

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 07/10/2012	
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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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: 7/9-10/12</p> <p>Facility number: 001148 Provider number: 001148 AIM number: N/A</p> <p>Survey team: Ellen Ruppel, RN</p> <p>Census bed type: Residential: 62 Total: 62</p> <p>Census payor type: Other: 62 Total: 62</p> <p>Residential sample: 7</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 11, 2012 by Bev Faulkner, RN</p>			R0000			

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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R0036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on observation, interviews and record review, the facility failed to notify the physician when 1 resident in a sample of 7 had laboratory test results which were at a critical level. Resident #74</p> <p>Findings include:</p> <p>Resident #74 was observed walking throughout the facility on 7/10/12, prior to breakfast and was interviewed on 7/10/12 at 8:05 a.m. She indicated she thought the care at the facility was adequate, but wanted to move to an independent living situation when possible.</p> <p>The clinical record of Resident #74 was reviewed on 7/10/12 at 1:00 p.m., and indicated the resident had been admitted to the facility 11/5/11, with diagnoses including, but not limited to: kidney transplant, borderline personality, and neoplasm of the pituitary and</p>	R0036	<p>410 IAC 16.2-5-1.2 Resident Rights 1. Effective 7-10-12 resident #74 physician was notified of critical lab. 2. Effective the week of 7-17-12, Health Services Coordinator audited charts to ensure any critical labs were reported to physicians. None found out of compliance. The nurse will monitor labs two times per week for three months and then on a monthly basis thereafter. 3. In-service conducted with all health services staff by Health Services Coordinator (LPN) on 7-18-12 on physician notification of lab results and proper documentation in nurse's notes. 4. Health Services Coordinator will continue to review all labs, this review will ensure that the nurses follow the process developed by the facility of notifying the physicians timely of critical labs. The process includes: nurse on duty will call physician to notify of critical labs as soon as Wood Ridge is notified by the lab. If ordering</p>	08/10/2012			

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	<p>craniopharyngeal duct.</p> <p>Review of laboratory tests, reported to the facility on 5/29/12 as a critical glucose levels of 47 on 5/29/12 and a critical level on 6/16/12 of 51 had been faxed to the physician, not called.</p> <p>The laboratory sheet indicated the level on 5/29/12 had been faxed on 5/29/12, with no indication of the physician response.</p> <p>The laboratory sheet indicated the level on 6/16/12 had not been faxed until 6/22/12 (six days after the critical level).</p> <p>During an interview with the Health Services Coordinator, on 7/10/12 at 2:30 p.m., she indicated the test results should have been called to the physician immediately when the facility knew they were in the critical levels.</p>		<p>physician is unavailable, nurse will call on-call physician for ordering physician to report results. The Health Services Coordinator will monitor all labs for critical values two times per week for the next three months, then monthly after that. Any trends or patterns will be reported to the Administrator. 5.</p> <p>Completion Date: 8-10-12</p>				

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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interviews, the facility failed to maintain the ice machine, light covers, cabinets, ceramic tile and weather stripping on the doors in good repair.</p> <p>Findings include:</p> <p>1. During the kitchen tour on 7/9/12 at 8:40 a.m., the ice machine was observed to be leaking water onto the floor in front of the machine. The machine was located in an alcove area in front of the main kitchen where residents could obtain ice from the machine.</p> <p>When queried about the ice machine, the Dietary Manager indicated sometimes the</p>	R0148	<p>410 IAC 16.2.5-1 Sanitation and Safety 1. Effective 7-11-12, the machine was cleaned and serviced to eliminate the findings noted. A regular maintenance and cleaning schedule was established. Due to the nature of the findings of the coffee/ice machine area that includes missing ceramic tiles and gaps, we are receiving bids to have this area repaired to meet the standards of sanitation and safety. Completion date 8-10-12. Effective 7-10-12, the missing lens was replaced providing protection from potential glass on food items. Effective 7-11-12, the exit doors on both hallways have repaired weather stripping eliminating gaps. Due to the nature of the patio doors, repair</p>	08/10/2012			

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	<p>drainage tube did not drain directly into the drain and water would run out onto the floor. The water puddle was where anyone walking up to the machine could slip.</p> <p>The cover of the ice machine was removed and the ice making area above the ice hopper was observed to be coated with rust, white flaky mineral substances and greenish-brown material which was slippery to touch. The Dietary Manager indicated the machine was leased and needed repair.</p> <p>The Administrator was queried about the substances in the ice machine at 11:15 a.m., on 7/9/12, and she indicated the machine would be fixed or replaced. She also indicated the facility would be using bagged ice obtained from an outside source until the machine was repaired or replaced.</p> <p>2. During the observation of the resident coffee/ice machine area on 7/9/12 at 8:50 a.m., the ceramic tile at the bottom of the area around the ice machine was broken and sharp to touch. The area at the base of the coffee maker cupboard was missing all but two tiles, leaving dark, debris covered gaps at the floor/wall angles. The cabinet next to the resident accessible coffee/ice area was deteriorated and</p>		<p>scheduled to be completed no later than 8-10-12. 2. Dining Services Coordinator reviewed other sanitation and safety areas to ensure no other areas are out of compliance. A training inservice will be provided to all dining services staff regarding sanitation and safety measures. All weather stripping on all doors will be reviewed to ensure no other gaps appear under doors. 3. Safety Committee will review sanitation and safety on a monthly basis to ensure compliance. 4. Safety Committee will report to Administrator any trends or patterns for review. Administrator will follow up on any areas of concern. 5. Completion Date: 8-10-12</p>				

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	<p>flaking at the bottom, leaving wood particles on the floor.</p> <p>3. Observation of the food storage area on 7/9/12 at 8:45 a.m., indicated the cover from the two bulb fluorescent light fixture in the area was missing, leaving the bulbs with no protection from glass chips falling onto the stored food items if the bulb broke.</p> <p>4. During the environmental tour on 7/9/12 at 2:10 p.m., with the Maintenance Director, the doors at the patio entrance next to the main dining room and the exit doors on both hallways were observed to have weather stripping missing or torn. The gap between the doors and floor was large enough to see daylight through and when measured, the patio door gap was 1/2 inch, enough for pests to enter the facility.</p>						

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R0242	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense</p> <p>(2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on record review and interviews, the facility failed to notify the physician of potential side effects of an anti-diabetic medication when laboratory test results were within critical levels for 1 of 7 residents, whose records were reviewed. Residents #35 and #74.</p> <p>Findings include:</p> <p>The clinical record of Resident #35 was reviewed, on 7/10/12 at 8:30 a.m., and indicated the resident had been admitted to the facility on 3/26/10 with diagnoses including, but not limited to: diabetes, polycythemia, and stage four kidney disease.</p> <p>The record indicated Resident #35 had been seen at the physician's office, on 5/22/12, and the physician had noted the resident was receiving glyburide 2.5 mg daily for diabetes. The physician ordered a basic metabolic panel to be done at the resident's earliest convenience. The physician had not ordered glucometer</p>	R0242	<p>410 IAC 16.2-5-1.2 Resident Rights</p> <ol style="list-style-type: none"> Effective 7-10-12 resident #35 physician was notified of critical lab. Effective the week of 7-17-12, Health Services Coordinator audited charts to ensure any critical labs were reported to physicians. None found out of compliance. The nurse will monitor labs two times per week for three months and then on a monthly basis thereafter. In-service conducted with all health services staff by Health Services Coordinator (LPN) on 7-18-12 on physician notification of lab results and proper documentation in nurse's notes. Health Services Coordinator will continue to review all labs, this review will ensure that the nurses follow the process developed by the facility of notifying the physicians timely of critical labs. The process includes: nurse on duty will call physician to notify of critical labs as soon as Wood Ridge is notified by the lab. If ordering physician is unavailable, nurse will call on-call 	08/10/2012

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	<p>checks to be done by the facility.</p> <p>The laboratory test indicated the blood had been drawn on 5/25/12 at 6:57 a.m., and reported 5/26/12. The test report indicated the resident's blood glucose level was critical at 53 mg/dl (milligrams per deciliter) with the normal level being 64-105.</p> <p>Review of nurses notes indicated no notations for the month of May 2012. The laboratory report sheet was initialed as being faxed to the physician on 5/31/12, five days after the critical level.</p> <p>Interview with LPN# 1 on 7/10/12 at 12:10 p.m., indicated she had just begun the position of Health Services Coordinator (HSC) and was unaware of the critical blood glucose level. She indicated the physician should have been called, not faxed of the report, at the time.</p> <p>On 7/10/12 at 2:30 p.m., the HSC indicated she had called the physician, on 7/10/12, to discuss the previous low blood glucose levels and he had discontinued the resident's glyburide and ordered weekly blood glucometer tests.</p>		<p>physician for ordering physician to report results. The Health Services Coordinator will monitor all labs for critical values two times per week for the next three months, then monthly after that. Any trends or patterns will be reported to the Administrator.</p> <p>5. Completion Date: 8-10-12</p>				