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	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOOD RIDGE ASSISTED LIVING	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 Complaint IN00278921and IN00282340. Complaint IN00278921 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00282340 - Substantiated. State Residential Finding related to the allegations are cited at R241. Survey date: January 24 and 25, 2019. Facility number: 001148 Residential Census: 70 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality Review was completed on January 31, 2019.	R 0000		
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 observation, the facility failed to ensure physician orders were followed for a resident who was an insulin dependant diabetic. This deficient practice affected 1 of 3 residents reviewed for physician's orders.	R 0241	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of	02/15/2019

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

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	(Resident B) Finding includes: During an interview, on 1/24/19 at 6:05 P.M., Resident B indicated that he was a insulin dependent diabetic, and the facility gives him his insulin but he was displeased with the facilities monitoring of his diabetes. Resident B indicated the facility was not educated adequately on his need for insulin, and he had been caring for himself and administering his insulin since he was 10 years old and he knew better than anyone when he needs a dose of insulin. On 1/24/19 at 6:10 P.M., a capped insulin syringe and a half- filled bottle of Novolog insulin were observed sitting on a coffee table in Resident B's living room. During an interview, on 1/24/19 at 6:12 P.M., Resident B indicated he gives himself insulin when he feels as though he needs it. He indicated the facility says he should not do that becasuse they have to follow the doctors orders but none of them know how to manage his blood sugars like he does. During an interview, on 1/24/19 at 6:30 P.M., The Wellness Director indicated that Resident B had several episodes of low blood sugars that required medical evaluation and intervention as a result of him administering insulin to himself. The Wellness Director indicated that the emergency room physician evaluated Resident B and an order was written for the facility to administer Resident B's insulin for his safety even though he can pass the facility self-administration evaluation. The Wellness Director indicated that Resident B had been on a leave of absence with his family and		correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. Resident B no longer resides at the community. Resident B, who was his own POA, provided a written move out notice, during the investigation on 1/24/19. 1. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All insulin dependent diabetics records were reviewed to ensure all Physician orders were current, clarified when appropriate and implemented. In addition, self-administration assessments were completed for those managing their own insulin and filed in record. 1. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: ¿ All staff who assist with medication management will be in in-serviced by 2/12/19 on how to clarify orders when those	

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	that she was not aware that he had insulin in his room. During an interview, on 1/24/19 at 6:45 P.M., The Wellness Director indicated that Resident B was upset she asked for his insulin as he believes he should manage his diabetes and insulin, independant of the facility and physicians. The Wellness Director indicated that the insulin was located in Resident B's truck that was sitting in the facilities parking lot, she indicated she was unaware the resident's brother had returned it. She indicated she should have looked in the resident's truck after Resident B returned. A physician order sheet, dated 9/27/18 at 11:50 A.M., "...Patient is not allowed to administer insulin by himself, this has to be administered by medical staff only at the his facility...." A policy, titled Medication, with a revision date of 10/2/18 was provided by the Wellness Director on 1/25/19 at 10:30 A.M. The policy indicated "...Medication Assistance 2. Medication Assistance with medications will hereby be catagorized as either assistance with administration or self- medication which and will occur in accordance with MD [Medical Doctor] orders, Resident preference and ability, state regulations, and Community Policy...." This State tag is related to Complaint IN00282340.		orders are unable to be implemented as written. How to document Resident Rights, including the Resident's individual right to make decisions when they are designated their own POA and how to notify appropriate providers. ¿ All residents who manage their own medications will be assessed quarterly for their ability to self-administer and a copy faxed to their primary care physician for collaboration of care when appropriate. ¿ Review of Policy & procedure to ensure proper documentation of medication disposition occurs when a resident signs out their medications for a leave of absence. 1. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: ¿ The Administrator, Health Services Director (HSD) or designee will utilize the electronic risk management software program to track and trend all residents signed out on a leave of absence. ¿ The Administrator, HSD or designee will ensure audits are completed in accordance with the Quality Assurance policy. The QA audits includes an ongoing quality improvement program	

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			that evaluates health care services within the Community. HSD to complete audits monthly, take action on any findings and report results during monthly QA meetings. ¿ The Administrator or his/her designee will report quarterly to the quality assurance (QA) committee the ongoing results of Health Services QA audits.	