STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/11/2026

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 Intakes 467596, 467744, and 469800. Intake 467596 - No deficiencies related to the allegations are cited. Intake 467744 - State deficiencies related to the allegations are cited at R0052. Intake 469800 - No deficiencies related to the allegations are cited. Survey date: June 10, & 11, 2026 Facility number: 001148 Residential Census: 55 These State Residential Findings are cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-5.	R 0000		

	Quality Review completed on 6/15/2026			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based of interview and record review, the facility failed to report an incident of resident to resident abuse to the State Agency, when two facility residents entered into a physical altercation which resulted in one resident requiring Emergency Room (ER) intervention for a facial fracture. This deficient practice involved 2 of 3 residents reviewed for abuse, (Resident C and Resident D). Finding includes: 1. On 6/11/16 at 9:41 A.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to adjustment disorders, nicotine	R 0052	The facility will report allegation of abuse to the IDOH per requirements. The incident identified during the State visit was reported while the State was in the building. Follow up has been completed with no new issues noted. The Administrator has been in-serviced on reporting guidelines of reporting to the State Department of Health. 24-hour reports, complaints, grievances and nurses' documentation will be reviewed to ensure that any incident that meets criteria is reported to the state in a timely manner. Audits will continue until problem is considered resolved Problem is considered resolved after three months of no new issues identified.	07/10/2026

dependence, alcohol abuse, cirrhosis, altered mental status, and dementia.

A Nursing Progress Note, dated 1/29/26 at 6:44 P.M., indicated Resident C had walked in the lobby toward the Nurses' Station with his left cheek bone swollen and a skin tear to his left nosal bone. He indicated Resident D had punched him in the face causing the swelling. Other resident statements indicated Resident C had been aggressive to all other residents in the smoking area, had screamed and had provoked Resident D.

On 1/30/26 at 6:42 A.M., the resident's Nursing Progress Note indicated Resident C had returned to facility from a local ER at or around 2:00 A.M. with a diagnosis of a maxillary (cheek bone) fracture on the left side. The resident reported feeling better and knew to keep ice on his face. The Director of Nursing was notified.

A Nursing Progress Note, on 1/30/26 at 10:48 A.M., indicated Resident C's physician was notified of the incident with Resident D and of the injuries sustained. The Nursing Progress Note indicated the facility was waiting for a response from the physician.

Review of an ER note, dated

1/29/26, indicated Resident C had been seen in the ER for "Battery", and had been diagnosed with a left maxillary fracture that had required ice and pain relievers for relief.

2. On 6/11/26 at 10:33 A.M., Resident D's clinical record was reviewed. Diagnoses included but were not limited to depression, history of stoke, emphysema, and altered mental status.

A Nursing Progress Note, dated 1/30/26 at 10:33 A.M., written as a Behavior Note, indicated Resident C, who had been allegedly under the influence of alcohol had made comments to Resident D. Resident C had then stood up and pushed Resident D's shoulder and had threatened to beat him up. Resident D had then swung at Resident C striking him on the left side of the upper cheek area. The description of the behavior indicated both residents had been yelling and cussing at each other and using threatening words followed by physical action. Resident D had been noted to have been antagonizing other residents all day making comments that he wanted to fight them. Witnesses indicated both residents were throwing chairs and ashtrays at each other. Witnesses had alerted the staff and Resident C

and Resident D had been separated for safety and assessed for injuries. Both Residents were evaluated, and Resident C was sent to ER for an evaluation related to facial swelling. Resident D had a middle finger injury with a cut and swelling and indicated it felt broken but had refused outside treatment. Staff had cleaned and wrapped the wound. Interventions documented for the behavioral issues included education, separation, and administration notification.

On 6/11/26 at 9:00 A.M., during an interview with Resident D, he indicated he did not remember the details of the incident but did remember he had gotten angry with Resident C for being rude and verbally aggressive in the smoking area. Resident D indicated he and Resident C were equally involved in the incident and felt the management had handled the incident well. Resident C indicated there have been no further incidents and he felt safe and enjoyed the facility.

During an interview with Resident C, on 6/11/26 at 9:15 A.M., he indicated he had been in an altercation with Resident D a few months ago and Resident D had hit him in the face. Resident C indicated he may have hit Resident D but could

not remember clearly. Resident D indicated he notified nursing staff of the incident and they had sent him to the ER for medical care. Resident D indicated he his face had been broken and he had to use ice topically, but had not required any further treatment. Resident D indicated he felt safe at the facility but did not want to be around Resident C anymore.

During an interview on 6/11/26 at 10:30 A.M., the Administrator indicated he was aware that the incident required notification to the State Agency and that when he and the Director of Nursing had attempted to report the incident, the State Agency electronic system for reporting incidents had not been working. The Administrator indicated after their failed attempts, they had not continued attempting to access the State Agency electronic reporting system.

On 6/10/26 at 2:00 P.M., the Director of Nursing provided a facility policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 9/8/23, and indicated it was the current facility policy. The policy indicated, " ...The facility will not tolerate Abuse,,,of its residents ...Facility staff should immediately report all such allegations to the ...Indiana

	Department of Health ..." This Residential citation relates to Intake 467744 410 IAC (Indiana Administrative Code) 16.2-5-1(v)(2)			

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 SIGNATURERich	TITLEExe	(X6) DATE06/25/2026