Amber Hardy

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

03/05/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		f 1	A. BUILDING <u>00</u>			(3) DATE SURVEY COMPLETED 02/07/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
R 0000							
Bldg. 00	IN00427673, IN004 Complaint IN00427	ne Investigation of Complaints 427621 and IN00427280. 7673 - State deficiencies related e cited at R0087, R0241 and	R 0000				
	R0245. Complaint IN00427	7621 - State deficiencies related e cited at R0087, R0241 and					
	Complaint IN00427 the allegations are c	7280 - No deficiencies related to itted.					
	Survey date: Februa	ary 7, 2024					
	Facility number: 00	1148					
	Residential Census:	51					
	These State Resider accordance with 410	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	plted on 2/12/24.					
R 0087 Bldg. 00	staff as required to of the facility, inclu following: (1) Initial orientation	d Management - hall provide the number of carry out all the functions					
	training program fo	or all employees. pervision for all employees.					
		and record review, the	R 0087	,	1 Inservice on <u>Ins</u>	ulin_	03/08/2024
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN			GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 1 of 13

Administrator

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		02/07/	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	10	DATE
	Administrator faile	d to maintain licensed and/or			Administration per InTouch		
	certified staff mem	bers who were available to			Pharmacy RN Educator to be		
	administer insulin f	For the 5 insulin dependent			completed by 3/8/24.		
	residents who resid	ed in the facility. (Residents C,			2 New policy implemented	i '	
	D, E, F and G)				and QMA's educated on QMA	<u>L</u>	
					Insulin Administration on 2/23	/24.	
	Finding includes: On 2/7/24 at 10:45 A.M., the Administrator				3 QMA Insulin Certification	า	
					class set up for the QMA's on	ļ	
					staff that are not yet certified.	ļ	
	provided a list of re	esidents who required "Special			4 Nursing Scheduler educ	ated	
	Care Needs". This	list included 5 residents			on Scheduling of Nurses/QMA	ls	
	requiring insulin, R	esident C, Resident D,			<i>For Insulin Administration</i> on		
	Resident E, Resident F and Resident G.				2/23/24. This includes the QN	ЛAs	
					being designated on the nursi	ng	
	During an interviev	v, on 2/7/24 at 2:15 P.M., the			schedule if they are insulin		
	Scheduler/QMA pr	ovided a schedule for 1/13/24,			certified.		
	1/14/24 and 1/26/24	4 through 2/7/24. She indicated			5 QMA Insulin Administrat	ion	
	she only had a few	staff members who could			competency check-off to be		
	administer insulin.	This consisted of 1 LPN and 3			completed by 3/8/24, then		
	insulin certified QN	MAs (Qualified Medication			completed annually.		
	Aides). Only QMA	4 worked full time. QMA 5			6 Nursing schedule to be		
	worked as needed,	and QMA 6 worked every			audited for Nurse/Insulin-Certi	fied	
	other weekend. She	e indicated LPN 7 started			QMA on shift at insulin		
	working this week	Monday through Friday, and			administration times per		
	_	rked only on Monday,			Administrator, or designee, da	ily x	
		esday. The Administrator was			14 days, then weekly x 4 weel	KS,	
		assist with insulin injections,			then monthly x 6 months.		
		times. After reviewing the			7 Nursing schedule audit a	and	
	schedule, the Sched	duler/QMA indicated there was			POC to be reviewed in QA		
		certified staff member to			meeting monthly x 6 months for	or	
		njections on 1/13/24, 1/14/24,			compliance.		
	1/26/24, 2/3/24 and	1 2/4/24.					
						ļ	
	_	v, on 2/7/24 at 3:27 P.M., the				ļ	
		cated there was no policy or				ļ	
		MAs to follow if there was no				ļ	
		, to provide insulin injections.				ļ	
		nere were times there was no				ļ	
		ilable for the administration of				ļ	
	insulin. She indicat	ed she had no policy regarding				ļ	

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 2 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/07/2024	
	PROVIDER OR SUPPLIER	.	•	17650 (ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0241	staffing and covera were being adminis physician's order, b QMA.	ge to ensure the residents tered their insulin, per the y a trained/certified nurse or to Complaints IN00427621		TAU			DATE
Bldg. 00	Health Services - (e) The administration of residence as ordered by the shall be supervised the premises or of the Medication shall be supervised the premises or of the premises of the p	Offense ation of medications and the ential nursing care shall be resident 's physician and ed by a licensed nurse on					
	Based on interview failed to ensure 3 or residents were adm prescribed times, por resulted in high blo D and E) Findings include: 1. On 2/7/24 at 12:: record for Resident resident's diagnoses limited to: insuling a schizoaffective discontinuous manner.	and record review, the facility of the 5 insulin dependent inistered insulin at the er the physician's orders, which od sugar levels. (Residents C, 52 P.M., a review of the clinical C was conducted. The ex included, but were not dependent diabetic, order and Parkinson's Disease. ethe resident's Physician's gar tests and insulin	R 02	241	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 2/23/3 QMA Insulin Certification class set up for the QMA's on staff that are not yet certified. 4 Nursing Scheduler eduction Scheduling of Nurses/QMA For Insulin Administration on 2/23/24. This includes the QI being designated on the nursing schedule if they are insulin certified.	 /24. n ated A <u>s</u>	03/08/2024
	- Insulin U-100 inje subcutaneously, be	fore meals at 6:30 A.M., 11:30 ltime at 9:00 P.M., for diabetes.			5 QMA Insulin Administrat competency check-off to be completed by 3/8/24, then completed annually.	ion	

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 3 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/07/2024	
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	- Lantus 100 units/subcutaneously, on 5:00 P.M Novolog 100 units scale (dosage according three times a day, a 4:00 P.M. The slidid INJECT PER SLIDINJECT	ministration Record (MAR) for ated the insulin injections for are not documented as a following dates and times: as 1/31/24 (11 days) at 6:30 and 4:30 P.M. 23/24 at 9:00 P.M. 30 A.M. and 4:30 P.M. ary indicated the insulin as -15 units were not anistered, per the physician wing dates and times: 0 P.M. 0 P.M. 0 P.M. ary indicated the resident's at tested and insulin and times: 00 and 4:00 P.M. 0 P.M., next blood sugar result,	TAG	6 Nursing schedule to be audited for Nurse/Insulin-Cer QMA on shift at insulin administration times per Administrator, or designee, d 14 days, then weekly x 4 weethen monthly x 6 months. 7 Nursing schedule audit POC to be reviewed in QA meeting monthly x 6 months compliance.	aily x eks, and

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 4 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING B. WING	00 00	COMPLETED 02/07/2024
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		O A.M. and 12:00 P.M., next on 1/26/24 was high at 327.			
	10 unit insulin inject administered, on the - On 2/3/24 at 6:30	tions were not documented as e following dates and times: A.M., 11:30 A.M. and 4:30 P.M. A.M., 11:30 A.M. and 4:30 P.M.			
	insulin injections w				
	blood sugar was not administered, if nee the following dates - On 2/3/24 at 8:00	ded per the sliding scale, on and times. A.M., 12:00 P.M. and 4:00 P.M. ar result, on 2/4/24 at 8:00			
	Resident D indicate when he was not ad	ew, on 2/7/24 at 1:48 P.M., d he had experienced days ministered his insulin ted this occurred mostly on the			
	record for Resident resident's diagnoses limited to: insulin d	.M., a review of the clinical D was conducted. The included, but were not ependent diabetic with ow the knee amputation.			
	Orders for blood su administration:	the resident's Physician's gar tests and insulin RPen - inject 60 units			

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 5 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 02/07/2024		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
WOODR	IDGE VILLAGE			GENERATIONS DR I BEND, IN 46635		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION the afternoon (5:00 P.M.)	TAG	DEFICIENCY)		DATE
	daily.	the afternoon (5:00 P.M.),				
	_	Pen - inject 85 units				
		e time a day (8:00 A.M.)				
	- Novolog-Aspart F	lexPen - inject 8 units				
	subcutaneously, bef	Fore meals and bedtime (8:00				
	A.M., 12:00 P.M., 5	5:00 P.M. and 9:00 P.M.)				
	- Novolog 100 units	/milliliter, inject per sliding				
	scale (dosage accord	ding to blood sugar results)				
	four times a day, at	8:00 A.M., 12:00 P.M., 4:00				
		The sliding scale was"if 150				
		-250 = 4 units; $251 - 300 = 6$				
		Units; $351 - 400 = 10$; $401 - 450$				
	_	Medical Doctor] for anything				
	greater than 451"					
		ministration Record (MAR) for				
	-	ated the Novolin NPH insulin				
	-	ts, were not documented as				
		e following dates and times:				
	- On 1/13/24 at 5:00 - On 1/14/24 at 5:00					
	- On 1/26/24 at 5:00					
		ry indicated the Novolin NPH				
	-	85 units, was not documented				
		the following date and time:				
	- On 1/26/24 at 8:00) A.M.				
	The MAR for Janua	ary indicated the insulin				
		g Aspart - 8 units, were not				
		inistered, on the following				
	dates and times:	-				
	- On 1/13/24 at 12:0	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 Janua	ary indicated the resident's				
	blood sugar was not					
	_	ded per the sliding scale, on				
	· ·	- · · ·	1	I		1

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 6 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
			B. WIN	NG		02/07/	/2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	I BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	the following dates	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	_						
	- 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						
	-	A., and results were high at 336.					
		0 P.M. and 9:00 P.M.					
		0 A.M., 12:00 P.M., and 5:00					
		d sugar test was completed, on					
		f., and results were high at 450.					
		ministration Record (MAR) for the Novolin NPH insulin					
		its, were not documented as					
	1 -						
	administered, on the following dates and times: - On 2/3/24 at 5:00 P.M.						
	- On 2/4/24 at 5:00						
	- On 2/4/24 at 3.00	1 .171.					
	The MAR for Febru	uary indicated the insulin					
	injection, of Novole	og Aspart - 8 units, were not					
	documented as adm	ninistered, 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 Febr	uary indicated the insulin					
		og Aspart - 8 units, were not					
		ninistered, on the following					
	dates and times:	inistered, on the following					
	- 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						
	- On 2/6/24 at 9:00	P.M.					
	TI MAD C D 1	' 1' 7 1 A 1 A 1 A					
		uary indicated the resident's					
	blood sugar was no						
		eded per the sliding scale, on					
	the following dates						
	- On 2/2/24 at 9:00	r.IVI.					

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 7 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			l` ′	JILDING	00	COMPLETED 02/07/2024	
	PROVIDER OR SUPPLIER			17650 G	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	- On 2/3/24 at 8:00 9:00 P.M On 2/4/24 at 8:00 The next blood suga 2/4/24 at 9:00 P.M. at 450. 3. On 2/7/24 at 2:44 record for Resident resident's diagnoses limited to: visual di dependant diabetic The following were Orders for blood su administration: - Lantus - inject 30 afternoon (5:00 P.M Novolog Aspart - three times a day (8 P.M.) - Novolog 100 units subcutaneously, per according to blood 8:00 A.M., 12:00 P. scale was"if 150 units; 251 -300 = 6 400 = 10;above 4 Doctor]" The MAR for Janua injections for Lantua documented as administrated as administration:	A.M., 12:00 P.M., 5:00 P.M. and A.M., 12:00 P.M. and 5:00 P.M. ar test was completed on with blood sugar results high P.M., a review of the clinical E was conducted. The included, but were not sturbances and insulin the resident's Physician's gar tests and insulin units subcutaneously, in the 1.), daily. inject 4 units subcutaneously, :00 A.M., 12:00 P.M. and 4:00 s/milliliter, inject insulin r sliding scale (dosage sugar results) before meals at M., and 5:00 P.M. The sliding - 200 = 2 units; 201 - 250 = 4 units; 301 - 350 = 8 Units; 351 - i01 call MD [Medical ary 2024 indicated the insulin s -30 units were not inistered, per the physician wing dates and times: 0 P.M. 0 P.M. 0 P.M. 0 P.M.					

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 8 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 00 COMPLETE B. WING 02/07/20			ETED	
	PROVIDER OR SUPPLIER	1		17650 G	DDRESS, CITY, STATE, ZIP COD ENERATIONS DR BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	injection, of Novold documented as adm dates and times: - On 1/13/24 at 12:0 - On 1/14/24 at 6:00 - On 1/18/24 at 8:00 - On 1/26/24 at 8:00	O A.M., 12:00 P.M. and 4:00 P.M. O A.M., 12:00 P.M. and 4:00 P.M. ary indicated the resident's					
	administered, if nee the following dates - On 1/13/24 at 12:0 blood sugar test wa A.M., and results w - On 1/18/24 at 8:00 P.M. The next bloo 1/19/24 at 8:00 A.M - On 1/26/24 at 8:00 P.M. The next bloo	ded per the sliding scale, on and times: 00 P.M. and 5:00 P.M. The next s completed, on 1/14/24 at 8:00					
	injections for Lantu documented as adm						
	injection, of Novolo documented as adm dates and times: - On 2/3/24 at 8:00	pary indicated the insuling Aspart - 4 units, were not inistered, on the following A.M., 12:00 P.M. and 4:00 P.M. A.M., 12:00 P.M. and 4:00 P.M.					
	The MAR for Febru blood sugar was no	nary indicated the resident's tested and insulin					

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 9 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION				nstruction <u>00</u>	(X3) DATE COMPL 02/07/	ETED
	PROVIDER OR SUPPLIEF	R		17650 0	DDRESS, CITY, STATE, ZIP COD GENERATIONS DR BEND, IN 46635	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
IAU	administered, if need the following dates - On 2/3/24 at 8:00 - On 2/4/24 at 8:00 The next blood sug 2/5/24 at 8:00 A.M. at 400. During an interview Scheduler/QMA properties of the properties of the second of th	and times: A.M., 12:00 P.M., and 5:00 P.M. A.M., 12:00 P.M., and 5:00 P.M. ar test was completed, on ., with blood sugar results high w, on 2/7/24 at 2:15 P.M., the rovided a schedule for 1/13/24, 4 to 2/7/24. She indicated she as schedule a few weeks ago. staff members who could This consisted of 1 LPN and 3 MAs (Qualified Medication and the other only working d. She indicated the LPN rough Friday. The an LPN and would assist at njections. After reviewing the ated there was no one working njections on 1/13/24, 1/14/24, 2/4/24. book, indicated on page 21, or certified medication direct Resident services		IAU			DATE
	target range can als	o help improve your energy					

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 10 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

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	ROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635	
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	should try to reach meal: 80 to 130" On 2/7/24 at 1:12 P	sugar target is the range you as much as possibleBefore a .M., the Administrator provided			
	AND PROCEDURI indicated the policy by the facility. The Insulin is used for a	SIDENTIAL CARE POLICIES ES", dated 12/10/07 and was the one currently used policy indicated "Purpose: resident whose body does insulin. Insulin is given by			
	subcutaneous inject assist the resident w authorized in writin Administrator indic she had regarding in	ions. Policy: The nurse will with Insulin injections when g by a physician" The ated that was the only policy asulin administration. nistrator provided a form titled			
	"QMA with Insulin which indicated "! sugar testing and ad the physician ordere administer insulin to	Certification Job Description", QMA shall complete blood lminister insulin according to ed time frameFailure to o residents according to the time frame has the potential to			
	put resident health a disciplinary action, termination"	at risk, and will result in written up to and including			
	This citation relates and IN00427673.	to Complaints IN00427621			
R 0245 Bldg. 00	410 IAC 16.2-5-4(Health Services - (5) Injectable med	, , ,			
	failed to ensure a Q (QMA) had addition administer insulin to	and record review, the facility ualified Medication Aide nal certification/education to o 1 of 3 residents reviewed nistration assistance with	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	

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 11 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		02/07/	2024
			<u> </u>				
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Insulin Administration on 2/23	/24.	
	Finding includes:				3 QMA Insulin Certification	1	
					class set up for the QMA's on		
	On 2/7/24 at 12:52 P.M., a review of the clinical				staff that are not yet certified.		
		C was conducted. The			4 Nursing Scheduler educ	ated	
	resident's diagnoses	s included, but were not			on Scheduling of Nurses/QMA	<u>ls</u>	
	limited to: insulin d	-			<i>For Insulin Administration</i> on		
	schizoaffective disc	order and Parkinson's Disease.			2/23/24. This includes the QI	MAs	
					being designated on the nursi	ng	
	_	e the resident's Physician's			schedule if they are insulin		
	Orders for blood su	gar tests and insulin			certified.		
	administration:				5 QMA Insulin Administrat	ion	
	-	s/milliliter, inject per sliding			competency check-off to be		
		ding to blood sugar results)			completed by 3/8/24, then		
	_	t 8:00 A.M., 12:00 P.M. and			completed annually.		
	4:00 P.M. The slidi	ng scale was"if $150 - 189 = 1$			6 Nursing schedule to be		
	INJECT PER SLID	DING SCALE; $190 - 229 = 2$			audited for Nurse/Insulin-Certi	fied	
	INJECT PER SLID	DING SCALE; $230 - 269 = 3$			QMA on shift at insulin		
	INJECT PERT SLI	DING SCALE; $270 - 309 = 4$			administration times per		
	INJECT PER SLID	DING SCALE; $310 - 349 = 6$			Administrator, or designee, da	ily x	
	INJECT PER SLID	DING SCALE; $350 - 389 = 8$			14 days, then weekly x 4 weel	κs,	
		DING SCALE; $390 - 429 = 10$			then monthly x 6 months.		
		DING SCALE AND CALL MD			7 Nursing schedule audit a	and	
	[Medical Doctor]	."			POC to be reviewed in QA		
					meeting monthly x 6 months for	or	
		lministration Record (MAR)			compliance.		
		4 at 8:00 A.M., the resident had					
	_	ed, which was 383, and had					
	been administered	_					
		QMA 2. On 2/4/24 at 12:00					
	-	d the resident's blood sugar,					
		d administered Novolog 6 units					
	subcutaneously.						
	During an interviev	v, on 2/7/24 at 2:15 P.M., the					
	-	rovided a schedule for 1/13/24,					
		4 through 2/7/24. She indicated					
		staff members who could					
	•	This consisted of 1 LPN and 3					
		MAs (Qualified Medication					
	4		1		İ		

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 12 of 13

PRINTED: 03/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/07/2024	
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 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 Aide). She indicated QMA 2 was scheduled to be		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE O THE APPROPRIATE	
	certified for insulin administration on 2/12/24, and currently should not be administering insulin.					
	a policy titled, "RE AND PROCEDUR indicated the policy by the facility. The Insulin is used for a not produce enough subcutaneous inject	P.M., the Administrator provided SIDENTIAL CARE POLICIES ES", dated 12/10/07 and was the one currently used policy indicated "Purpose: a resident whose body does in insulin. Insulin is given by tions. Policy: The nurse will				
	authorized in writir Administrator indic she had regarding i	with Insulin injections when ag by a physician" The cated that was the only policy insulin administration.				

State Form Event ID: NQZR11 Facility ID: 001148 If continuation sheet Page 13 of 13