STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the Investigation of Complaints IN00427673, IN00427621 and IN00427280. Complaint IN00427673 - State deficiencies related to the allegations are cited at R0087, R0241 and R0245. Complaint IN00427621 - State deficiencies related to the allegations are cited at R0087, R0241 and R0245. Complaint IN00427280 - No deficiencies related to the allegations are cited. Survey date: February 7, 2024 Facility number: 001148 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review complted on 2/12/24.	R 0000		
R 0087 Bldg. 00	410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees. Based on interview and record review, the	R 0087	1 Inservice on *Insulin*	03/08/2024

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

Amber Hardy | Administrator | 03/05/2024

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	Administrator failed to maintain licensed and/or certified staff members who were available to administer insulin for the 5 insulin dependent residents who resided in the facility. (Residents C, D, E, F and G) Finding includes: On 2/7/24 at 10:45 A.M., the Administrator provided a list of residents who required "Special Care Needs". This list included 5 residents requiring insulin, Resident C, Resident D, Resident E, Resident F and Resident G. During an interview, on 2/7/24 at 2:15 P.M., the Scheduler/QMA provided a schedule for 1/13/24, 1/14/24 and 1/26/24 through 2/7/24. She indicated she only had a few staff members who could administer insulin. This consisted of 1 LPN and 3 insulin certified QMAs (Qualified Medication Aides). Only QMA 4 worked full time. QMA 5 worked as needed, and QMA 6 worked every other weekend. She indicated LPN 7 started working this week Monday through Friday, and prior to that, he worked only on Monday, Tuesday and Wednesday. The Administrator was an LPN and could assist with insulin injections, and had done so at times. After reviewing the schedule, the Scheduler/QMA indicated there was no licensed and/or certified staff member to administer insulin injections on 1/13/24, 1/14/24, 1/26/24, 2/3/24 and 2/4/24. During an interview, on 2/7/24 at 3:27 P.M., the Administrator indicated there was no policy or procedure for the QMAs to follow if there was no nurse in the facility, to provide insulin injections. She was unaware there were times there was no Nurse or QMA available for the administration of insulin. She indicated she had no policy regarding		*Administration* per InTouch Pharmacy RN Educator to be completed by 3/8/24. 2 New policy implemented and QMA's educated on *QMA Insulin Administration* on 2/23/24. 3 QMA Insulin Certification class set up for the QMA's on staff that are not yet certified. 4 Nursing Scheduler educated on *Scheduling of Nurses/QMAs For Insulin Administration* on 2/23/24. This includes the QMAs being designated on the nursing schedule if they are insulin certified. 5 QMA Insulin Administration competency check-off to be completed by 3/8/24, then completed annually. 6 Nursing schedule to be audited for Nurse/Insulin-Certified QMA on shift at insulin administration times per Administrator, or designee, daily x 14 days, then weekly x 4 weeks, then monthly x 6 months. 7 Nursing schedule audit and POC to be reviewed in QA meeting monthly x 6 months for compliance.	

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	staffing and coverage to ensure the residents were being administered their insulin, per the physician's order, by a trained/certified nurse or QMA. This citation relates to Complaints IN00427621 and IN00427673.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure 3 of the 5 insulin dependent residents were administered insulin at the prescribed times, per the physician's orders, which resulted in high blood sugar levels. (Residents C, D and E) Findings include: 1. On 2/7/24 at 12:52 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: insulin dependent diabetic, schizoaffective disorder and Parkinson's Disease. The following were the resident's Physician's Orders for blood sugar tests and insulin administration: - Insulin U-100 inject 10 units, inject subcutaneously, before meals at 6:30 A.M., 11:30 A.M. 4:30 P.M. bedtime at 9:00 P.M., for diabetes. The start date was 1/20/24.	R 0241	1 Inservice on *Insulin Administration* per InTouch Pharmacy RN Educator to be completed by 3/8/24. 2 New policy implemented and QMA's educated on *QMA Insulin Administration* on 2/23/24. 3 QMA Insulin Certification class set up for the QMA's on staff that are not yet certified. 4 Nursing Scheduler educated on *Scheduling of Nurses/QMAs For Insulin Administration* on 2/23/24. This includes the QMAs being designated on the nursing schedule if they are insulin certified. 5 QMA Insulin Administration competency check-off to be completed by 3/8/24, then completed annually.	03/08/2024

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	- Lantus 100 units/milliliter (ml) inject 15 units subcutaneously, one time a day for diabetes, at 5:00 P.M. - Novolog 100 units/milliliter, inject per sliding scale (dosage according to blood sugar results) three times a day, at 8:00 A.M., 12:00 P.M. and 4:00 P.M. The sliding scale was ..."if 150 - 189 = 1 INJECT PER SLIDING SCALE; 190 - 229 = 2 INJECT PER SLIDING SCALE; 230 - 269 = 3 INJECT PERT SLIDING SCALE; 270 - 309 = 4 INJECT PER SLIDING SCALE; 310 - 349 = 6 INJECT PER SLIDING SCALE; 350 - 389 = 8 INJECT PER SLIDING SCALE; 390 - 429 = 10 INJECT PER SLIDING SCALE AND CALL MD [Medical Doctor]...." The Medication Administration Record (MAR) for January 2024 indicated the insulin injections for U-100 - 10 units were not documented as administered, on the following dates and times: - On 1/21/24 through 1/31/24 (11 days) at 6:30 A.M.. - On 1/22/24 and 1/23/24 at 9:00 P.M. - On 1/26/24 at 11:30 A.M. and 4:30 P.M. The MAR for January indicated the insulin injections for Lantus -15 units were not documented as administered, per the physician orders, on the following dates and times: - On 1/13/24 at 5:00 P.M. - On 1/14/24 at 5:00 P.M. - On 1/19/24 at 5:00 P.M. The MAR for January indicated the resident's blood sugar was not tested and insulin administered, if needed per the sliding scale, on the following dates and times: - On 1/13/24 at 12:00 and 4:00 P.M. - On 1/14/24 at 4:00 P.M., next blood sugar result, on 1/15/24, was high at 281 .		6 Nursing schedule to be audited for Nurse/Insulin-Certified QMA on shift at insulin administration times per Administrator, or designee, daily x 14 days, then weekly x 4 weeks, then monthly x 6 months. 7 Nursing schedule audit and POC to be reviewed in QA meeting monthly x 6 months for compliance.	

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	- On 1/26/24 at 8:00 A.M. and 12:00 P.M., next blood sugar result, on 1/26/24 was high at 327. The MAR for February 2024 indicated the U-100 10 unit insulin injections were not documented as administered, on the following dates and times: - On 2/3/24 at 6:30 A.M., 11:30 A.M. and 4:30 P.M. - On 2/4/24 at 6:30 A.M., 11:30 A.M. and 4:30 P.M. The MAR for February indicated the Lantus insulin injections were not documented as administered, per the physician orders, on the following dates and times: - On 2/3/24 at 5:00 P.M. The MAR for February indicated the resident's blood sugar was not tested and insulin administered, if needed per the sliding scale, on the following dates and times. - On 2/3/24 at 8:00 A.M., 12:00 P.M. and 4:00 P.M. and next blood sugar result, on 2/4/24 at 8:00 A.M., was 383. - On 2/4/24 at 4:00 P.M. 2. During an interview, on 2/7/24 at 1:48 P.M., Resident D indicated he had experienced days when he was not administered his insulin injection. He indicated this occurred mostly on the weekends. On 2/7/24 at 1:54 P.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: insulin dependent diabetic with neuropathy and below the knee amputation. The following were the resident's Physician's Orders for blood sugar tests and insulin administration: - Novolin NPH FlexPen - inject 60 units			

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	subcutaneously, in the afternoon (5:00 P.M.), daily. - Novolin NPH FlexPen - inject 85 units subcutaneously, one time a day (8:00 A.M.) - Novolog-Aspart FlexPen - inject 8 units subcutaneously, before meals and bedtime (8:00 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M.) - Novolog 100 units/milliliter, inject per sliding scale (dosage according to blood sugar results) four times a day, at 8:00 A.M., 12:00 P.M., 4:00 P.M. and 9:00 P.M. The sliding scale was ..."if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 -300 = 6 units; 301 - 350 = 8 Units; 351 - 400 = 10; 401 - 450 = 12...CALL MD [Medical Doctor] for anything greater than 451...." The Medication Administration Record (MAR) for January 2024 indicated the Novolin NPH insulin injections of 60 units, were not documented as administered, on the following dates and times: - On 1/13/24 at 5:00 P.M. - On 1/14/24 at 5:00 P.M. - On 1/26/24 at 5:00 P.M. The MAR for January indicated the Novolin NPH insulin injection of 85 units, was not documented as administered, on the following date and time: - On 1/26/24 at 8:00 A.M. The MAR for January indicated the insulin injection of Novolog Aspart - 8 units, were not documented as administered, on the following dates and times: - On 1/13/24 at 12:00 P.M., 5:00 P.M. and at 9:00 P.M. - On 1/26/24 at 8:00 A.M., 12:00 P.M. and 5:00 P.M. The MAR for January indicated the resident's blood sugar was not tested and insulin administered, if needed per the sliding scale, on			

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	the following dates and times: - On 1/13/24 at 12:00 P.M., 5:00 P.M. and 9:00 P.M. The next blood sugar test was completed, on 1/14/24 at 8:00 A.M., and results were high at 336. - On 2/18/24 at 5:00 P.M. and 9:00 P.M. - On 1/26/24 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. The next blood sugar test was completed, on 1/26/24 at 9:00 P.M., and results were high at 450. The Medication Administration Record (MAR) for February indicated the Novolin NPH insulin injections, of 60 units, were not documented as administered, on the following dates and times: - On 2/3/24 at 5:00 P.M. - On 2/4/24 at 5:00 P.M. The MAR for February indicated the insulin injection, of Novolog Aspart - 8 units, were not documented as administered, on the following dates and times: - On 2/1/24 at 8:00 A.M. - On 2/3/24 at 8:00 A.M. - On 2/4/24 at 8:00 A.M. The MAR for February indicated the insulin injection, of Novolog Aspart - 8 units, were not documented as administered, on the following dates and times: - On 2/2/24 at 9:00 P.M. - On 2/3/24 at 8:00 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M. - On 2/4/24 at 8:00 A.M., 12:00 P.M. and 5:00 P.M. - On 2/5/24 at 9:00 P.M. - On 2/6/24 at 9:00 P.M. The MAR for February indicated the resident's blood sugar was not tested and insulin administered, if needed per the sliding scale, on the following dates and times: - On 2/2/24 at 9:00 P.M.			

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	- On 2/3/24 at 8:00 A.M., 12:00 P.M., 5:00 P.M. and 9:00 P.M. - On 2/4/24 at 8:00 A.M., 12:00 P.M. and 5:00 P.M. The next blood sugar test was completed on 2/4/24 at 9:00 P.M. with blood sugar results high at 450. 3. On 2/7/24 at 2:44 P.M., a review of the clinical record for Resident E was conducted. The resident's diagnoses included, but were not limited to: visual disturbances and insulin dependant diabetic The following were the resident's Physician's Orders for blood sugar tests and insulin administration: - Lantus - inject 30 units subcutaneously, in the afternoon (5:00 P.M.), daily. - Novolog Aspart - inject 4 units subcutaneously, three times a day (8:00 A.M., 12:00 P.M. and 4:00 P.M.) - Novolog 100 units/milliliter, inject insulin subcutaneously, per sliding scale (dosage according to blood sugar results) before meals at 8:00 A.M., 12:00 P.M., and 5:00 P.M. The sliding scale was ..."if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 -300 = 6 units; 301 - 350 = 8 Units; 351 - 400 = 10; ...above 401 call MD [Medical Doctor]...." The MAR for January 2024 indicated the insulin injections for Lantus -30 units were not documented as administered, per the physician orders, on the following dates and times: - On 1/13/24 at 5:00 P.M. - On 1/14/24 at 5:00 P.M. - On 1/18/24 at 5:00 P.M. - On 1/19/24 at 5:00 P.M. - On 1/26/24 at 5:00 P.M.			

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	The MAR for January indicated the insulin injection, of Novolog Aspart - 4 units, were not documented as administered, on the following dates and times: - On 1/13/24 at 12:00 P.M. and 4:00 P.M. - On 1/14/24 at 6:00 P.M. - On 1/18/24 at 8:00 A.M., 12:00 P.M. and 4:00 P.M. - On 1/26/24 at 8:00 A.M., 12:00 P.M. and 4:00 P.M. The MAR for January indicated the resident's blood sugar was not tested and insulin administered, if needed per the sliding scale, on the following dates and times: - On 1/13/24 at 12:00 P.M. and 5:00 P.M. The next blood sugar test was completed, on 1/14/24 at 8:00 A.M., and results were high at 320. - On 1/18/24 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. The next blood sugar test was completed, on 1/19/24 at 8:00 A.M. and results were high at 396. - On 1/26/24 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. The next blood sugar test was completed, on 1/27/24 at 8:00 A.M., with blood sugar results high at 400. The MAR for February 2024 indicated the insulin injections for Lantus -30 units were not documented as administered, per the physician orders, on the following dates and times: - On 2/3/24 at 5:00 P.M. - On 2/4/24 at 5:00 P.M. The MAR for February indicated the insulin injection, of Novolog Aspart - 4 units, were not documented as administered, on the following dates and times: - On 2/3/24 at 8:00 A.M., 12:00 P.M. and 4:00 P.M. - On 2/2/24 at 8:00 A.M., 12:00 P.M. and 4:00 P.M. The MAR for February indicated the resident's blood sugar was not tested and insulin			

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	administered, if needed per the sliding scale, on the following dates and times: - On 2/3/24 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. - On 2/4/24 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. The next blood sugar test was completed, on 2/5/24 at 8:00 A.M., with blood sugar results high at 400. During an interview, on 2/7/24 at 2:15 P.M., the Scheduler/QMA provided a schedule for 1/13/24, 1/14/24 and 1/26/24 to 2/7/24. She indicated she just started doing the schedule a few weeks ago. She only had a few staff members who could administer insulin. This consisted of 1 LPN and 3 insulin certified QMAs (Qualified Medication Aide) with only one of them being full time, one working as needed, and the other only working every other weekend. She indicated the LPN worked Monday through Friday. The Administrator was an LPN and would assist at times with insulin injections. After reviewing the schedule, she indicated there was no one working to provide insulin injections on 1/13/24, 1/14/24, 1/26/24, 2/3/24 and 2/4/24. The Resident Handbook, indicated on page 21, "...Licensed nurses or certified medication technicians provide direct Resident services 24-hours a day, including medication administration to Assisted Living Residents...." An article titled, "Manage Blood Sugar" (September 30, 2022) was retrieved, on 2/6/24, from the Centers of Disease Control (CDC) website. The article indicated "...It's important to keep your blood sugar levels in your target range as much as possible to help prevent or delay long-term, serious health problems, such as heart disease, vision loss, and kidney disease. Staying in your target range can also help improve your energy			

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	and mood...A blood sugar target is the range you should try to reach as much as possible...Before a meal: 80 to 130...." On 2/7/24 at 1:12 P.M., the Administrator provided a policy titled, "RESIDENTIAL CARE POLICIES AND PROCEDURES", dated 12/10/07 and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: Insulin is used for a resident whose body does not produce enough insulin. Insulin is given by subcutaneous injections. Policy: The nurse will assist the resident with Insulin injections when authorized in writing by a physician...." The Administrator indicated that was the only policy she had regarding insulin administration. However, the Administrator provided a form titled "QMA with Insulin Certification Job Description", which indicated "...QMA shall complete blood sugar testing and administer insulin according to the physician ordered time frame...Failure to administer insulin to residents according to the physician-ordered time frame has the potential to put resident health at risk, and will result in written disciplinary action, up to and including termination...." This citation relates to Complaints IN00427621 and IN00427673.			
R 0245 Bldg. 00	410 IAC 16.2-5-4(e)(5) Health Services - Offense (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure a Qualified Medication Aide (QMA) had additional certification/education to administer insulin to 1 of 3 residents reviewed who required administration assistance with insulin. (Resident C)	R 0245	1 Inservice on *Insulin Administration* per InTouch Pharmacy RN Educator to be completed by 3/8/24. 2 New policy implemented and QMA's educated on *QMA*	03/08/2024

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	Finding includes: On 2/7/24 at 12:52 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: insulin dependent diabetic, schizoaffective disorder and Parkinson's Disease. The following were the resident's Physician's Orders for blood sugar tests and insulin administration: - Novolog 100 units/milliliter, inject per sliding scale (dosage according to blood sugar results) three times a day, at 8:00 A.M., 12:00 P.M. and 4:00 P.M. The sliding scale was ..."if 150 - 189 = 1 INJECT PER SLIDING SCALE; 190 - 229 = 2 INJECT PER SLIDING SCALE; 230 - 269 = 3 INJECT PERT SLIDING SCALE; 270 - 309 = 4 INJECT PER SLIDING SCALE; 310 - 349 = 6 INJECT PER SLIDING SCALE; 350 - 389 = 8 INJECT PER SLIDING SCALE; 390 - 429 = 10 INJECT PER SLIDING SCALE AND CALL MD [Medical Doctor]...." The Medication Administration Record (MAR) indicated, on 2/4/24 at 8:00 A.M., the resident had his blood sugar tested, which was 383, and had been administered Novolog 8 unit subcutaneously by QMA 2. On 2/4/24 at 12:00 P.M., QMA 2 tested the resident's blood sugar, which was 311, and administered Novolog 6 units subcutaneously. During an interview, on 2/7/24 at 2:15 P.M., the Scheduler/QMA provided a schedule for 1/13/24, 1/14/24 and 1/26/24 through 2/7/24. She indicated she only had a few staff members who could administer insulin. This consisted of 1 LPN and 3 insulin certified QMAs (Qualified Medication		*Insulin Administration* on 2/23/24. 3 QMA Insulin Certification class set up for the QMA's on staff that are not yet certified. 4 Nursing Scheduler educated on *Scheduling of Nurses/QMAs For Insulin Administration* on 2/23/24. This includes the QMAs being designated on the nursing schedule if they are insulin certified. 5 QMA Insulin Administration competency check-off to be completed by 3/8/24, then completed annually. 6 Nursing schedule to be audited for Nurse/Insulin-Certified QMA on shift at insulin administration times per Administrator, or designee, daily x 14 days, then weekly x 4 weeks, then monthly x 6 months. 7 Nursing schedule audit and POC to be reviewed in QA meeting monthly x 6 months for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/07/2024

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

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	Aide). She indicated QMA 2 was scheduled to be certified for insulin administration on 2/12/24, and currently should not be administering insulin. On 2/7/24 at 1:12 P.M., the Administrator provided a policy titled, "RESIDENTIAL CARE POLICIES AND PROCEDURES", dated 12/10/07 and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: Insulin is used for a resident whose body does not produce enough insulin. Insulin is given by subcutaneous injections. Policy: The nurse will assist the resident with Insulin injections when authorized in writing by a physician...." The Administrator indicated that was the only policy she had regarding insulin administration. This citation relates to Complaints IN00427621 and IN00427673.			