STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE VILLAGE	17650 GENERATIONS DR, SOUTH BEND, , 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00390968 Complaint IN00390968 - Substantiated. State Residential Findings related to the allegations are cited at R090 and R145. Survey date: September 26, 2022 Facility number: 001148 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/29/22.	R 0000	This statement of corrections is prepared and submitted solely because of requirements under state and federal laws. We cordially request a review of this Plan of Correction regarding the alleged deficiencies in lieu of any revisit. Completion date 9/27/2022	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	Corrective Action: All 3 residents are in Infection Control precautions and in isolation procedures. They did not exhibit and adverse difficulties, or any health decline. Will continue to monitor.	09/27/2022

	for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that		Reportable submitted 9/27/2022 Incident Number 124. for Compliant IN00390968 R_0090 and R_0145. Event JOJC11 How to Identify other residents affected by deficient practice: All residents have the potential to be affected by deficient practice. Administrator was educated by State Surveyor on reportable policy. Administrator has policy for Indiana State Department of Health. Division of Long Term Care. Reportable Incidents Policy and ISDH Reportable Unusual Occurrence Policy. Policy reviewed by Administrator and implemented. Measures to ensure deficient practice does not recur: Administrator will review reportable during morning meetings and discuss possible reportable occurrences with department heads during morning meetings. Remain diligent with what is reportable and report if unsure anyway. Quality assurance program in place: Administrator or designee will discuss reportable during morning meetings and be educated on policy for examples of reportable incident to ISDH. Results of reportable will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance.	

	indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, record review and interviews the facility failed to ensure the administrator reported a COVID infection outbreak and the lack of functioning elevators to the division of long term care within 24 hours of becoming aware of the unusual occurrences. Findings include: 1.During an interview with the Administrator, conducted on 9/26/2022 at 11:00 A.M., he indicated both facility elevators were not functioning from 9/19/2022 through the morning of 9/24/2022. He indicated he did not inform the Department of			

	Health or any other entity as he did not consider the occurrence one that required reporting. 2.During the initial tour of the facility, conducted on 9/26/2022 between 9:45 A.M. - 10:15 A.M., there were three separate rooms on the second level noted with "Red Zone" isolation signs on the apartment doors and three drawer plastic carts with Personal Protection Requirement in them noted in he hallway outside the apartment doors. During an interview with the Marketing and Sales Director, on 9/26/2022 at 10:00 A.M., she indicated she knew some of the residents had a COVID infection last week but she was not sure of their status currently. During an interview with the Director of Nursing, conducted on 9/26/2022 at 11:10 A.M., he confirmed there were 7 residents who had tested positive for COVID 19 on 9/17/2022. During an interview with the Administrator, conducted on 9/26/2022 at 11:15 A.M. he indicated he had not reported the COVID 19 infections to the Department of Health as he did not realize it was required. Reviewed with the Administrator, on 9/26/2022 at 11:00 A.M., the Indiana State			

	Department of Health - Division of Long Term Care Reportable Incident Policy and ISDH (Indiana State Department of Health) Unusual Occurrence Policy, utilized by the facility as their policy, indicated the following was included in the portion of the policy addressing residential care facilities: "...B. Types of Incidents reportable under Residential State rules 1. Occurrence that directly threatens the welfare, safety, or health of a resident, including:...k. Utility interruption of more than four (4) hours in length in one or more major utilities to the facility...2. Epidemic Outbreaks - At least 3 residents with the same infection in one defined areas (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48 hour period or 10% or more of the current building census with the same infection...." This State Residential finding relates to Complaint IN00390968. Based on observation, record review and interviews the facility failed to ensure the administrator reported a COVID infection outbreak and the lack of functioning elevators to the division of long term care within 24 hours of becoming aware of the unusual occurrences.			

	Findings include: 1.During an interview with the Administrator, conducted on 9/26/2022 at 11:00 A.M., he indicated both facility elevators were not functioning from 9/19/2022 through the morning of 9/24/2022. He indicated he did not inform the Department of Health or any other entity as he did not consider the occurrence one that required reporting. 2.During the initial tour of the facility, conducted on 9/26/2022 between 9:45 A.M. - 10:15 A.M., there were three separate rooms on the second level noted with "Red Zone" isolation signs on the apartment doors and three drawer plastic carts with Personal Protection Requirement in them noted in he hallway outside the apartment doors. During an interview with the Marketing and Sales Director, on 9/26/2022 at 10:00 A.M., she indicated she knew some of the residents had a COVID infection last week but she was not sure of their status currently. During an interview with the Director of Nursing, conducted on 9/26/2022 at 11:10 A.M., he confirmed there were 7 residents who had tested positive for COVID 19 on 9/17/2022. During an interview with the			

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R 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, record review and interviews, the facility failed to ensure two of two elevators in the facility were maintained in a safe, functional manner. This potentially affected 31 of 51 residents who resided on the second floor of the facility. Finding includes: During the initial tour of the facility, conducted on 9/26/2022 at 10:15 A.M., one of two elevators (Elevator B) in the facility was noted to have an "Out of Order" sign on the doors and was not functioning. Elevator A had a taped second floor button, but was functioning. During an interview with the Marketing/Sales Director, conducted on 9/26/2022 at 10:15 A.M., she indicated Elevator B had not been functioning for several months as the "pit" needed cleaned before it could be repaired. She indicated she had heard the "pit" was to be	R 0145	What corrective actions will be taken: Reportable submitted Incident Number 125 September 27, 2022 for Event JOJC11 Compliant IN 00390968. R_0090, R_0145. Contacted OTIS Elevator September 19, 2022 to expedite repair. On September 21, 2022 Administrator spoke with local Fire Marshall, spoke with Department of Homeland Security Chief Inspector of Elevators and Amusement Mr. Thomas Hendricks. He suggested there is no statue that states the elevator has to be working but it is a local code for building that could require that, his advise was pressure OTIS Elevator to give repair the highest priority as Fire Marshall was involved. How facility will identify other residents: All residents have the potential to be affected by deficient practice. Elevator repair was made September 24, 2022 at 11:00 am Saturday morning. What measures will be put in place or systemic changes to ensure that the deficient practice does not recur. Getting second elevator repaired this October 2022 so we will have two elevators in operation, if one elevator stops working we will have a second elevator still in operation. Looking into mounting electric chair in stairwell if possible. What Quality Assurance program put into place: Compliance with	09/27/2022

	cleaned this week. She indicated Elevator A had not been functioning the previous week. She indicated meals were taken upstairs to the residents and if a resident needed to come to the main floor, they were assisted by the aides. She did not have any specific information regarding the exact times Elevator A had not been functioning. There were 31 residents noted to reside on the second floor of the facility and 12 of the 31 were not ambulatory. Ten additional residents required the use of a walker and/or cane to ambulate. During an interview with the Administrator, conducted on 9/26/2022 at 11:00 A.M., he confirmed Elevator B had not been functioning for "sometime." Elevator A was now functioning but had been "broke down" for most of the previous week. A timeline was requested. Review of the documentation regarding the elevators indicated Elevator A had been functioning properly with an occasional temporary (less than a half day) mechanical problem that was resolved in less than a half days time until last Monday, 9/19/2022 at around 10:00 A.M. The Elevator repair/maintenance company was notified immediately and a technician came and discovered an "overload switch" had burnt out. The repair technician		state inspection for Department of Homeland Security, Remain in contact with OTIS Elevator for any elevator concerns, inspections, or repairs. Annual and or 6 months inspections of Elevator by OTIS Elevator for preventive maintenance. Discuss elevators in QA quarterly to be adapted or adjusted as needed to maintain compliance.	

indicated a new part had to be ordered and shipped to them as he could not locate the needed part from any local vendors and removing the needed part from the nonfunctioning elevator was not allowed. The facility checked with the Elevator company on 9/20/2022 - 9/22/2022 and the part was still in the process of being shipped and had not been received.

The Fire Marshall arrived to the facility on 9/22/2022 and demanded the facility fix the elevator immediately. The elevator part was received by the repair company on Friday evening, 9/23/2022 and the repair company arrived and fixed Elevator A on Saturday morning, 9/24/2022 around 10:00 A.M.

Documentation regarding repairing Elevator B indicated the Elevator repair company would not assess and/or complete repairs until the "pit" underneath the elevator was cleaned of excess oil. The facility indicated they were having trouble securing a third party vendor to complete the cleaning but had finally found a company to clean the "pit" on 9/28/2022.

The documentation indicated the following: "...It is our desire and commitment to resolving these issues and have both

elevators operational in case one goes down we have a back up. (sic) Staff have been trained in proper lifting procedures as CNA's not to use your back. (sic) We use several staff members to assist residents up and down stairs as needed, we have had no injuries to this date or even close calls...."

When the Administrator was queried regarding the expired operating permit located in Elevator A, he provided documentation from the Elevator inspection company indicating the required inspection had been completed on 3/2022 and instructions on how to retrieve the renewed permit had been sent to the Administrator.

This State Residential finding relates to Complaint IN00390968.

Based on observation, record review and interviews, the facility failed to ensure two of two elevators in the facility were maintained in a safe, functional manner. This potentially affected 31 of 51 residents who resided on the second floor of the facility.

Finding includes:

During the initial tour of the facility, conducted on 9/26/2022 at 10:15 A.M., one of two elevators (Elevator B) in the

facility was noted to have an "Out of Order" sign on the doors and was not functioning. Elevator A had a taped second floor button, but was functioning. During an interview with the Marketing/Sales Director, conducted on 9/26/2022 at 10:15 A.M., she indicated Elevator B had not been functioning for several months as the "pit" needed cleaned before it could be repaired. She indicated she had heard the "pit" was to be cleaned this week. She indicated Elevator A had not been functioning the previous week. She indicated meals were taken upstairs to the residents and if a resident needed to come to the main floor, they were assisted by the aides. She did not have any specific information regarding the exact times Elevator A had not been functioning. There were 31 residents noted to reside on the second floor of the facility and 12 of the 31 were not ambulatory. Ten additional residents required the use of a walker and/or cane to ambulate.

During an interview with the Administrator, conducted on 9/26/2022 at 11:00 A.M., he confirmed Elevator B had not been functioning for "sometime." Elevator A was now functioning but had been "broke down" for most of the previous week. A timeline was requested. Review

of the documentation regarding the elevators indicated Elevator A had been functioning properly with an occasional temporary (less than a half day) mechanical problem that was resolved in less than a half days time until last Monday, 9/19/2022 at around 10:00 A.M. The Elevator repair/maintenance company was notified immediately and a technician came and discovered an "overload switch" had burnt out. The repair technician indicated a new part had to be ordered and shipped to them as he could not locate the needed part from any local vendors and removing the needed part from the nonfunctioning elevator was not allowed. The facility checked with the Elevator company on 9/20/2022 - 9/22/2022 and the part was still in the process of being shipped and had not been received.

The Fire Marshall arrived to the facility on 9/22/2022 and demanded the facility fix the elevator immediately. The elevator part was received by the repair company on Friday evening, 9/23/2022 and the repair company arrived and fixed Elevator A on Saturday morning, 9/24/2022 around 10:00 A.M.

Documentation regarding repairing Elevator B indicated the Elevator repair company

would not assess and/or complete repairs until the "pit" underneath the elevator was cleaned of excess oil. The facility indicated they were having trouble securing a third party vendor to complete the cleaning but had finally found a company to clean the "pit" on 9/28/2022.

The documentation indicated the following: "...It is our desire and commitment to resolving these issues and have both elevators operational in case one goes down we have a back up. (sic) Staff have been trained in proper lifting procedures as CNA's not to use your back. (sic) We use several staff members to assist residents up and down stairs as needed, we have had no injuries to this date or even close calls...."

When the Administrator was queried regarding the expired operating permit located in Elevator A, he provided documentation from the Elevator inspection company indicating the required inspection had been completed on 3/2022 and instructions on how to retrieve the renewed permit had been sent to the Administrator.

This State Residential finding relates to Complaint IN00390968.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE