| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 06/30/2023 |

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

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00407407, IN00402960, IN00400895, IN00400637, and IN00398282.<br><br>Complaint IN00407407 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00402960 - State deficiencies related to the allegations are cited at R0052.<br><br>Complaint IN00400895 - State deficiencies related to the allegations are cited at R0052.<br><br>Complaint IN00400637 - State deficiencies related to the allegations are cited at R0052.<br><br>Complaint IN00398282 - No deficiencies related to the allegations are cited.<br><br>Survey dates: June 26, 27, 28, 29, & 30, 2023.<br><br>Facility number: 001148<br><br>Residential Census: 50<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed 7/6/2023. | R 0000 | | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse; | | | |

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

Stephen Sokolow | ED | 07/20/2023

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.

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| | (4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br>Based on interview, and record review, the facility failed to ensure a resident was free from physical abuse when a facility administrator, (previous Administrator 4 ) attempted to search a resident (Resident K), by touching the resident without permission and searching his pockets to look for marijuana. The facility also failed to ensure 1 resident (Resident F), was free from mental anguish causing an emergency room visit due to the odor of marijuana in the facility; and failed to ensure 10 of 25 residents who attended a Resident Council meeting felt safe and free from mental anguish from facility residents who smoked marijuana in or on the facility grounds (Residents N, O, P, Q, R, S, T, V, W, and X).<br><br>Findings include:<br><br>On 6/26/23 at 12:42 P.M., Employee 2 provided Incident Report #138. The report indicated on 5/02/23 at 1:01 P.M., previous Administrator 4 inappropriately tried to conduct a search for drugs on Resident K's body. Resident K alleged he was outside the facility smoking when previous Administrator 4 approached him and accused him of smoking marijuana. According to Resident K, previous Administrator 4 tried to go in his pockets to search for drugs.<br>The report indicated previous Administrator 4 was placed on immediate leave pending an investigation, and Resident K was educated on facility smoking areas and drug policy. The report follow up dated 5/11/23, indicated, "... based on the resident interview it appears previous Administrator 4 acted inappropriately in using unwanted physical actions in trying to enforce the law...." | R 0052 | R052<br>This plan of Correction is the facility's credible allegation of compliance.<br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by<br>the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal<br>and state law.<br>This facility respectfully request paper compliance for this citation.<br>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>Resident F returned to the facility and is followed by physician routinely and continues normal daily<br>routine. Resident K continues with normal daily routine and no further effects noted. Residents council held to review plan of correction with residents N, O,P,Q,R,S,T,V,W and X and no further effects noted.<br>Resident K has been provided with a 30-day notice and facility working with ombudsman on proper | 08/11/2023 |

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| | On 6/26/23 at 1:00 P.M., Employee 2 provided the facility grievances from 1/1/23 to 6/26/23. A grievance dated 3/27/23 at 8:55 A.M., indicated Resident F reported to Employee 2 that she smelled marijuana and got very sick. The resident indicated she got very sick and had to go to the hospital and that the smell of the marijuana threw her into an anxiety attack. The grievance indicated the facility's immediate action taken was to, "Advise resident to follow up with doctor for appointment. Also spoke with several residents to determine where weed was coming from. Provided residents [Residents B and K] with [discharge] notice..."The grievance also indicated the Director of Nursing was also aware of the concern. Employee 2 indicated she reported the incident to Previous Administrator 2 but that the incident was not reported to the State Agency, and neither Resident B nor Resident K were ever discharged from the facility.<br><br>On 6/26/23 at 10:24 A.M., the clinical record for Resident F was reviewed. Resident F was admitted to the facility on 1/31/20, diagnoses included schizo-affective disorder, major depressive disorder, anxiety disorder.<br><br>Review of local Emergency Room (ER) report dated 3/25/23 at 3:38 P.M., indicated "...She [Resident F] was noted that she was very anxious because people were smoking marijuana at her regular care facility. her blood pressure at that time 150/100. A repeat blood pressure here was much more 180/100...She just felt anxious...I gave her Ativan she felt much better...Clinical impression 1. Primary hypertension 2. Anxiety 3. Palpitations..." Resident F was prescribed Amlodipine 5 mg tablet daily, upon discharge...." | | placement<br>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>All residents have the potential to be affected by this alleged deficient practice.<br>Administrators 2 and 4 are no longer employed at the facility.<br>Resident interviews conducted to determine any additional concerns related to physical abuse or mental<br>anguish with any concerns identified to be followed up on immediately.<br>Resident education complete on smoking and drug use and smoking is staff supervised<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:<br>All staff in service on Abuse with emphasis on resident rights, conducting a search and mental anguish.<br>Facility initiated supervised smoking to ensure that residents are following smoking policy and no illegal<br>substances present.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:<br>ED/Designee will audit resident | |

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| | On 6/27/23 at 9:45 A.M., during an interview with Resident F, she indicated she wears a mask at the facility to help decrease the amount of the marijuana scent. The resident indicated she went to the hospital because she was overcome by the scent of the marijuana.<br><br>On 6/27/23 at 1:46 P.M., during a Resident Council meeting, 10 of 25 Residents present, Residents Residents N, O, P, Q, R, S, T, V, W, and X, indicated the smell of marijuana in the building caused them anxiety and to feel unsafe in the facility. Resident N indicated if they tell staff that residents are smoking weed, they just don't care and they don't do anything about it.<br><br>A grievance dated 3/24/23 at 9:00 P.M., indicated Resident G reported to Employee 2 that she "...smelled pot on 2nd floor down the hall on the left from the elevator. Immediate action taken, "Investigated and find out where smoking was coming from. Provided documentations for resident to be moved. Please see incident with [Resident F] 3/27...."<br><br>A policy titled, "Resident Bill of Rights," dated 12/2/15, was provided by Employee 2 on 6/26/23 at 11:17 A.M. and indicated, "...Residents have the right to be free from...mental abuse...."<br><br>A policy titled, "Abuse, Neglect, Exploitation & Misappropriation of Resident Property," dated 11/1/19, indicated, "...The facility will not tolerate Abuse...Abuse. The willful infliction of injury...resulting in...mental anguish...."<br><br>This state residential finding relates to complaints IN00400637, IN00400895, and IN00402960. | | smoking supervision, audit will be completed weekly x 4, monthly x 5<br>ED/Designee to interview 5 residents related to abuse, interviews will be completed weekly x 4, monthly<br>x 5 with any new findings or concerns to be addressed immediately<br>ED/Designee to host resident council 2 x monthly x 3 months to determine resident comfort and satisfaction with plan of correction, administration, resident comfort and safety | |

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| R 0092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:<br>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.<br>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.<br>Based on interview and record review, the facility failed to ensure 12 fire and evacuation drills were completed through the year, fire and disaster drills in conjunction with the local fire department were attempted, and failed to document the names and signatures of the personnel who were present at the fire and evacuation drills that the facility did implement. This deficient practice had the potential to affect 50 of 50 residents who reside in the facility.<br><br>Findings include: | R 0092 | R092<br>This plan of Correction is the facility's credible allegation of compliance.<br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by<br>the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it | 08/11/2023 |

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| | On 6/26/23 at 1:00 P.M., the Marketing Director provided the Fire and Safety binder. The binder lacked documentation of fire drills conducted for January 2023 and June 2023, fire drills were not conducted in conjunction with the local fire department in the past 6 months and there was no documentation of staff attendance nor signatures on the forms titled "Fire and Disaster Emergency Evaluation & Drill," dates; 2/17/23, 3/06/23, 4/12/23, and 5/10/23.<br><br>On 6/29/23 at 11:20 A.M., during an interview with the Administrator, he indicated the facility Maintenance Director left the position that day so was unavailable for interview. The Administrator indicted he was aware the Fire and Safety binder was not up to date and the facility did not have the required fire drills completed as required. The Administrator indicated the facility does not have a policy regarding fire drills.<br><br>On 6/29/23 at 11:37 A.M., during an interview with the Marketing Director, she indicated the facility did not have regular fire drills and that the facility had not had a fire drill with evacuation completed with the local fire department and there had been no evacuation drills conducted. The Marketing Director indicated the facility did not have a fire drill policy.<br><br>A facility policy regarding fire safety and fire drills was requested on 6/29/23 at 11:30 A.M., no policy was provided prior to the survey exit. | | is required by the provisions of federal<br>and state law.<br>This facility respectfully request paper compliance for this citation.<br>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>No residents were affected by this alleged deficient practice<br>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:<br>All residents have the potential to be affected by this alleged deficient practice.<br>Fire Drill conducted with staff ( DATE AT FACILITY )<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:<br>ED/ Maintenance/ Designee educated on Fire Drill Regulation and Expectations including timeframes,<br>staggered shifts fire department involved, documentation of drills completed.<br>All Staff education on Fire Drill policy<br>Fire Drills will be conducted quarterly on each shift to ensure that all staff are familiarized with the<br>signals and emergency steps required. At least 12 drills will be | |

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| | | | completed every year and conducted on various timeframes between 9pm and 6am.<br>The Local Fire Department contacted and requested disaster drill be scheduled with facility as soon as possible and then at least every 6 months moving forward.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:<br>ED/Designee to review fire drills monthly to ensure compliance, if compliance is not maintained appropriate corrective action will be taken | |