

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE AT EDISON LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 1409 E DAY ROAD MISHAWAKA, IN 46545
---	---

(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
R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194998.</p> <p>Complaint IN00194998 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated finding is cited.</p> <p>Survey dates: March 30, 31 and April 1, 2016.</p> <p>Facility number: 013236 Provider number: 013236 AIM number: N/A</p> <p>Residential Census: 52</p> <p>Sample: 3</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 14454 on April 4, 2016.</p>	R 0000		

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 <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE AT EDISON LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 1409 E DAY ROAD MISHAWAKA, IN 46545			
(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			
R 0349 Bldg. 00	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to maintain clinical records that were readily accessible and complete for 1 of 3 records reviewed. (Resident #D)</p> <p>Finding includes:</p> <p>During an interview on 3-30-16 at 12:00 P.M., the ED (Executive Director) indicated "... Resident D's chart is locked up in the DON's [Director of Nurses] office and we don't know where the extra key is ... we are waiting on a call back from her to find out where the key is...."</p> <p>During an interview on 3-31-16 8:44 A.M., the ED indicated "...we cannot find the clinical chart for Resident #D...we have the administrative file, but not the clinical file...the DON, who is out of the country on vacation, made copies of parts of the chart for the family, but we do not know where she has put the chart ...we</p>	R 0349	<p>North Woods Village at Edison Lakessubmits this Plan of Correction ("POC") in accordance with specific regulatoryrequirements. It shall not be construed as an admission of any allegeddeficiency cited. The Provider submits this POC with the intention thatit be inadmissible by any third party in any civil or criminal action againstthe Provider or any employee, agent, officer, director, or shareholder of theProvider. The Provider hereby reserves the right to challenge thefindings of this survey if at any time the Provider determines that thedisputed findings: (1) are relied upon to adversely influence or serve asa basis, in any way, for the selection and/or imposition of future remedies, orfor any increase in future remedies, whether such remedies are imposed by thestate of or any other entity; or (2) serve, in any way, to facilitate orpromote action by any third party against the Provider. Any changes toProvider policy or procedures should be considered to be subsequent remedialmeasures as that concept</p>	05/09/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE AT EDISON LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 1409 E DAY ROAD MISHAWAKA, IN 46545			
(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>are having the family fax back the copies we sent them...."</p> <p>On 3-31-16 at 9:30 A.M., the ED provided nursing notes dated 12-7-15 through 1-21-16.</p> <p>On 3-31-16 at 10:00 A.M., the ADON (Assistant Director of Nursing) provided the clinical chart for Resident #D which did not include any nurses notes. The ADON indicated "... I don't know where the nurses notes are"</p> <p>Clinical record review for Resident #D on 3-31-16 at 10:10 A.M., indicated that the form titled "Nurse Admission Record," dated 8-6-15, was not complete or signed.</p> <p>During an interview on 3-31-16 at 10:45 A.M., the ADON indicated " ... no the Nursing Admission Record is not completed but it should be...."</p> <p>During an interview on 3-31-16 at 12:12 P.M., the ED indicated "... it's common sense ... I expect nurses to complete paper work and sign it off...."</p> <p>On 4-1-16 at 9:00 A.M., the ED provided nurses notes from 8-8-15 through 11-26-15.</p>		<p>is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p> <p>Resident D expired back in January 2016. The clinical record was removed from the active files in the nurse's station to be converted to electronic storage for longer term retention. Resident D's clinical record was subsequently located and provided to the surveyor during the survey. Once the record was located, it was observed that one of Resident D's re-admission nurse's record was completed but not signed.</p> <p>In the future all current and former resident clinical records will be organized so that they are readily accessible when needed. In addition, a resident admission checklist was implemented in March 2016. An audit of all admissions since March of 2016 will be completed to ensure all admission or re-admission forms are signed. The Director of Health and Wellness or designee will audit the admission checklist for completeness within 72 hours of an admission.</p> <p>The Director of Health and Wellness will re-educate the nursing staff on admission documentation compliance. On an ongoing basis, the Director of Health and Wellness will review compliance with the admission checklist and ensure forms are being filled out completed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE AT EDISON LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 1409 E DAY ROAD MISHAWAKA, IN 46545
---	---

(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>On 4-1-16 at 9:30 A.M., the ADON provided nurses notes for Resident #D for 4-9-15 through 8-7-15. She indicated at this time that "...I found them on the shelf in the nurses office..."</p> <p>On 3-31-16 at 9:00 A.M., the ED provided the policy titled "Admission /Discharge Criteria," dated 7-1-15, and indicated it was the current facility policy. The policy did not indicate that forms should be completely filled out and signed.</p>		<p>andsigned. Any discrepancies will be addressed with staff and also communicated tothe Executive Director on a monthly basis for ongoing quality assurance.</p>	