a kitchen tour was conducted with the Certified Dietary Manager. The following were observed on the tour of the kitchen:</p> <p>Observation of the floor in the serving area indicated dark colored stains that covered the perimeter of the service area where the floor met the wall.</p> <p>Observation of the blue serving cabinet a large square shaped stain on the top of</p>	R000154	<p>It is the practice of this facility to comply with sanitation and safety standards. 1. Effective 7/29/2014 the floor in the serving area was cleaned. The cabinet that was noted to have a stain and peeling apart with the particle board will be either removed or replaced no later than August 30, 2014. 2. The drain cover for the ice machine was cleaned on 7/29/2014, and a new water filter was replaced 8/1/2014. Cleaning of the ice machine will be completed weekly, and the ice machine will be delimed monthly. The cleaning log for the cleaning and deliming of the ice machine, will be made available in the kitchen for review at all times. 3. The dietary manager will monitor the cleaning logs weekly and will review with the administrator monthly. Any trends of patterns of deficient</p>	08/30/2014

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	<p>the counter and the Formica on the side of the counter that is adjacent to the white stove is peeling apart with the particle board showing.</p> <p>Observation of the ice machine indicated a brown substance was surrounding the drain cover.</p> <p>In an interview during the tour, the Certified Dietary Manager indicated the ice machine was cleaned twice a month but there was lime build up around the drain plate.</p> <p>On 7/30/14 at 2:07 P.M., interview with Certified Dietary Manager indicated the ice machine is the main source of ice for the facility. It is supposed to be cleaned twice a month with delimer as needed. The Certified Dietary Manager indicated she did not know when the last time the ice machine had been cleaned.</p> <p>On 7/30/14 at 2:45 P.M., an interview was conducted with the Administrator. The Administrator indicated she thought the ice machine was cleaned twice a week. She further indicated the cleaning logs were in the Certified Dietary Managers office and she was not in the facility at the time of the interview.</p>		<p>practice will be monitored by the administrator and corrected by the dietary manager or designee. Completion date: August 30, 2014.</p>	

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R000192	<p>410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet.</p> <p>Based on observation and interview, the facility failed to ensure the janitor's closet door was closed in the kitchen. This deficient practice affect 1 of 1 kitchen's in the facility.</p> <p>Findings include:</p> <p>On 7/29/14 at 10:45 A.M., while touring the kitchen with the Certified Dietary Manager an observation was made of the janitor closet. The closet door was observed to be open at that time with chemicals stored on the shelves of the closet.</p> <p>An interview was conducted with the Certified Dietary Manager at the time of the tour. The Certified Dietary Manager indicated they (staff) do not keep the door open at all times because there was a sign on the front of the door that indicated the door should be closed at all times.</p>	R000192	<p>It is the practice of this facility to comply with physical plant standards 1. The janitor's closet located in the kitchen has been closed and locked to meet the regulations. A sign is posted on the closet door as a reminder that the door must remain closed and locked at all times. 2. All kitchen staff will be given instructions on the regulations by the dietary manager. 3. A kitchen sanitation review completed monthly by the dietary manager will include checking the janitor's closet to ensure compliance. 4. Completion date: August 30, 2014.</p>	08/30/2014

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R000273	<p>On 7/30/14 at 3:36 P.M., an interview was conducted with the Administrator and the Maintenance Director. The Administrator and the Maintenance Director both indicated there was no policy regarding the janitor's closet.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to serve food to resident's using proper sanitary techniques and proper hand washing. This had the potential to affect 46 out of 68 residents who ate lunch in the dining room.</p> <p>Findings include:</p> <p>On 7/29/14 at 12:07 P.M., Employee #6 was observed serving nine bowls of beef and noodle soup to resident with his thumb on the inside the bowl each time.</p> <p>On 7/29/14 at 12:12 P.M., Employee #5 was observed carrying a serving tray into the dinning room, with six plates of cheeseburgers and french fries on it. One of the plates was sitting in the middle of the other five plates with the bottom of</p>	R000273	<p>It is the practice of this facility to maintain sanitation and food handling standards 1. Employees# 5,6,8,9, and 10 were all given instructions as to what was discovered and why it was noted by the state surveyor on July 30, 2014. 2. The dietary manger is designated to observe the dining services area on a regular basis, to ensure that sanitation and food handling standards are being met. Atany time the standard is not being met, the dietary manager will retrain the employee (s). 3. August 26, 2014 and in-service will be given to allstaff by the dietitian, covering Sanitation Safety, Proper Hand Washing, and the right way to serve. 4. A review will be completed monthly covering sanitation and food handling practices by a designated employee. This review will be given to the</p>	08/30/2014

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	<p>the plate resting on the french fries of the surrounding plates. She was then observed serving those six plates of food with her thumb on the inside edge of plate.</p> <p>On 7/29/14 at 12:13 P.M., Employee #6 was observed serving 4 residents food with his fingers touching the top of the soup bowls. Employee #6 did not wash his hands before serving the next set of residents.</p> <p>On 7/29/14 at 12:15 P.M., an observation was made of Employee #5 standing in front of the serving area of the kitchen. Employee #5 received a plate of food and then proceeded to place it on a red serving tray. Employee #5 then answered her cell phone while leaning over the red serving tray. Employee #5 finished her call and went to the sink and washed her hands for 6 seconds. Employee #5 then picked up the serving tray and proceeded to serve residents with her thumbs on the side of the plate.</p> <p>On 7/29/14 at 12:16 P.M., Employee #8 was observed serving a resident a lunch plate then pushed up her glasses then continued serving lunch plates to residents without washing her hands.</p> <p>On 7/29/14 at 12:18 P.M., Employee #5</p>		<p>administrator for review. Any trends or patterns of deficient practice will be monitored and the administrator will designate an employee to correct the deficient practice. Completion date: August 30, 2014.</p>	

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	<p>was observed washing her hands for 13 seconds then served coffee to residents from a carafe with no lid on it. Employee #5 was further observed carrying the coffee carafe down at her side in between serving coffee to the residents.</p> <p>On 7/29/14 at 12:23 P.M., Employee #9 was observed washing her hands for 8 seconds then assisted residents with their lunch.</p> <p>On 7/29/14 at 12:25 P.M., Employee #10 was observed with a red large serving tray that contained 7 plates of food. One of those plates was in the center of the tray and touched the food on the surrounding plates. Employee #10 was observed serving a resident her food and then picking up a pad and writing on the pad. Employee #10 then placed the pad on the red serving tray and began serving the next resident. She did not wash her hands before proceeding to the next resident.</p> <p>On 7/29/14 at 12:27 P.M., Employee #10 was observed carrying a serving tray with resident lunch plates on it into the dining room then serving a resident a plate of french fries with her thumb on the inside of the plate, she then served another resident a cheeseburger and french fries with her thumb on the inside of the plate.</p>			

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	<p>On 7/29/14 at 12:30 P.M., Employee #8 was observed wiping up a spill on the floor in the kitchen serving area with a paper towel, threw the paper towel away she then walked to the kitchen serving window, picked up the top bun off a cheeseburger that was sitting in the serving window with her bare hand put mustard on the bun placed the bun back on the cheeseburger and served it to a resident.</p> <p>On 7/29/14 at 12:31 P.M., Employee #5 was observed with a red large serving tray that contained 7 plates of food. One of those plates was in the center of the tray and touched the surrounding plates and food on the surrounding plates. Employee #5 was observed serving the plates of food to 7 residents with her thumbs on the plate touching the food. She did not wash her hands in between serving the residents.</p> <p>On 7/30/14 at 1:50P.M., a review of the current but undated policy "Proper Handwashing" provided by the Administrator at this time, indicated "...employees shall clean their hands at the following times...E. After handing soiled equipment or utensils...I. After engaging in other activities that contaminate the hands...rubbing together</p>			

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(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
R000354	<p>the surfaces of hands and arms for 20 seconds...."</p> <p>On 7/30/14 at 2:30 P.M., a review of the current, but undated, policy "Food Preparation and Serving Procedures" provided by the Administrator indicated "...food will be prepared, transported and served with the least possible manual contact, with suitable utensils...."</p> <p>An interview with the Administrator on 7/30/14 at 3:53 P.M., indicated food should not be handled with bare hands and hands should be washed after cleaning up a spill.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and</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 07/30/2014	
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	<p>(E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to give TB (tuberculin) testing upon admission to 2 or 7 residents reviewed. (Resident #2 and #3)</p> <p>Findings include:</p> <p>On 7-29-2014 at 1:00 P.M., clinical record review of Resident #2 indicated no 2-step TB testing was administered on admission. A clinical document titled "TB Screening/Risk Assessment" from Resident #2's stay at previous facility, dated 1-3-14, indicated a TB test was administered on 1-3-2014. There was documentation to indicate a "Read date or Result."</p> <p>On 7-29-2014 at 1:18 P.M., an interview with the DON (Director of Nursing) indicated, "...it doesn't look like they did a TB test when he was admitted...I don't know where to look [for one]...."</p> <p>On 7-30-2014 at 12:00 P.M., clinical record review of Resident #3 indicated no 2nd step in the 2-step TB testing was administered after admission.</p> <p>On 7-30-2014 at 12:10 P.M., an interview with the DON indicated, "...he</p>	R000354	<p>It is the practice of this facility to maintain clinical records, including TB testing. 1. Resident# 2 and resident # 3 will have a TB test completed to meet the regulations 2. A record review of residents will be completed by the facility nurse or designee, no later than August 30, 2014 any residents found to not have a current or a TBtest completed upon moving into the facility, will be given a TB test to include the 2 step test to meet the regulations. Documentation will be completed for review. 3. Upon a resident moving into the facility, the TB record will be reviewed. If a resident needs a TB test, this will be completed by giving the TB test, reading the TB test, and documenting the results. Resident records will be kept in file for review. 4. The administrator or designee will review each resident record upon moving into the facility to monitor TB testing to meet the regulations. Completion date: August 30, 2014.</p>	08/30/2014			

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	[Resident #3] did not have a 2nd step TB test done...I think he [Resident #3] should have [had a second TB test]...."				