STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u>		(X3) DATE SURVEY  COMPLETED		
			B. WI	NG		08/26/	2022
	ROVIDER OR SUPPLIER			17650 0	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	Survey. This visit is Complaints IN0038 and IN00367315.  Complaint IN00387 Residential Finding R217, R241, R243, and R406.  Complaint IN00382 Residential Finding R217, R241, R299, Complaint IN00380 Residential Finding R217, R241, R243, Complaint IN00367 residential findings cited.  Survey dates: Augur Facility number: 00 Residential Census:	236 - Substantiated. State s are cited at R036, R214, R215, R246, R299, R 300 and R349. 2315 - Substantiated. No state related to the allegations were st 23, 24, 25, and 26, 2022	R 00	000			
	These State Resider accordance with 410	ntial Findings are cited in 0 IAC 16.2-5.					
	Quality review com	pleted on 9/6/22.					
R 0036 Bldg. 00	, ,						

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

TITLE (X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 08/2			08/26/	/2022
			_	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			GENERATIONS DR		
MOODD					BEND, IN 46635		
WOODRIDGE VILLAGE				30016	1 BEND, IN 40035		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	legal representati	ve when the facility has					
	noticed:						
	(1) a significant de	ecline in the resident 's					
	physical, mental,	or psychosocial status; or					
	(2) a need to alter	treatment significantly, that					
	is, a need to disco	ontinue an existing form of					
	treatment due to a	adverse consequences or to					
	commence a new	form of treatment.					
		on, record review and	R 0	036			10/10/2022
	interviews, the facility failed to notify the				R 036- Resident Rights		
	physician of resident changes regarding						
	medication and treatment refusals, medication				1. What corrective action	n(s)	
	omission and laboratory results for 3 residents in				will be accomplished for tho	se	
	a sample of 23. (Re	esidents D, G and C)			residents found to have beer	า	
					affected by the deficient		
	Findings include:				<b>practice.</b> The Physician		
					was notified of residents D, G	and	
	_	l tour of the facility, conducted			Cs refusals of care related to I	•	
		een 9:45 A.M 11:30 A.M., with			treatments, and medications.		
		Admission Director, Resident D			physician was also notified of	the	
	_	t himself up out of his bed and			medication and laboratory		
		lker to the doorway area of his			omissions.		
		8 indicated Resident D was alert			2. How the facility will		
	and oriented.				identify other residents having	_	
		0.5.4.5			the potential to be affected b	-	
		for Resident D was reviewed			the same deficient practice a		
		0 P.M. Resident D was			what corrective action will be	9	
		lity with diagnoses included,			taken.		
		diabetes mellitus type 2, chronic			· All residents have the		
		sive disorder, cerebella stroke			potential to be affected by		
	symptoms and anxi	ety disorder.			deficient practice.		
	The current physici	an's orders for Resident D			Facility will audit 10	alca	
		the resident to receive			resident charts weekly x 4 wee and then 5 residents weekly u		
		(milligrams per milliliter)			all resident charts have been	ridi	
		eek for diabetes. The resident			reviewed. Results of audit will	he	
	1 -				reviewed with MD to ensure a		
	was also to have his blood glucose level assessed three times a day and was to receive Humolog				adequate notifications have be		
	insulin as directed with a sliding scale dependent				addressed.	-CII	
		cose level. In addition, the			3 What measure		
	apon ins blood glud	ose ievei. in addition, the	1		J willat illeasure	73	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022			
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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 CROSS-REFERENCED TO THE APPROVIDENCY)	ON (X5) BE COMPLETION DATE		
	30 units at bedtime administration record had only received to in August from the addition, the reside refused his blood g from August 1 throwere no nursing not electronic record on During an interview D's physician, who medical director, shoutified her of Residinability of the facility of the facility of the facility on the facility on 6/20, included, but were hemipligia, anxiety  The physician's ord period included but (muscle relaxant) 5 daily, Lorazepam (mouth 2 times daily, Lorazepam (mouth 2 times daily) 10 mg tablet 1 times  Review of the Med (MAR), dated 6/01, Resident C did not following dates and 6/07/22 morning ar 6/19/22 evening	ers during the admission were not limited to Baclofen mg tablet by mouth 3 times anitanxiety) tablet 0.5 mg by y, and Cetirizine(antihistamine) daily.  ication Administration Record /22 to 6/20/22, indicated receive Baclophen on the I times:		will be put into place or w systemic changes the fac will make to ensure that the deficient practice does not recur;  Licensed staff and Q will be in-serviced on QMA Scope of Practice, Staff Administered Medication emphasis on MD notification medication omission documentation 4 How the corrective action(s) will be monitored to ensure the de practice will not recur, i.e., quality assurance program be put into place; and Upon orientation with licensed nursing staff, train be provided regarding QMA Scope of Practice, Job Description, and Staff Administered Medication. Health Services Dire designee will monitor week then monthly with Health S Review Schedule Audit too months. Results of the aud be reviewed in QA and plan adapted or adjusted as nee maintain compliance	ility he bit  IMA's Is Is In and  ficient what m will h new ing will A's  ctor or ly x 4 ervices I for 6 its will h will be		

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PRINTED: 10/11/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  08/26/2022	
	PROVIDER OR SUPPLIE	R	17650	r address, city, state, zip cod ) GENERATIONS DR TH BEND, IN 46635	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		receive Lorazepam on the			
	following dates an	d times:			
	6/09/22 morning				
	6/13/22 morning				
	6/15/22 morning				
		receive Cetirizine on the			
	following dates an 6/03/22 morning	a times:			
	6/06/22 morning				
	6/10/22 morning				
	6/14/22 morning				
		mentation explaining the			
	medication omissions listed above.				
	medication omissi  3.The clinical reco on 8/25/22 at 9:25 admitted to the fac included, but were obstructive pulmor failure, diabetes, a  The current physic not limited to: Lev replacement) 200n Methoprol Suc (be failure) 25mg exte time daily, Montel treat allergies) 10n Trazodone (antide at bedtime, Vitami 1 time daily, Clone mouth 2 times dail by mouth 3 times retention) 10mg ta Hydromorphone (g times daily, and H per sliding scale th	ons listed above.  ord for Resident G was reviewed A.M. Resident G was originally cility with diagnoses that not limited to: chronic nary disease (COPD), heart			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	A. BUILDING 00  B. WING		COMPLETED 08/26/2022		
	PROVIDER OR SUPPLIER			17650 G	DDRESS, CITY, STATE, ZIP COD SENERATIONS DR BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Review of the Medi (MAR), dated 7/1/2 Resident G did not following dates and 8/13/22 morning Resident G did not following dates and 8/13/22 morning Resident G did not following dates and 8/22/22 morning Resident G did not following dates and 8/23/22 bedtime Resident G did not following dates and 8/23/22 bedtime Resident G did not following dates and 8/22/22 morning Resident G did not following dates and 8/22/22 morning Resident G did not following dates and 8/22/22 morning Resident G did not following dates and 8/22/22 morning Resident G did not following dates and 8/2/22 through 8/10/8/17/22, and 8/22/2 8/22/22 morning an Resident G did not following dates and 8/22/22 morning, but There was no documedication omission On 8/23/22 at 2:15 provided the policy POLICIES AND PI ADMINISTERED 3/1/2010, and indicipolicy. The policy i resident's Medication	receive Montelukast on the times:  receive Vitamin D3 on the times:  receive Clonazepam on the times:  receive Acetaminophen on the times:  receive Acetaminophen on the times:  receive Bethanechol on the times:		TAG			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIE	R	17650	T ADDRESS, CITY, STATE, ZIP COD O GENERATIONS DR TH 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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
R 0039 Bldg. 00	informationUse to community require regulationDraw a initial it when the man ordered medicate Medication Sheet to medication was not On 8/24/22 at 11:0 indicated nursing signedication adminitial Administration Remedication adminition on the Medication physician should but This state residential IN00380236, IN0000410 IAC 16.2-5-1 Residents' Rights (n) Residents man their stay, voice of or to an outside recommend charmand receive reason requests without interference. Based on observation failed to ensure resopportunity to file concerns. This definition in the community of the concerns. This definition in the properties of the concerns in the community of the concerns. This definition is not the community of the concerns.	the Medication Sheets that the est according to State circle around the square and resident is observed not taking tion. Indicate on the back of the he date, time andreason the taken  O A.M. an interview with LPN 1 taff should document all stration on the Medication cord. Any omissions of stration should be documented Administration Record and the enotified.  al finding relates to Complaints (382840 and IN00387635).  2(n) S- Deficiency yy, throughout the period of prievances to the facility staff expresentative of their choice, toges in policy and procedure, conable responses to their fear of reprisal or ton and interview, the facility idents were provided the grievances when they had icient practice had the potential esidents who resident in the	R 0039	R039- Resident Rights- Grievances  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient	10/15/2022 (s)
	Finding includes: On 8/23/22 at 2:30 Resident G indicat	P.M., an interview with ed she does not know how to the facility and would not		practice. The administr met with resident G and H an reviewed grievances, grievan were recorded and appropriation follow up  2. How the facility will	d ces

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	B. WING				
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP COD  17650 GENERATIONS DR  SOUTH BEND, IN 46635				
WOODK	DGE VILLAGE						
(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)	(X5) COMPLETION DATE		
TAG	know where to local G indicated she could with concerns, but he address her concerns.  On 8/23/22 at 2:50 at Resident H indicated grievance process a grievance forms in the indicated he would with concerns because not act on any concerns.  On 8/25/22 at 3:12 at facility entry area in that held grievance interview, at that time Manager indicated as Grievance Binder of Manager indicated at grievance form for a concerns.  On 8/26/22 at 10:35 Administrator indicated to grievance book or grievance book or grievance book or grievance open door policy and to go to him and tall. The Administrator in have any current correcord of previous corrections.	te a grievance form. Resident ld go to the Administrator ne is not always able to as.  P.M., an interview with d the facility did not have a nd was not aware of any the facility. Resident H not go to the Administrator ase the Administrator does erns.  P.M., an observation of the ndicated there was no place forms for the residents. In an ane, the Business Office she was not aware of a r Book. The Business Office the facility did not have residents to complete with  S.A.M., an interview with the ated the facility did not have a grievance forms. The ated the residents did not have forms because he had an and the residents were allowed k to him about their concerns. Indicated the residents did not	TAG	identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken.  All residents have the potential to be affected by deficient practice.  IDT team will complete resident QIS questionnaire for resident to determine any outstanding grievances or concerns  Hereiten to determine any outstanding grievances or concerns  Hereiten the place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Administrator educated corporate staff on Grievance process and procedure, Grievance process and procedure, Grievance process and procedure access  IDT team educated on Grievance process and procedure  All staff will be in service on Grievance process and procedure  Administrator will hold resident council meeting and provide education to residents Grievance process and procedure  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur, i.e., whe quality assurance program we have the deficient practice will not recur process and pro	ng y ind e  s t by ance nt dure ed ent dure ent in dure		
	was the current poli			·			

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PRINTED: 10/11/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG 00		ESURVEY LETED 5/2022		
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION		PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)				
	the Nurse's Station OfficeAdministra concern or grievand residentoffindir resolution when nee Taken & Resolution	torwill investigate the		Upon orientati licensed nursing staff be provided regarding rights and the Grieval and procedure     Administrator will monitor grievance 4 then monthly to engrievances have been with adequate follow months. Results of the reviewed in QA and adapted or adjusted maintain compliance.	ff, training will ag Resident ance process or designee se log weekly x asure resident en completed oup for 6 he audits will and plan will be as needed to			
R 0090 Bldg. 00	(g) The administrative overall management responsibilities of include, but are not (1) Informing the coccurrence that diveliare, safety, or of unusual occurrence that diveliare, safety, or of unusual occurrence that diveliare, safety, or of unusual occurre telephone, followed a written report or electronic mail to twenty-four (24) hoccurrences inclut (A) epidemic outbe (B)poisonings; (C) fires; or (D) major accident If the division can be made to the er published by the coccurrence over the computation of the computation of the control of t	d Management - Deficiency ator is responsible for the ent of the facility. The the administrator shall of limited to, the following: division within twenty-four oming aware of an unusual rectly threatens the health of a resident. Notice ence may be made by ed by a written report, or by ally that is faxed or sent by the division within the our time period. Unusual de, but are not limited to: reaks;						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	COMPLETED 08/26/2022				
	ROVIDER 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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	nursing care or oth requested by the representative.  (3) Obtaining direct admission of an inyears of age to an (4) Ensuring the fapremises, an accumorked that indicated. (A) employee's full (B) dates and hout twelve (12) month (5) Posting the rest annual survey of the state surveyors, and effect with respect subsequent surve available for examplace readily accentice posted of the (6) Maintaining reploy the division in examplating the facility effect of these systems potential to result in ensure the provision clean safe environmental to result in ensure the provision clean safe environmental to result in the facility effect of these systems and the facility effect of the fa	her health care services as resident or resident's legal ctor approval prior to the adividual under eighteen (18) adult facility. Accility maintains, on the arate record of actual time attes the:  I name; and resident's of the most recent the facility conducted by any plan of correction in the to the facility, and any yes. The results must be an ination in the facility in a assible to residents and a meir availability. Proof of surveys conducted each facility for a period of making the reports action to any member of the standard record review, and policy and Administrator failed to ibility for determining, monitoring facility policies that operations. The cumulative mic problems had the atte facility's inability to a forquality health care and a ment for 53 of 53 residents who	R 0090	R090 Administration and Management  1. What corrective action will be accomplished for tho residents found to have been affected by the deficient practice.  • On September 15, 202 Trash barrels covered, scoops removed from food bins, Ice scoops stored in proper location of the scoops s	10/15/2022 (s) se n		

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING _		08/26	/2022
				STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹	17650 GENERATIONS DR				
WOODR	IDGE VILLAGE		SOUTH BEND, IN 46635				
	Г				, 10000		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		not covered, scoops were			employed at the facility		
		ice cup scoop was stored on					
	1 -	ine, door to outside open,			LPN 2, CNA's 2, 4, 5, had		
	1	chind appliances. See R154 and			tuberculin skin test initiated		
	and food storage.	l information regarding kitchen			Maintanana Dinastan		
	and food storage.				Maintenance Director	iro	
	On 8/23/22 of 0.20	A.M. an interview with the			scheduled fire drill with local F		
		eated QMA 2 was the Nursing			Department for this community	у	
					· Employees will be curre	ent	
	Director before 8/16/22, when Licensed Practical Nurse 2 began to work full time at the facility. The				with In-service for Dementia b		
	Administrator indicated he did not think a Nursing				October 10, 2022	У	
	Director was the same as a Director of Nursing				0010001 10, 2022		
	and that QMA 2 was never registered at the State				· Employee file audit		
		ctor of Nursing. The			completed and scheduled job		
		cated a QMA was not qualified			specific training to be complet	ed	
		or of Nursing. See R117 for			with current facility staff by		
		ion regarding QMA 2.			October 10th, 2022		
					,		
	On 8/24/22 at 9:30	A.M., an employee record			· CPR class scheduled f	or	
	review was comple	ted, and indicated that QMA 2,			staff		
	LPN 2, and CNA's	2, 4, and 5, did not have a 1st					
	and 2nd step tuberc	rulin skin test completed prior			· Grievance program		
		e R121 for additional			initiated		
	information regardi	ing staff tuberculin skin test					
	status.				<ul> <li>Service plan completed</li> </ul>	b	
					with resident C, D and P		
		10 P.M., an interview with the					
		cated the facility had not			Semi Annual Evaluatio		
		n practices with fire drills since			completed for resident F, H, L	, M,	
		Covid-19 pandemic. On			N and P		
		P.M., the Administrator provided					
		na State Department of Health			Service Plans reviewed		
	Residential Regulations regarding required fire				and completed for residents C	, G,	
	safety drills. Section 410 IAC 16.2-5-1.3(i)(1-2)				M, D, F, L, N, P		
		e exit drill in facilities shall			Decident Dwith no		
		ssion of a fire alarm signal and			Resident P with no	N I	
	1	gency fire conditions, except			negative effects related to PR		
		of nonambulatory residents to equired" See R92 for			medication administration by (	ZIVIA	
l .		Admed Dec 17/2 101	1		I		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
			B. W	ING _		08/26/2	022
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R	17650 GENERATIONS DR				
WOODR	IDGE VILLAGE				BEND, IN 46635		
					T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	additional informat	ion regarding facility fire drills.			Dietary orders reviewe	d	
	0.0/05/2022 +0.20 + M +1 +1 +1 +1 +1				and sign by the physician for		
		30 A.M., the Administrator			residents D, M, F, L and P		
	provided a policy titled, "Alzheimer's and dementia care annual training requirement for				Dhama aist mariann		
		residential care facilities",			Pharmacist review	_	
	-	l indicated the policy was the			completed for residents C, D, G, H, L, M, N, P and JJ	Γ,	
		by the facility. The policy			G, H, L, W, N, F and JJ		
		hree-hour annual dementia			· Medications carts 1, 2	and	
		quirement will be based on a			3 were audited and correction		
	calendar year. The	•			made		
	-	raining requirement begins in			l made		
	the year following the employee's date of hire.				· All 23 sample resident		
	Upon the request of a current employee, former				records to be reviewed for		
		ncility, the ISDH requests that			accuracy		
	health facilities pro	vide a copy of an employee's			,		
	dementia specific tr	raining records" See R119			· All 53 residents' charts		
	for additional infor	mation regarding Staff			reviewed for accuracy of		
	orientation, job des	criptions, and education.			emergency contact information	n	
	On 8/25/2022 at 11	:45 A.M., an interview with the			· All staff in servicing		
		cated that he did not have staff			completed related to mask use	e	
		ing general or specific job					
	-	descriptions available. The			· All house TB test blitz		
		cated there had been some			completed		
	_	A policy was requested for job					
	descriptions and or				· Corporate staff to revie		
		cated he could not find a			Job Description with Administr	rator	
	-	See R119 for additional					
	_	ing staff orientation, job					
	descriptions, and ed	iucation.					
	On 8/25/2022 at 1.1	10 P.M., an interview with the			2. How the facility will		
		cated he was unable to produce			identify other residents havi	na	
		certifications for the staff that			the potential to be affected b	-	
	-	rent week. See R117 for			the same deficient practice a	-	
		ion regarding CPR/First-aid			what corrective action will be		
	certifications.	6 6			taken.		
					· All residents have the		
	On 8/26/22 at 10:35	5 A.M., an interview with the			potential to be affected by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 08/26/2022			/2022		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF 1	PROVIDER OR SUPPLIE	R						
WOODB	IDGE VILLAGE			17650 GENERATIONS DR SOUTH BEND, IN 46635				
WOODIN				30011				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Administrator indicated the facility did not have a				deficient practice			
	grievance book. The residents did not have				<ul> <li>Facility working through</li> </ul>			
	_	cause he had an open door			2567 and plan of corrections f	or all		
		dents were welcome to go and			citations and concerns.			
	talk with him about their concerns. See R39 for				3. What measures will be			
	additional information regarding grievances.				put into place or what syster			
					changes the facility will mak	.e		
		ssments were either not			to ensure that the deficient			
	completed or signed and dated, by both the				practice does not recur;			
	resident and the facility staff for 3 of 8 residents				<ul> <li>Corporate team providi</li> </ul>	ng		
	reviewed for preadmission evaluations,				education to Administrator and	d IDT		
	(Residents, C, D, and P).				Team			
	See R214 for additional information regarding				<ul> <li>New Health Service</li> </ul>			
	preadmission evalu	nations for Residents C, D, and			Director Started at facility			
	P.				<ul> <li>Facility working through</li> </ul>	1		
					2567 and plan of corrections f	or all		
		tions were not completed for 6			citations and concerns.			
	1	esident F, H, L, M, N and P).			<ul> <li>Administrator will notify</li> </ul>			
		ional information regarding			regional director with facility			
		tions for Residents F, H, L, M,			operational concerns			
	N, and P.				· Regional staff will provi	de		
					oversite completing at a minin	num		
		completed upon admission,			weekly visit			
		or signed and dated by the			4. How the corrective			
		residents reviewed for Service			action(s) will be monitored to	٥		
	· ·	C, G, M, D, F, L, N, and P). See			ensure the deficient practice			
		l information regarding Service			will not recur, i.e., what qual	ity		
	Plans for Residents	s C, G, M, D, F, L, N, and P.			assurance program will be p	ut		
					into place; and			
	1 -	medications were not			· Health Services Directo			
	_	rder for 13 of 14 records			designee will monitor facility p	lan		
		cations. (Residents D, H, C, G,			of correction weekly x 4 then			
		N, Q, W, and LL). See R241 for			monthly for at least 6 months			
		tion regarding medication			ensure compliance is maintair	ned.		
		s D, H, C, HH, BB, P, DD, S, N,			Results of the audits will be			
	Q, W, and LL.				reviewed in QA and plan will b			
					adapted or adjusted as neede	d to		
		ation in the medical records			maintain compliance			
		ion had been administered for 8			· Regional staff will provi			
	of 23 residents reviewed for medications,				oversite completing at a minin	num		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY PLETED 6/2022	
	PROVIDER OR SUPPLIEF		17650	ADDRESS, CITY, STATE, ZIP CO GENERATIONS DR 1 BEND, IN 46635	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION JULD BE PROPRIATE	(X5) COMPLETION DATE
	additional informat	P, Q, C, G, and D ). See R243 for ion regarding medication Residents F, L, N, P, Q, C, G,		weekly visit		
	QMA (Qualified M signed off by a licer reviewed for medic for additional information	edications administered by a edication Aide) were not used nurse for 1 of 16 residents ations, (Resident P). See R246 mation regarding PRN tration for Resident P.				
	for 5 of 23 Residen See R275 for additi	e not signed by the physician ts, (Resident D, M, F, L and P). onal information regarding the esidents D, M, F, L, and P.				
	for 10 of 23 residen G, H, L, M, N, P as information regardi	ts reviewed by a pharmacist ts reviewed, (Residents C,.D, F, and JJ). See R299 for additional ng Residents pharmacy ats C,.D, F, G, H, L, M, N, P and				
	stored and labeled a medication carts, (N See R300 for additi	medication carts were not appropriately in 3 of 3 Medication Carts 1, 2 and 3). onal information regarding the in Medication Carts 1, 2, and 3.				
	complete for 23 of for additional information	cords were not accurate and 23 sampled residents. See R349 mation regarding the accuracy e resident's clinical records.				
	incomplete resident residents. See R356	mergency information, and information on file for 53 of 53 of for additional information acy and completes of the ecords.				

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	OF CORRECTION IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 08/26/2022
	PROVIDER OR SUPPLIER IDGE VILLAGE	17650 (	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Upon entrance to the facility, on 8/23/2022 at 9: 30 A.M., only one staff member was noted to be wearing a face mask. All other staff members, including the Administrator, were not wearing a face mask and were noted to be interacting with residents in close, less than 6 foot proximity. Resident chest X-rays were not completed prior to admission for 1 of 2 residents admitted in the past year in a sample of 23. Tuberculin skin testing was not completed upon admission and annually for 23 of 23 sampled residents. Nursing staff did not follow standards of care during a medication administration observation. See R406, R408, R410, and R414 for additional information regarding infection control.  On 8/26/22 at 10:35 A.M., an interview with the Administrator indicated he did not have a policy regarding his responsiblies in the facility. The Administrator indicated the Administrator was the person responsible for overseeing the daily operations of the facility.  On 8/26/22 at 12:30 P.M., the Administrator provided a form titled," Health Administrator Duties and Responsibility's" and indicated as the Administrator, these would be among his duties. The form indicated,"Health Administratorsoversee the administrative tasks of a healthcare facilitySchedule employees based on patient needs, Oversee the organization of all patient records, stay up to date on healthcare laws and regulationsA Healthcare Administrator, is responsible for overseeing practices and procedures within a healthcare organizationensuring their facility adheres to health laws and regulations"			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JILDING	onstruction 00	(X3) DATE COMPL <b>08/26</b> /	ETED	
	PROVIDER OR SUPPLIER			17650 (	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	TE	(X5) COMPLETION DATE
R 0092	410 IAC 16.2-5-1.	3(i)(1-2)					
Bldg. 00	disaster prepared continuity of care of emergency as follows:  (1) Fire exit drills in transmission of a simulation of emergency that the more residents to safe at the building is not conducted quarter familiarize all facilia and emergency acconditions. At least held every year. Whetween 9 p.m. are announcement manualible alarms.  (2) At least every shall attempt to he in conjunction with A record of all trains.	st maintain a written fire and mess plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, overment of nonambulatory areas or to the exterior of required. Drills shall be try on each shift to otty personnel with signals of the city personnel with signals of the					
	of the personnel p	resent.	R 0	002	R 092- Admin Noncomplianc	0 –	10/15/2022
	failed to ensure fire completed as direct deficient practice ha 53 residents who re: Finding includes:	and record review, the facility and evacuation drills were ed by the facility policy. This ad the potential to affect 53 of sided in the facility.		072	Emergency Preparedness Fire Evac  1. What corrective action( will be accomplished for the residents found to have been affected by the deficient practice.  No residents were affected.	s) se	10/13/2022
	the Administrator, h	the indicted the facility had not lithat included evacuation ding since January 24, 2020.			by alleged deficit practice.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022	
	ROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
170	The administrator in monthly drills hower that were incompleted October 28,2021).  On 8/24/2022 at 2:1 Administrator indice included evacuation long time because of "he has not contacted follow up but is awayso."  Documentation producted January 24, 22 Fire Department, in severe weather plant addition, there was the Administrator, of from the Clay Fire of they had suspended emergency inspection.  On 8/24/22 at 2:00 Emergency Evaluated	dicated he had conducted over there were two months are (January 31, 2021 and 0 P.M., an interview with atted the facility had not a practices with fire drills for a f COVID. Administrator stated at the fire department for are that it is important to do wided by the Administrator, 2020, at 2:00 P.M. from the Clay adicated a fire, evacuation and drill was conducted. In documentation, provided by lated June 23,2020 at 9:20 A.M. department which indicated routine in person fire or		2. How the facility will identify other residents have the potential to be affected in the same deficient practice what corrective action will be taken.  All residents have the potential to be affected by the alleged deficient practice Fire and evacuation dried held at facility;/bMonthly Fire Drill log audit tool was put in place. Maintenance Assista will provide Executive Director designee with Fire Drill log audit for review and signature. Maintenance Director scheduled fire drill with local Fire Department for this community	ing by and ee  into nt tor eg re.
	that time. The Repo occupants evacuated January 24, 2020	rts indicated there were no d during the drills since		put into place or what syste changes the facility will make to ensure that the deficient practice does not recur;  Management members	mic ce
	drills was requested copy of the resident required fire safety facility policy was p highlighted regulati facility must mainta	on 8/25/2022 at 1:00 P.M. A ial regulations regarding the drills was provided and no provided. Review of the on indicated. "0092 (i) The in a written fire and disaster assure continuity of care of		in-serviced on the Community Emergency management pro with emphasis on fire alarm d and evacuation policy includir Fire exit drills In facilities shal Include the transmission of a alarm signal and simulation o emergency fire conditions, ex that the movement of	r's cess rill ng I fire

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION PRIATE DATE
				nonambulatory residents to areas or to the exterior of the building Is not required. Dribe conducted quarterly on a shift to familiarize all facility personnel with signals and emergency action required varied conditions. At least to (12) drills shall be held event of Maintenance Directors scheduled fire drill with local department for this community of the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be into place; and the Administrator or designee will confirm month and evacuation drills are be conducted and complete drivation monthly for 6 months. For the audits will be reviewed QA and plan will be adapted adjusted as needed to main compliance	ne ills shall each  under welve ry year. r al Fire nity  e put  nly fire eing ill audit Results ed in d or
R 0117 Bldg. 00	qualifications, and applicable state la twenty-four (24) h	• •			
		. The number, qualifications,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/26/2022			
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	required to provide the residents. A m staff person, with a certificates, shall be fifty (50) or more regularly receiver or administration of least one (1) nursi site at all times. Rover one hundred receiving resident administration of rhave at least one person awake and every additional fift shall be assigned they are trained to shall conform with Based on observation interview, the facility staff CPR (cardioput first aid certified for schedule reviewed. To ensure one Quality did not refer to him when communicating facilities. These definities. These definities in the facility.  Findings include:  1. A nursing schedula August 26th, indication CPR/ first aid certified for these dates and one from 7 A.M 7 P.M.	ff shall depend on skills of for the specific needs of inimum of one (1) awake current CPR and first aid one on site at all times. If desidents of the facility esidential nursing services of medication, or both, at any staff person shall be on esidential facilities with (100) residents regularly ital nursing services or medication, or both, shall (1) additional nursing staff of on duty at all times for fity (50) residents. Personnel only those duties for which the perform. Employee duties written job descriptions. On, record review and the staff of the did and the service of the servi	R 0117	R117- Personnel CPR/ QMA Scope  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice.  No residents were affe by the alleged deficient practic  QMA 2 is no longer employed at the facility  2. How the facility will identify other residents havi the potential to be affected by the same deficient practice a what corrective action will be	n cted ce

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WING 08/26/2022			/2022	
		1	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			GENERATIONS DR		
WOODD	IDGE VILLAGE				JENERATIONS DR I BEND, IN 46635		
WOODR	IDGE VILLAGE			30018	I DEND, IN 40033		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		first aid certification was			taken.		
	requested, but one	was not provided.			<ul> <li>All residents have the</li> </ul>		
					potential to be affected by		
		30 A.M., the Administrator	1		deficient practice.		
		ow the state guideline for			· Audit of all staff comple		
	CPR/First aid.				to identify staff in need of CPF	₹	
					certification/recertification		
		10 P.M., during an interview, the			· CPR class scheduled to		
		unable to produce any			ensure facility staff have been		
		fications for the staff that had			CPR certified		
		LPN (Licensed Practical Nurse),					
		Iedication Assistant) 3, and 4,					
		a book they are kept in, but all			3. What measures will be put	t	
	_	d and the staff should have			into place or what systemic		
		n 8/23/22 at 8:00 A.M., an			changes the facility will mak	е	
		A 2 indicated he was not the			to ensure that the deficient		
		g, but had referred to himself as			practice does not recur;		
	-	or on occasions when speaking			During the onboarding		
		swering the phone. QMA 2			process at the facility,		
		t think the Nursing Director			BOM/designee will verify staff		
		Director of Nursing. QMA 2			CPR status and obtain copy o		
		e Resident Care Coordinator			certificate or assist in placing	staff	
	_	Director nor a Director of			in CPR class	20	
	Nursing.				· Audit conducted and CF		
	On 8/22/22 at 0.20	A.M. an interview with the			tracking system initiated, CPR		
		A.M., an interview with the			binder to be maintained with		
		cated QMA 2 was the Nursing 6/22, when Licensed Practical			documentation with dates of		
		ork full time at the facility. The			certification and expiration to ensure staff remain current wi	th	
		cated he did not think a Nursing				u i	
		me as a Director of Nursing			this requirement  Facility staff educated of	'n	
		as never registered at the State			requirement for facility to ensu		
		ctor of Nursing. The			CPR certified staff on schedul		
		cated a QMA was not qualified			always working in facility	C	
	to work as a Direct				· Facility staff educated o	n	
	to work as a Directi	or or running.	1		QMA scope of practice with	71.1	
	On 8/26/22 at 11:00	0 A.M., an undated note located			emphasis in properly identifyir	na	
		per chart was provided by the			self during resident and family	•	
		ed at that time. The note			conversations and interactions		
		own entity indicated, "This			Conversations and interactions	•	
	I III III III III III III III III III		1		I		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022	
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	[Resident JJ] can co your programs. Sign On 8/26/22 at 1:00 titled, "QUALIFIEI of Practice," was pr and indicated this w practice policy. The for a QMA to act as Nursing Director.	P.M., an undated document D MEDICATION AIDE Scope ovided by the Administrator as the current QMA scope of e policy did not give authority a Director of Nursing or as a		4.How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and  Upon orientation with licensed nursing staff will have verification of CPR status  Administrator/designer monitor monthly for expiring certifications and schedule subsequent training to recert  Administrator or desig will monitor daily schedule to ensure that CPR certified state always present in building. Results of the audits will be reviewed in QA and plan will adapted or adjusted as need maintain compliance	put new ve e will ify. nee
R 0119 Bldg. 00	Personnel - Nonco (d) Prior to workin employee shall be facility by the supe designee) of the d employee will wor	g independently, each given an orientation to the ervisor (or his or her epartment in which the k. Orientation of all include the following: the needs of the ations:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. Wl	NG		08/26	/2022
NAME OF I			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	X.		17650 (	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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEI ICIENCI I		DATE
	(E) children; served in the facil	ity					
		e facility's policy manual and					
	applicable proced						
	(A) organization c	•					
	(B) personnel poli						
	(C) appearance a	nd grooming policies for					
	employees; and						
	(D) residents' righ						
	' '	irst aid, emergency					
	procedures, and f						
	1	cluding evacuation					
	procedures.	cal considerations and					
	' '	esident care and records.					
	I	e staff, personal introduction					
		in, the particular needs of					
		whom the employee will be					
	providing care.						
	' '	n of the orientation in the					
		nnel record by the person					
	supervising the or						10/15/2022
		view and interview, the facility	R 0	119	R119- Personnel- Job		10/15/2022
		y had staff orientation to the descriptions for 5 out of 5			Descriptions, Orientation, Dementia Training		
		ewed, and 4 out of 10 reviewed			Dementia Training		
		ng (CNA (Certified Nursing			1. What corrective action(	s)	
		QMA (Qualified Medication			will be accomplished for those	-	
		(Licensed Practical Nurse), and			residents found to have beer		
	housekeeper.				affected by the deficient		
					practice.		
	Finding includes:						
		1 . 1			No residents were affe		
		d review was conducted on			by the alleged deficient practic	ce	
		A.M., and indicated CNA 2, 4, N did not have documentation			. Joh description provide	ad.	
		on of general and job specific			<ul> <li>Job description provide and reviewed with CAN 2,4,5</li> </ul>		
		cription upon hire. And no			LPN	, and	
	-	rovided for LPN, housekeeper,					
	and CNA 2 & 5.	, <b>r</b> ,			General orientation and	d iob	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
	SUMMARY (EACH DEFICIEN REGULATORY OF  During an interview the Administrator in any general or spec descriptions available and there should ha requested, and the A could not find a pol description.  On 8/25/2022 at 9:3 provided a policy ti dementia care annu comprehensive and dated 6/1/2005, and one currently used l indicated " The ti specific training rec calendar year. The dementia-specific to the year following t Upon the request of employee, health fa	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  of on 8/25/2022 at 11:45 A.M., adicated that he does not have iffic orientation, job ale, and some dementia training we been. A policy was administrator indicated he icy for orientation or job  10 A.M., the Administrator thed, "Alzheimer's and al training requirement for residential care facilities", indicated the policy was the by the facility. The policy aree-hour annual dementia quirement will be based on a three hours annual raining requirement begins in the employee's date of hire. To a current employee, former cility, the ISDH requests that wide a copy of an employee's	17650	GENERATIONS DR	DATE  ded  er,  er,  er,  eted
				to identity staff in need of Job Specific Orientation  · Audit of staff completed identify staff in need of Deme Training  · Weekly Training will on to address orientation and training required until compliance of a staff achieved  3. What measures will be purinto place or what systemic	d to ntia cur ining ill

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	F CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 08/26/2022
	ROVIDER OR SUPPLIEI DGE VILLAGE	₹	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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) SE COMPLETION DATE
				changes the facility will may to ensure that the deficient practice does not recur;  Facility staff educated orientation process, checklist procedures with emphasis of general orientation, Job specific orientation and dementia trate.  During the onboarding process at the facility, BOM/designee completely references and Job Specific Orientation is completed.  During Orientation, Dementia Training will be completed during the orientation process.  Audit of all staff complete doined and to dentify staff in need of Job Specific Orientation.  Audit of all staff complete identify staff in need of Dementation.  Audit of staff complete identify staff in need of Dementation.  Weekly Training will of to address orientation and the required until compliance of staff achieved.	t d on st, and on st, and on st, and on scific sining g sew t d sector sciential sector raining all sector sciential sector sciential sector sciential sector sciential sector sciential sector sciential scie
				deficient practice will not recur, i.e., what quality assurance program will be into place; and Upon orientation with new hires, Administrator/ de	all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED		
			B. WING		08/26/2022
NAME OF P	PROVIDER OR SUPPLIEF	 R		ADDRESS, CITY, STATE, ZIP COD	
				GENERATIONS DR	
WOODRI	IDGE VILLAGE		SOUTH	H BEND, IN 46635	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		
				will complete New Hire checkl to ensure that employee has	191
				completed all required aspect	s of
				orientation	
				· Administrator or design	
				will audit new hire employee f	
				weekly x 4 then monthly x 6 to	
				ensure that employees have received adequate orientation	and
				training . Results of the audits	
				be reviewed in QA and plan w	
				adapted or adjusted as neede	d to
				maintain compliance	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET  B. WING 08/26/20					
	PROVIDER OR SUPPLIER			17650 0	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR BEND, IN 46635		
	T			<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC DENTIFYING DIFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
R 0121		LSC IDENTIFYING INFORMATION		IAG			DATE
KUIZI	410 IAC 16.2-5-1.4						
Bldg. 00	employee of a faci	shall be required for each lity prior to resident					
		en shall include a tuberculin					
		e Mantoux method (5 TU,					
		eviously positive reaction					
		ed. The result shall be					
		eters of induration with the					
	date given, date re	_					
		facility must assure the					
	following:	employment, or within one					
	' '	employment, and at least					
	annually thereafter, employees and nonpaid						
	1	ies shall be screened for					
		first tuberculin skin test					
		to the employee starting					
	· ·	are workers who have not					
		l negative tuberculin skin					
		he preceding twelve (12)					
	_	ine tuberculin skin testing					
	should employ the	two-step method. If the					
	first step is negative	e, a second test should be					
	performed one (1)	to three (3) weeks after the					
		uency of repeat testing will					
	depend on the risk	of infection with					
	tuberculosis.						
	, ,	who have a positive					
		n test shall be required to					
		and other physical and					
		ations in order to complete					
	a diagnosis.	II assistation a base 10					
		Ill maintain a health record					
		that includes reports of all					
		ed health screenings.					
		vith symptoms or signs of mptoms suggestive of					
	, .	including, but not limited					
		ight sweats, and weight					
	1 10, 00 agri, 16 voi, 11	ignit owodio, and wolghi					

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	A. BUILDING 00 COMPLETED  B. WING 08/26/2022			
			B. W	ing		00/20/2022	
NAME OF F	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
				17650 GENERATIONS DR			
WOODR	IDGE VILLAGE			SOUTH BEND, IN 46635			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEFEIENCT		DATE
	tuberculosis is ru	permitted to work until					
		and record review, the facility	R 0	121	R119- Personnel- Job		10/10/2022
		aployee health screens were	I K U	121	Descriptions, Orientation,		10/10/2022
		it of 5 reviewed (CNA 2, 5,			Dementia Training		
		2) and TB (tuberculosis) first and					
	1	entation available for 5 out of			1. What corrective action	(s)	
	_	eviewed. (CNA (Certified			will be accomplished for the		
	Nursing Assistant)	2, 4, 5, QMA (Qualified			residents found to have bee		
	Medication Assista	ant) 2, LPN (Licensed Practical			affected by the deficient		
	Nurse) 2,				practice.		
	F:4:				No maridanta como affa	-41	
Finding includes:				No residents were affe			
	An employee recor	rd review was completed on			by the alleged deficient practi	ce	
		A.M., and indicated that QMA 2,			Job description provide	ad l	
		2, 4 and 5, did not have a 1st and		and reviewed with C			
		completed prior to or upon hire.			LPN	, and	
	•	1 1					
	During an interview	w, on 8/24/2022 at 12:55 P.M.,			· General orientation an	d job	
		indicated they could not find			specific orientation was provide	ded	
		here was no documentation			to CNA 2,4,5 and LPN		
		te the testing was completed,					
	but it should have	been.			· Dementia training was		
	0.0/25/2022	00 D.M. d. A.1. * * * *			provided to LPN, Housekeepe	er,	
		00 P.M., the Administrator			and CNA 2,4, and 5		
	1	ow the CDC (Center for Disease ntion) titled, "Screening and			· QMA 2 is no longer		
		Care Personnel," updated			employed at the facility		
		icated the policy was the one			cimployed at the lability		
		he facility. The policy					
		S. health care personnel should					
		upon hire. Review result *			2. How the facility will		
		TB infected, no second TST			identify other residents havi	ng	
	needed; evaluate for	or TB disease. *Negative - a			the potential to be affected by	-	
	second TST is need	ded, Retest 1 to 2 weeks after			the same deficient practice a	-	
	first TST result rea	ıd"			what corrective action will b	е	
					taken.		
		1:30 A.M., a policy was			· All residents have the		
	requested for healt	h screening but one was not			potential to be affected by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00		00	COMPLETED			
			B. WI	NG		08/26/2022	
	PROVIDER OR SUPPLIE	R		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<b></b>	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	provided prior to s				deficient practice.  Audit of all staff comple to identify staff in of General Orientation  Audit of all staff comple to identity staff in need of Job Specific Orientation  Audit of staff completed identify staff in need of Demer Training  Weekly Training will occ to address orientation and trai required until compliance of all staff achieved	ted I to ntia cur ning	
					3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Facility staff educated or orientation process, checklist, procedures with emphasis on general orientation, Job specific orientation and dementia train.  During the onboarding process at the facility, BOM/designee completely new hire check list to ensure that General and Job Specific Orientation is completed.  During Orientation, Dementia Training will be completed during the orientation process  Audit of all staff completo identify staff in of General	e on and fic ing w	

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IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022		
PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  17650 GENERATIONS DR  SOUTH BEND, IN 46635				
IDGE VILLAGE SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	17650	GENERATIONS DR H BEND, IN 46635  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Orientation  Audit of all staff complet to identity staff in need of Job Specific Orientation  Audit of staff completed identify staff in need of Demei Training  Weekly Training will oc to address orientation and tra required until compliance of a staff achieved  4.How the corrective action( will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place; and  Upon orientation with a new hires, Administrator/ desi will complete New Hire check to ensure that employee has	ted  I to intia cur ining ill  s) the ut  II gnee iist		
			completed all required aspect orientation  Administrator or design will audit new hire employee f weekly x 4 then monthly x 6 to ensure that employees have received adequate orientation training. Results of the audit be reviewed in QA and plan wadapted or adjusted as needed maintain compliance	ee iles o and s will vill be		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING		
	ROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	(X5) COMPLETION DATE
R 0144 Bldg. 00	(a) The facility sha a state of good repand shall provide residents. Based on observation interview the facility environment was obgood repair.  Finding includes:  During the tour of the 8/24/2022 at 9:30 A Maintaince Superviolation Room 203 had a streather than the state of th	5(a) fety Standards - Deficiency all be clean, orderly, and in pair, both inside and out, reasonable comfort for all on, record review and by failed to ensure the resident ean, orderly, and in a state of the environment conducted on a.M., with the Administrator and sor, the following was noted: ong pet odor permentating to ong was heavily stained as heavily stained as heavily stained	R 0144	R119- Personnel- Job Descriptions, Orientation, Dementia Training  1. What corrective actions will be accomplished for the residents found to have been affected by the deficient practice.  No residents were affer by the alleged deficient practice.  Job description provides	se n cted ce

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WI	NG		08/26/2022	
		l	<del>'                                    </del>	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			GENERATIONS DR		
WOODD	IDGE VILLAGE		SOUTH BEND, IN 46635				
WOODR	IDGE VILLAGE			3001H	I DEND, IN 40033		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	apartment had a str	9			and reviewed with CAN 2,4,5	, and	
	•	vas heavily stained and a yellow			LPN		
	stain was noted around the base of toilet						
		as ripped by the kitchenette			<ul> <li>General orientation and</li> </ul>	-	
		spot measuring 2 x 4 inches			specific orientation was provid	ed	
	1 -	try way, bathroom door had a			to CNA 2,4,5 and LPN		
	large hole in it with	-					
		vas heavily stained and carpet			· Dementia training was		
	was coming loose f				provided to LPN, Housekeepe	r,	
	Room 103 carpet w	as heavily stained			and CNA 2,4, and 5		
		d hair on floor, combs and			· QMA 2 is no longer		
		them on the counter, and a			employed at the facility		
		unit had rusted metal on the					
	_	o bowl had a heavy					
		d dried debris and the floor was					
	visibly soiled.				2. How the facility will		
					identify other residents having	_	
	I -	nad "cob" webs behind the			the potential to be affected b	-	
	_	nbs in the kitchenette drawer,			the same deficient practice a		
	and multiple stained	a ceiling tiles.			what corrective action will be	9	
	Florescent light firm	tures were not to have sither			taken.		
	1	tures were not to have either covers, in the 100 hallway by			· All residents have the		
	_	0 hall resident laundry room,			potential to be affected by		
		room, and 100 hall mechanical			deficient practice.	tod	
	room, and the halls				<ul> <li>Audit of all staff completo identify staff in of General</li> </ul>	ıeu	
	100m, and the half	way by Koom 211.			l		
	There were stained	, bulging and or broken ceiling			Orientation  Audit of all staff complete	tod	
		out the building. During an			<ul> <li>Audit of all staff completo identity staff in need of Job</li> </ul>	ıeu	
		ed with the Administrator at			Specific Orientation		
	· ·	ted they didn't have any active			Audit of staff completed	to	
	water leaks.	ted they didn't have any active			identify staff in need of Demer		
	water reaks.				Training	ıua	
	The facility laundry	room hand washing sink was			· Weekly Training will occ	nır	
		th dried plaster and there were			to address orientation and trai		
	no paper towels.	ar arroa praster and there were			required until compliance of al	•	
	no paper towers.				staff achieved		
	A policy regarding	environmental cleaning and			Stan achieved		
		equested on August 25th at					
	I mannenance was re	question on ringust 25th at	1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	PROVIDER OR SUPPLIE	R	17650	ADDRESS, CITY, STATE, ZIP COE GENERATIONS DR H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION le was provided by the survey	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION JUD BE ROPRIATE  COMPLETION DATE
	exit.	tial finding relates to Complaint		3. What measures will be into place or what syste changes the facility will to ensure that the defici practice does not recur;  Facility staff educate orientation process, check procedures with emphasing general orientation, Job so orientation and dementiate.  During the onboard process at the facility, BOM/designee complete hire check list to ensure the General and Job Specific Orientation is completed.  During Orientation Dementia Training will be completed during the orientation orientation.  Audit of all staff conto identify staff in of General of Specific Orientation.  Audit of all staff conto identify staff in need of Specific Orientation.  Audit of staff compliance of Specific Orientation.  Weekly Training with to address orientation and required until compliance staff achieved.  4. How the corrective active in the corrective in the corre	emic make ient is ated on cklist, and is on specific training ding  ly new that c  make interest of the control

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/26/2022	
	F PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
				assurance program into place; and  Upon orientati new hires, Administr will complete New H to ensure that emplo completed all require orientation Administrator will audit new hire er weekly x 4 then mon ensure that employe received adequate o training. Results of be reviewed in QA a adapted or adjusted maintain compliance	on with all ator/ designee ire checklist yee has ed aspects of or designee inployee files thly x 6 to es have rientation and the audits will and plan will be as needed to		

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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLE		(X3) DATE SURVEY COMPLETED 08/26/2022	
	ROVIDER OR SUPPLIER		170	REET ADDRESS, CITY, STATE, ZIP COD 650 GENERATIONS DR DUTH BEND, IN 46635	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE APPROP	E COMPLETION
R 0148 Bldg. 00	(e) The facility sha grounds, and equin good repair, and adversely affect the residents or the position (1) Each facility sha implement a writtent to ensure the conformal (2) The electrical sappliances, cords sources, fire alarm shall be maintained functioning and concelectrical codes.  (3) All plumbing shaded comply with state (4) At least yearly systems shall be in Based on observation failed to ensure the compiled with state.  Finding includes:  During the environal conducted on 8/24/2 connected to the sparesting on the botto the drain. The hose	fety Standards - Deficiency all maintain buildings, ipment in a clean condition, d free of hazards that may he health and welfare of the sublic as follows: hall establish and en program for maintenance tinued upkeep of the facility. system, including h, switches, alternate power h and detection systems, hed to guarantee safe compliance with state hall function properly and plumbing codes. h heating and ventilating hispected. hall interview the faculty plumbing in the beauty shop	R 0148	R 148- Sanitation and Safe Beaty Shop Plumbing  1. What corrective active will be accomplished for the residents found to have be affected by the deficient practice.  No residents affected alleged deficient practice	on(s) nose een
	valve located near t contaminated water system.	he sink to prevent from entering the clean water		Plumbing to beauty s sink corrected, anti-reflex va replaced	•

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 08/26/2022
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	(X5) COMPLETION DATE
	maintenance was re	environmental cleaning and quested on August 25th at e was provided by the survey		2. How the facility will identify other residents havi the potential to be affected in the same deficient practice awhat corrective action will be taken.  Residents that visit the beauty shop have the potential be affected by alleged deficient practice  Maintenance educated Spray attachment for shampor bowl  Hairdresser educated of spray attachment for shampor bowl  What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur;  Maintenance educated Spray attachment for shampor bowl  Hairdresser educated Spray attachment for shampor bowl  Hairdresser educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated of spray attachment for shampor bowl  Maintenance staff educated spray attachment for shampor bowl  Maintenance staff educated spray attachment for shampor bowl  Maintenance staff educated spray attachment for shampor bowl	and e  al to ont ono ono ono ono ono ono ono ono ono

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	PROVIDER OR SUPPLIEF		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR 1 BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)  audit environmental rounds. Rounds conducted in Beauty to ensure compliance with	
				plumbing and shampoo bowl maintenance and cleaning · Audit to be completed weekly x 4 then monthly x 6 to ensure compliance · Results of the audits wi reviewed in QA and plan will be adapted or adjusted as needed.	ll be pe
				maintain compliance	

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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 APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
R 0154 Bldg. 00	(k) The facility shakitchen areas, corequipment, and ut and rubbish, and ut accordance with 4 Based on observation failed to ensure the covered when not in in food bins and labstored on top of mafor low temp dishwoutside was closed, appliances and covered with the covered when not in the covered when not in food bins and labstored on top of mafor low temp dishwoutside was closed, appliances and covered with the covered when not in the covered when not in the covered when not in the covered was closed, appliances and covered with the covered was closed, appliances and covered with the covered was closed.	fety Standards - Deficiency all keep all kitchens, nmon dining areas, tensils clean, free from litter maintained in good repair in	R 0154	R154- Sanitation and Safety-Kitchen  1. What corrective action(will be accomplished for thos residents found to have been affected by the deficient practice.	e	
	the Dietary Manage the kitchen door wa with no staff curren barrels one by the d on the other side of with the lids proppe bin labeled sugar w starch, breadcrumbs them, a bin was not scoop sitting on top Behind the stove ly mitts, dry noodle, at by the dietary manage	the kitchen on 8/23/2022 with for from 9:05 A.M. to 9:30 A.M., is propped open to the outside the working in the kitchen, two ishwasher area and the other the stove were uncovered and next to the barrels. A food as dated 1/13/2022, corn is undated all had a scoop in labeled with salt, and ice cube of machine was uncovered. Sing on the floor were two oven and dirt. No hair net was worn ger during the tour.		No residents were affect by alleged deficient practice  Trash barrels covered, scoops removed from food bins Ice scoops stored in proper location.  Food bins cleaned and appropriately labeled  Floor cleaned behind appliances  Dishwasher strips were disposed and replaced		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED	
			B. WI	ING		08/26/2	2022	
		I .		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R		17650 GENERATIONS DR				
WOODR	IDGE VILLAGE			SOUTH BEND, IN 46635				
	T				T	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE	
		dicated that the barrels should						
		, no scoops were to be in the			Coverings were replac	ed		
	food bins, appropriate labeling should have been on the outside of the bins and, the ice cube scoop				for light fixtures in kitchen			
		-			D			
		covered and a hair net worn			Prop was removed and			
		n. They have no cleaning			door was closed to the kitcher	n		
		tchen but sweep and mop every						
	_	to pull out the stove and have been swept behind						
	appliances.	nave occii swept ociiiid			2. How the facility will			
	аррнансев.				2. How the facility will identify other residents havi	na		
	2. During an observation on 8/23/2022 at 10:15				the potential to be affected by	-		
	_	n the kitchen to the outside			the same deficient practice a	- 1		
	was open, the dishwasher was running with the				what corrective action will b			
	temperature logged as 120 degrees, a chemical test				taken.	е		
		ed strips dated 3/31/2018, with			All residents have the			
	_	washer testing and no covers			potential to be affected by alle	hand		
	_	ne fluorescent light fixtures.			deficient practice	geu		
	were noted over th	ie Huorescent fight fixtures.			Deep clean of the kitch	en		
	During an interview	w on 8/23/2022 at 10:25 A.M.,			was completed			
	_	er indicated the outside door			· Audit completed and all	ı		
		en closed, the chemical strips			food labeled and dated as	'		
		ere was no log present on			appropriate			
		e and should have been and			· Dishwasher temp log			
		fixtures have been like that			initiated			
	since she has been				· Kitchen cleaning sched	uled		
					initiated			
	During an interview	w on 8/23/2022 at 11:05 A.M.,			3. What measures will be	,		
	the Administrator	ndicated that the light fixtures			put into place or what syster	mic		
	have been like that	since he has worked here and			changes the facility will mak	1		
	were not addressed	l in the past.			to ensure that the deficient			
					practice does not recur;			
	On 8/23/2022 at 2:	45 P.M., the Administrator			· Dietary Manager educa	ited		
		itled, " Food Identification And			on dishwasher temp log and			
		hine Temperatures,			kitchen cleaning schedule			
	effectiveness of hair restraints"undated and				· Dietary staff educated of			
		was the one currently used by			dishwasher temp log and kitcl	hen		
		olicy indicated "a. Determine			cleaning scheduled			
		achine the community utilizes,			· Dietary staff educated of	1		
	either a high temperature or low temperature				Food labeling and Storage an	d		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022
	ROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION (X5) D BE COMPLETION DATE
	utilizes low tempershould be obtained During each period dinner, the employed will record the wash sanitizer PPM for low wash and rinse temperature of note the wash cycle and 25 PPM concentrate provided in subsect wear hair restraints nets, beard restraints body hair, that are obtained with the wash cycle and 25 PPM concentrate provided in subsect wear hair restraints nets, beard restraints body hair, that are obtained with the wash cycle and 25 PPM concentrate provided in subsect wear hair restraints body hair, that are obtained with the provided in subsect wear hair restraints body hair, that are obtained with the provided in subsect wear hair from (2) clean equipmen unwrapped single-sworking containers ingredients that are packages for use in such as: (1) cookin potato flakes, (5) sa shall be identified with food, except that cobe readily and unm dry pasta, need not On 8/23/2022 11:13 light fixtures, open kitchen, ice cube see	termined that the community ature machine, PPM strips from the chemical vendor. b. of use; breakfast, lunch and se utilizing the dish machine in temperatures and level of ow temperature machines, and peratures for the high temp are Dish Machine Temperature machines must have a sess than 120 degrees during rinse must have a minimum of iton sanitizer. Except as iton (b), food employees shall a such as hats, hair covering or is, and clothing that covers designed and worn effectively in contacting: (1) exposed food; it, utensils, and linens; and (3) ervice and single use articles. It holding food or food removed from their original the retail food establishment, goils, (2) flour; (3) herbs, (4) llt; (6) spices; and (7) sugar; with the common name of the intainers holding food that can istakably recognized, such as be identified"		infection control requirements the kitchen  Dietary Manger to contain the kitchen  Dietary Manger to contain the kitchen environments an itation rounds  How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and  Administrator. Design complete Kitchen sanitation rounds to ensure compliant cleanliness and infection of practices  Audit to be complete weekly x 4 then monthly x ensure compliance  Results of the audit reviewed in QA and plan wadapted or adjusted as ne maintain compliance	complete al and  n(s) ure the t  pe put  gnee to on nce with control  ed 6 to s will be will be
R 0187 Bldg. 00	(k) Hot water tem	6(k) andards - Deficiency perature for all bathing and ilities shall be controlled by			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/26/2022			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  17650 GENERATIONS DR  SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	an automatic contemperature at pormaintained betwee degrees Fahrenho (120) degrees Fal Based on observation interview, the facility temperatures were of 6 rooms.  Finding includes:  During the environ conducted on 8/24/following hot water Room 203- temperatures Room 213 temperatures and interview Director, Employed had started two day checked hot water the hot water heater located in the main set at 122 degrees I indicated he would	rol valve. Water int of use must be en one hundred (100) eit and one hundred twenty hrenheit.  on, record review and ty failed to ensure hot water maintained at a safe level in 3  mental tour, of the facility, 2022 at 9:30 A.M., the remperature were noted:  ature 125 degrees Fahrenheit ature 126.1 degrees Fahrenheit ture 123.4 degrees Fahrenheit ture 123.4 degrees Fahrenheit et ature 125 degrees Fahrenheit ture 126.1 degrees Fahrenheit ture 127, at that time, he indicated he is prior and had not yet remperature. Observation of a mixing value thermostat, tenance room indicated it was Fahrenheit Employee 17 turn down the mixing value. indicated that no residents had	R 0187	F187- Physical Plan Standar Hot water Temps  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice.  No residents were affe by the alleged deficient practice.  Water mixing value thermostat adjusted  2. How the facility will identify other residents have the potential to be affected in the same deficient practice what corrective action will be taken.  All residents had the potential to be affected by alledeficient practice.  3. What measures will be put into place or what syste changes the facility will make to ensure that the deficient	n(s) use n ected ce and ee eged emic		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022				
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD				
WOODR	IDGE VILLAGE		17650 GENERATIONS DR SOUTH BEND, IN 46635					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG		LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE			
				practice does not recur;  Maintenance director educated on environmental reas it relates to hot water temperature checks  Maintenance director to check water temperatures  1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place; and  Administrator/ Designe audit water temperature logs verify water temps  Audit to be completed weekly x 4 then monthly x 6 to ensure compliance  Results of the audits wireviewed in QA and plan will adapted or adjusted as needed maintain compliance	ounds  o  ity  out  e to  and			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022				
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R 0214 Bldg. 00	each resident sha admission and sha semiannually and change in the reside A licensed nurse s needs of the resid Based on observation review, the facility assessments were endated, by both the reformed of 8 residents evaluations, (Residents evaluations, (Residents evaluations) include:  1. The clinical recommon 8/24/22 at 9:40 Are to the facility on 5/24.	ency of the individual needs of all be initiated prior to all be updated at least upon a known substantial dent's condition, or more ont's or facility's request. Shall evaluate the nursing ent. on, interview, and record failed to ensure preadmission other completed or signed and esident and the facility staff reviewed for preadmission ents, C, D, and P).  and for Resident C was reviewed A.M. The resident was admitted and limited to: hemiplegia,	R 0214	R 214- Evaluation- Preadmission Assessments  1. What corrective action will be accomplished for the residents found to have bee affected by the deficient practice.  No residents were affe by alleged deficient practice	se n			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
			B. WING			08/26/	2022
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD				
WOODD			17650 GENERATIONS DR				
WOODR	WOODRIDGE VILLAGE			SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DRAWINER'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	There was no pread	lmission assessment			· Resident C, D and P w	ere	
	evaluation located i	n the Electronic Medical			reviewed and had assessment		
	Record or in Resident C's paper chart.				completed		
					· ·		
	On 8/24/22 at 11:00	A.M., an interview with					
	Licensed Practical Nurse (LPN) 1, indicated						
		to the facility should have a			2. How the facility will		
	preadmission assess	sment in the their medical			identify other residents havir	ng	
	records. LPN 1 indi	icated he could not find a			the potential to be affected b	_	
	preadmission assessment for Resident C.				the same deficient practice a	-	
					what corrective action will be		
	On 8/24/22 at 11:10 A.M., an interview with QMA				taken.		
	2 indicated he did not know where Resident C's				· All newly admitted		
	preadmission assess	sment was, but that he			residents to the facility have th	ie	
	thought it was comp	pleted. 2. The clinical record			potential to be affected by alle		
	for Resident D was	reviewed on 8/24/2022 at 10:00			deficient practice	•	
	A.M. Resident D w	vas admitted to the facility on			An audit of new admissi	ons	
	5/9/2022 with diagr	noses included, but not limited			over the last sixty days		
	to: diabetes mellitus	s and hyperlipidemia.			completed, any resident without	ut a	
					preadmission evaluation		
	There was no pread	lmission assessment			completed reviewed and evalu	ation	
	evaluation located of	on the electronic or the hard			completed		
	chart for Resident I	D. During an interview with			3. What measures will be		
	QMA 2, the Reside	ntial Care Coordinator, on			put into place or what systen	nic	
	8/24/2022 at 11:00	A.M. regarding the			changes the facility will make	9	
	preadmission evalu	ation, he indicated he would			to ensure that the deficient		
	have to look for the	evaluation but he knew there			practice does not recur;		
	was one completed	because he remembered he			· Admissions Director		
	was present with the	e facility's previous licensed			provided education on		
	nurse when the eval	luation was completed for			preadmission evaluation		
	Resident D. On 8/2	5/2022 at 10:00 A.M., an			requirements		
	undated assessment	for Resident D was			· Licensed staff provided		
	presented by QMA	2. The assessment was			education on preadmission		
	signed by Resident	D but the it was unclear which			evaluation		
	type of assessment	was completed, there was no			· Preadmission checklist	to	
	indication which sta	aff had completed the			be completed prior to resident		
	evaluation and the '	"Total Score" portion was left			admission to the facility to be		
		the plan indicated the resident			reviewed by IDT team to ensu	re all	
		ith his mobility without			requirements are met		
	assistive devices, ha	ad adequate vision without			1. How the corrective		
	1		1		•		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/26/2022				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF glasses, took his me	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  Edications by himself, no mented by the injectable	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  action(s) will be monitored to ensure the deficient practice	DATE			
	medication section, sugar testing and in require coordination During an interview	was independent with blood sulin injections, did not n of care and denied any pain.		will not recur, i.e., what qual assurance program will be proposed into place; and  Health Services Director Designee to complete admissions.	lity out or/			
	he was observed to glasses. He indicate both his oral and in severe nerve type p	ted on 8/24/2022 at 1:15 P.M., utilize a walker and wear eye ed the facility administered jectable medications and had ain in his feet and legs. He		audit on all new admissions to ensure that preadmission checklist completed and preadmission evaluation is completed				
	indicated he had a tumor removed from his spinal cord and had had pain issues since the surgery.  He also indicated he had came to the facility from the homeless shelter and the facility's physician had wanted him to see the neurologist and the			Audit to be completed weekly x 4 then monthly x 6 tensure compliance     Results of the audits wereviewed in QA and plan will	ill be be			
	it had to be resched Although an assessi Resident D on 8/25.	ed his appointment for him but uled.  ment was provided for /2022 it was inaccurate and not member completing the		adapted or adjusted as neede maintain compliance	ed to			
	assessment.3. A clin completed on 8/25/2 current diagnoses in	nical record review was 2022 at 9:28 A.M. Resident P's acluded, but were not limited ions, atrial fibrillation and left						
	Evaluation prior to	lacked a Pre Admission her admission on 11/26/2021.						
	Evaluation was requested.	247 A.M., the Pre Admission dested, but one was not y, on 8/26/2022 at 10:05 A.M.,						
	_	e could not locate a Pre						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	COMPLETED 08/26/2022				
	ROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R 0215 Bldg. 00	provided the policy Assessment", dated policy was the one of The policy indicated each potential reside admission to ensure is appropriate as requirelating to residential initial assessment easemi-annually and a ensure continued ap Licensed Assisted Ladmission, semi annodition, each residential the form titled" Admission, semi annodition, each residential IN00387635, IN003410 IAC 16.2-5-2(Invaluation - Deficial (b) The preadmission shall provide the binitial evaluation. Signall compare the to his or her status be used to assure requires is within the and supervision profacility.  Based on record reversal facility.  Based on record reversal facility.  Findings include:  1. The clinical record.	•	R 0215	R 215- Evaluation- Semi Ann Assessments  1. What corrective action will be accomplished for the residents found to have been affected by the deficient practice.	(s) se		

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	l í	A. BUILDING <u>00</u>			COMPLETED	
			B. W	ING		08/26/	2022	
				CTREET	ADDRESS CITY STATE TIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
MOODE					GENERATIONS DR			
WOODR	WOODRIDGE VILLAGE			5001F	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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	admitted to the faci	lity with diagnoses included,						
		epilepsy, non pressure ulcers			<ul> <li>No residents were affe</li> </ul>	cted		
	of the skin, glaucoma, chronic pain, major				by alleged deficient practice			
	depressive disorder and hypertension,							
					· Residents, N .M,H,F,L	, N		
		ni annual assessment, located			and P assessments complete	d		
		as dated 4/21/2021. During an						
		A 2, conducted on 8/24/2022 at						
		ated the facility's previous			2.How the facility will identif	у		
		ied the facility when an			other residents having the			
		e but since they had changed			potential to be affected by the	ne		
	pharmacies, the reviews had not been completed				same deficient practice and			
	timely.2. The clinical record for Resident H was				what corrective action will b	e		
	reviewed on 8/24/22 at 9:50 A.M Resident H was				taken.			
		lity on 6/08/17, with diagnoses			· All residents to the facil	-		
	1	vere not limited to: dementia,			have the potential to be affect	ed		
	and alcohol depend	ence.			by alleged deficient practice			
					An audit of all residents			
		annual assessment located in			that reside in the facility will be	е		
		ical Record or in Resident H's			completed to determine			
	paper chart.				semiannual assessment and			
					service plan compliance, Faci	lity		
		A.M., an interview with			will audit 10 resident charts			
		Nurse (LPN) 1, indicated			weekly x 4 weeks and then 5			
		ve semiannual assessments			residents weekly until all residents			
	_	ne medical record. LPN1			charts have been reviewed ar			
		ot able to locate a semiannual		resident assessments and ser		rvice		
		dent H, but that the resident			plans are updated and in			
	should have had on	e completed.			compliance			
	0/24/22 4 11 10 4	M '4 ' '40 1'C 1			3.What measures will be put			
		M., an interview with Qualified			into place or what systemic			
		nt 2, indicated he was not able ual evaluation for Resident H			changes the facility will mak	е		
					to ensure that the deficient			
		dical record. 3. A clinical record			practice does not recur;			
		ted on 8/25/2022 at 3:48 P.M. sees included, but were not			· IDT team provided			
					education on Semi Annual			
	disease and schizoa	, bipolar, diabetes, Parkinson's			evaluation and service plan			
	disease and schizoa	meenve disorder.			requirements			
	A C	-111/21/2021 (1 1 )			· Resident evaluation			
	A Service Plan, dat	ed 11/21/2021, was the last			tracking system to be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	COMPLETED	
MIDILAN	or condiction	DENTH TEATTON NOWIDER	B. W.		00	08/26/2022
			B. W.			0012012022
NAME OF D	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	ROVIDER OR SUFFLIE.	IX.		17650 (	GENERATIONS DR	
WOODR	IDGE VILLAGE			SOUTH	1 BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	service plan compl	eted.			implemented and maintained	by
					Health Service Director/design	-
	A request for service plans completed in February and May was requested on 8/26/2022, but none				to ensure that all residents ha	ive
					scheduled semiannual evalua	ition
	were provided. There was no new evaluations				scheduled and completed	
	completed semi-annually.				Evaluation schedule wi	ll be
					reviewed with IDT in AM mee	
	4. A clinical record review was completed on,				4. How the corrective action(	_
		P.M. Resident L's diagnoses			will be monitored to ensure	•
		not limited to: diabetes,			deficient practice will not	
	· ·	, hypertension and anxiety.			recur, i.e., what quality	
					assurance program will be p	out
	A Service Plan, undated, was the only service				into place; and	,
	plan in the medical record. There was no new				linto piaco, ana	
	_	eted semi-annually.			i. Health Services	
	Cvaraations compre	seed semir dimidding.			Director/ Designee to complete	te
	5 A clinical record	l review was completed on			audit to ensure semiannual	
		P.M. Resident N's diagnoses		assessments and service plans		
		not limited to: hypertension,			are accurate and completed p	
		ain and congestive heart failure.			schedule	Jei
	attan normation, p	am and congestive heart familie.			Scriedule	
	A Service Plan, da	ted 11/21/2021, was the last			ii. Audit to be	
	service plan compl	eted.			completed weekly x 4 then	
					monthly x 6 to ensure complia	ance
	A request for servi	ce plans completed in February				
	and May was reque	ested on 8/26/2022, but none			iii. Results of the aud	lits
	were provided. The	ere was no new evaluations			will be reviewed in QA and pla	an
	completed semi-an	nually.			will be adapted or adjusted as	;
					needed to maintain compliand	
	6. A clinical record	l review was completed on				
	8/25/2022 at 9:28 A	A.M. Resident P's current				
	diagnoses included	l, but were not limited to:				
	-	ns, atrial fibrillation and left				
	hemiparesis.					
	A Service Plan, dated 11/21/2021, was the last					
	service plan compl	eted.				
	A request for some	ce plans completed in February				
	_					
	or iviay was reques	ted on 8/26/2022, but none	1		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
			B. WI	NG		08/26/	/2022
NAME OF P	ROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD		
			17650 GENERATIONS DR				
WOODR	IDGE VILLAGE			SOUTH	BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION are was no new evaluations		TAG	DEFICIENC!)		DATE
	completed semi-ani						
	On 8/24/2022 at 10:43 A.M., QMA 2 provided the policy titled," Service Plan", dated 3/22/2011, and						
	indicated the policy	was the one currently used					
		policy indicated"The service					
	_	fter resident's admission and					
		esident and or the responsible					
	party within the first two weeks after admission.  The comment column of the resident assessment						
	tool may serve as the temporary service plan until						
	the permanent service plan is completed6. The Service Plan is reviewed and/or revised as						
	appropriate followi	ng any significant changes in					
	needs and discussed	d by the resident and the					
	-	desires change. 7. Service					
	-	n the resident's individual					
		rvice Plan is reviewed and/or					
		ate upon significant changes					
	identified in the As	ble parties will be notified of					
		s in advance of the organized					
	•	nterdisciplinary team, the					
	-	her responsible party will be					
		participate to complete the					
	review"						
		g is related to Complaint					
	IN00387635, IN003	380236, and IN00382840.					
R 0217	410 IAC 16.2-5-2(	(a)(1 <sub>-</sub> 5)					
11 0217	Evaluation - Defic						
Bldg. 00		pletion of an evaluation, the					
-	, ,	ropriately trained staff					
	members, shall identify and document the						
	-	vided by the facility, as					
	follows:						
		offered to the individual					
	resident shall be appropriate to the:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/26/2022		
	PROVIDER OR SUPPLIEI	<b>.</b>	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	revised as appropresident and facilic change. Either the request a service (3) The agreed upsigned and dated of the service plan resident upon req (4) No identification services provided subsequent to the no need for a cha (5) If administration provision of reside both, is needed, a involved in identification the services to be 5. A clinical record 8/25/2022 at 3:48 Fincluded, but were diabetes, Parkinson disorder.  A service plan, date resident/responsible and date.  A request for a service plan or Ma but none were proven 6. A clinical record 8/25/2022 at 4:05 February and or Ma but none were proven 6. A clinical record 8/25/2022 at 4:05 February at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the resident record 8/25/2022 at 4:05 February and contact the record 8/25/2022 at 4:05 F	bon service plan shall be by the resident, and a copy in shall be given to the uest.  In and documentation of is needed if evaluations initial evaluation indicate inge in services.  In of medications or the certial nursing services, or a licensed nurse shall be ideation and documentation of provided.  The review was completed on the initial evaluation indicate in the ideation and services, or a licensed nurse shall be ideation and documentation of provided.  The review was completed on the initial evaluation in the ideation in the ideat	R 02	217	R 217- Evaluation- Service Plans  1.What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.  No residents were affect by alleged deficient practice.  Residents F,L,N, P, C,G,M,D had service plans reviewed and updated	ı	10/15/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		08/26/	2022
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH 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	\TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	depression, bipolar,	, hypertension and anxiety.					
					2.How the facility will identif	y	
	A undated service plan on the clinical record,				other residents having the		
	indicated the next service plan was due on				potential to be affected by the	ne	
	1/28/2022. The und	lated service plan lacked the			same deficient practice and		
	resident/responsible	e party, facility staff signatures			what corrective action will b	е	
	and date.				taken.		
					· All residents to the facil	lity	
	A request for service	ce plans completed in January,			have the potential to be affect	ted	
	April and or July w	ras requested on 8/25/2022, but			by alleged deficient practice		
	none were provided	1.			<ul> <li>An audit of all residents</li> </ul>	3	
					that reside in the facility will b	е	
	7. A clinical record review was completed on				completed to determine service	ce	
	8/24/2022 at 1:15 P.M. Resident N's diagnoses				plan compliance, Facility will a	audit	
		not limited to: hypertension,			10 resident charts weekly x 4		
	atrial fibrillation, pa	ain and congestive heart failure.			weeks and then 5 residents		
					weekly until all resident charts	3	
		ed 11/19/2021, lacked the			have been reviewed and resid	dent	
	_	e party and facility staff			assessments and service plan	ns	
	signatures				are updated and in compliand		
					3.What measures will be put	:	
	_	ce plans completed in February			into place or what systemic		
		ested on 8/26/2022, but none			changes the facility will mak	æ	
	•	ere was no new evaluations			to ensure that the deficient		
	completed semi-ani	nually.			practice does not recur;		
					· IDT team provided		
		review was completed on			education on service plan pol	icy	
		A.M. Resident P's current			and requirements		
		, but were not limited to:			· Licensed staff will be		
		s, atrial fibrillation and left			educated on Service Plan Pol	licy	
	hemiparesis.				and requirements		
	A 1 1 .	-11/11/2021 1 1 1.1			Resident Schedu	ııe	
	_	ed 11/11/2021, lacked the			and tracking system to be	h	
	_	e party and facility staff			implemented and maintained	•	
	signatures.				Health Service Director/desig		
	A request for some	og plans gomplated in Echanism			to ensure that all residents ha		
	_	ce plans completed in February ested but none were provided.			scheduled service plan review	VS	
	and may was reque	ested but none were provided.	Service Plan review schedule will be reviewed with IDT				
	During on internit	u on 8/26/2022 at 10:05 A M				וטוו	
	During an interviev	v, on 8/26/2022 at 10:05 A.M.,			in AM meeting		

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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 08/26/2022	
	PROVIDER OR SUPPLIEI	₹		17650 0	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· E	DATE	
	QMA 2 indicated here are plans for Residents.  On 8/24/2022 at 1 policy titled, "Servi indicated the policy by the facility. The service plan is come admission and revier responsible party we admission. The come assessment tool masservice plan until the completed. 2. The indicated Director, and the policy of the Activity Director, and develop the service plan development, by the resident will approaches and stowill be included in Service Plan is reviewed and discussed facility as needs or Plans will be kept in charts 13. The Service plan reviewed the plan reviewed meeting 15. The interesident, and his or	e could not locate Service F, L, N and P.  1:43 A.M., QMA 2 provided the fice Plan", 3/22/2011, and 7 was the one currently used policy indicated" 1. The pleted after resident's ewed with the resident and 7 within the first two weeks after ment column of the resident y serve as the temporary ne permanent service plan is interdisciplinary team administrator/Designee, food Service Supervisor, and other appropriate staff will plan. 3. As part of the Service all services and care required be outlined. 4. Specific ps required for the resident the Service Plan			Service Plans will be updated as necessary for acut changes as needed in clinical morning meeting  i. Health Services Director/ Designee to complete audit to ensure service plans a accurate and completed per schedule and upon admission  ii. Audit to be completed weekly x 4 then monthly x 6 to ensure complia  iii. Results of the audi will be reviewed in QA and pla will be adapted or adjusted as needed to maintain compliance.	e are nce ts n		
	This Residential Ta	ng is related to Complaint 380236, and IN00382840.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY TPLETED 26/2022			
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	failed to ensure Ser upon admission, redated by the resider for Service Plans, (and P). This deficie for negative outcon areas of care.  Findings include:  1. On 8/24/22 at 9:records were provided Nurse (LPN) 1 and (QMA) 2, and revided on 8/24/22 at 11:00 indicated Resident LPN1 indicated all Plan in place upon 2. On 8/23/22 at 10 records were provided Nurse (LPN) 1 and (QMA) 2, and revided on 8/24/22 at 11:00 indicated Resident LPN1 indicated all Plan in place upon record for Resident LPN1 indicated all Plan in place upon record for Resident at 3:30 P.M. Resident a	O A.M. an interview with LPN1 C did not have a Service Plan. residents should have a Service admission.  COO A.M., Resident G's medical ded by Licensed Practical Qualified Medication Aide ewed at that time.  O A.M. an interview with LPN1 G did not have a Service Plan. residents should have a Service admission. 3. The clinical M was reviewed on 8/23/2022 ent M was admitted to the bess, including but not limited essure ulcers of the skin, pain, major depressive disorder						
	in the hard chart wa	as dated 4/21/2021. During an						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	СОМ	(X3) DATE SURVEY COMPLETED 08/26/2022			
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
	interview with QM 1:30 A.M., he indic pharmacy had notif assessment was due pharmacies, the rev timely  During an interview on 8/23/2022 at 3:3 not recall staff revie needs with her in the	A 2, conducted on 8/24/2022 at rated the facility's previous and the facility when an a but since they had changed riews had not been completed with Resident M, conducted O P.M., she indicated she did ewing her service plan and							
	on 8/24/2022 at 10: admitted to the faci	00 A.M. Resident D was lity on 5/9/2022 with g but not limited to diabetes							
	evaluation located of chart for Resident I QMA 2, the Reside 8/24/2022 at 11:00 he indicated he work evaluation but he k because he remember facility's previous I	on the electronic or the hard D. During an interview with Intial Care Coordinator on A.M. regarding the evaluation, Ild have to look for the Inew there was one completed Inered he was present with the Inticensed nurse when the Inpleted for Resident D.							
	assessment for Res QMA 2. The asses D but the it was un- was completed, the staff had completed Score" portion was plan indicated the r his mobility withou adequate vision wit	200 A.M., an undated ident D was presented by sment was signed by Resident clear which type of assessment re was no indication which I the evaluation and the "Total left blank. In addition, the esident was independent with at assistive devices, had hout glasses, took his uself, no notation was							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			COMPL	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIE	R	1	7650 G	DDRESS, CITY, STATE, ZIP COD SENERATIONS DR BEND, IN 46635			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	documented by the was independent winsulin injections a of care and denied  During an intervier Resident D, conduction he was observed to glasses. He indicated both his oral and in severe nerve type prindicated he had a cord and had had precipited the homeless shelt had wanted him to facility had schedulit had to be resched. Although an assess Resident D on 8/25	w and observation with cted on 8/24/2022 at 1:15 P.M., outilize a walker and wear eye ted the facility administered again in his feet and legs. He tumor removed from his spinal pain issues since the surgery. The had came to the facility from the rand the facility's physician see the neurologist and the led his appointment for him but	T.	AG	DEFICIENCY)		DATE	
R 0241	410 IAC 16.2-5-4 Health Services -							
Bldg. 00	provision of resid as ordered by the shall be supervis the premises or of (1) Medication shall licensed nursing medication aides	all be administered by personnel or qualified						
	interview, the facil ordered medication for 13 of 14 record (Residents	on, record review and ity failed to ensure physician as were administered per order s reviewed for medications.  N, Q, W, LL, D, H, C and G)	R 0241		R 241- Health Services- Medications not administere Nurse not present for Injection  1. What corrective action	ons	10/15/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING	_	08/26/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		17650 (	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	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	F. 1				will be accomplished for tho		
	Findings include:				residents found to have beer	ו וי	
	1 Denies - Madiesties Administration on				affected by the deficient		
	1. During a Medication Administration on 8/23/2022 from 8:05 A.M. to 8:45 A.M., with QMA				practice.		
					MD was notified of		
	(Qualified Medication Aide) 5, the following was observed:				MD was notified of		
	observed:				residents HH,	n d	
	At 8:05 A M OM	A 5 pulled the medication roll			BB,P,DD,S,N,Q,W,LL,D,H,C a G medication administration	ıııu	
		esident HH and removed 3			omissions		
		oll. The medications given were:			OTTISSIONS		
	_	<del>-</del>					
	Amlodipine (blood pressure medication) 100mg (milligrams), Clopidogrel (blood thinner) 75 mg				2. How the facility will		
	and SMZ-TMP DS (antibiotic) 800-160 mg.				identify other residents havin	na	
	una Siviz Tivii DS	(unitiolotic) ood 100 mg.			the potential to be affected b	_	
	OMA 5 did not cor	mpare the current physician			the same deficient practice a	-	
		to the medications that were			what corrective action will be		
	pulled.				taken.		
	1				· All residents to the facili	itv	
	Resident HH's med	lication orders also included the			have the potential to be affecte	-	
	following: Biktarvi	every am; Ferrous Sulfate (iron)			by alleged deficient practice		
	325 mg 2 tablets da	aily on Tuesday and Thursday;			MAR to Cart audit to be		
	Metoprol 50 mg tw	rice a day; Thiamin (Vitamin			completed by Pharmacy		
	B-1) daily; Incruse	Ellipta Aerosol powder inhale 1			representative/ designee		
		ss of breath); Combivent			Clinical Meeting agenda	a	
		0-100 MCG 1 puff every 6 hours			initiated to include reviewing a	II	
		eath; Genovia 150-150-200-10			new medication orders to ensu	ure	
	1	r HIV. None of these			accuracy, EMAR review for		
		dministered during the			missing and refused medication		
	observation.				new admission reviews to ens		
					all admission orders transcribe	ed	
	· ·	A 5 removed the pill roll for			accurately	.	
		emoved 7 packets with pills in			Staffing patterns review	ed	
	1	not compare the pill packages to			with facility to ensure that		
		gave Resident BB the			Licensed staff is on duty to		
		Resident BB indicated that			administer injections if necess	ary	
	she did not take the Ferrous Sulfate pill any more.				· IDT team to complete		
		ne pill from the cup and placed			resident interviews to determine	іе	
	it on top of the med	neation cart.			any further medication or		
					treatment concerns, pain		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE'	TED
			B. WI	NG		08/26/2	022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			GENERATIONS DR		
WOODR	IDGE VILLAGE				BEND, IN 46635		
VVOODIN				00011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		harge medication list, dated			concerns or any additional		
	· ·	ed Resident BB had the order for			medical needs		
	Ferrous Sulfate 32:	5 mg 1 tablet three times a day.			· Administrator and Heal		
					Services Director to meet with		
		A 5 removed Resident P's			Medical Director to review nev	<b>N</b>	
		from the cart and pulled off 9			order process, staff to be		
	*	ved an Anura Ellipta inhaler and			educated		
	Fluticasone nasal s	pray.					
					3. What measures will be	_	
		edications, the inhaler and the			put into place or what system		
		e dining room where Resident P			changes the facility will mak	е	
	_	st. Resident P put the inhaler			to ensure that the deficient		
	_	d inhaled very shallow 1 time			practice does not recur;		
	_	ep breath. The resident then			All Nurses and QMAs in	ו	
	_	y and squirted 1 spray into the			serviced on Medication		
	right nostril and 2 s	squirts into the left nostril.			administration with return		
					demonstration and emphasis		
	1	n's Order, dated 10/3/2021,			comparing medications to EM		
		P was to receive Olopatadine			documentations of medication		
	0.2% solution of 1	drop to both eyes twice a day.			refusals and PRN medications		
					· All nurses and QMAS ir		
		served to not compare the			serviced proper on Oral, Inha		
		current MAR, did not			and nasal spray administration	n	
		lent to take deep breaths prior			· All nurses educated on		
	_	e inhaler, did not instruct the			admission process with emph		
		rays into both nostrils and did			on admission order verification	•	
	not administer the	eye drops.			new admission checklist provi	ded	
	4.020.434.034	4.5 ID 11 (DD) 4			as tool for floor staff		
		A 5 removed Resident DD's 4			All nurses and QMAs to		
		l pulled off 4 packages from the			educated on new physician or	der	
		l not compare the pill packages			process and procedure		
	to the MAR.				· All nurses and QMAs in	1	
					serviced on PRN medication		
	Resident DD's current physician orders, dated				administration policy with		
	3/30/2022, indicated the resident was to receive				emphasis on documentation in		
	Aspirin 81 mg (milligrams) every day, and Trelegy		MAR and the Narcotic count sheet				
	Ellipta 100 mcg-62.5 mcg-25 mcg inhalation				IDT educated on use of		
	powder - 1 puff ev	ery day.			clinical meeting agenda and for	Ollow	
					up		
	QMA 5 was not ob	QMA 5 was not observed to administer the			<ul> <li>Health Service</li> </ul>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING	<del></del>	08/26/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
WOODD	1005 \ /// 1 4 05				GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTE	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	aspirin and the inha	aler to Resident DD.			Director/Designee to complete	9	
					medication pass observations	with	
	At 8:30 A.M., QM	A 5 removed 3 packets from			staff to ensure compliance		
	Resident S's pill rol	ll: Eliquis (anticoagulant) 5 mg,			4. How the corrective		
	Gabapentin (nerve	pain) 300 mg, and Metoprolol			action(s) will be monitored to	0	
	100 mg.				ensure the deficient practice		
					will not recur, i.e., what quali	ity	
	QMA 5 indicated s	he was not sure what			assurance program will be p	ut	
	medications the resident was on due to she just				into place; and		
	returned from the h	ospital recently. QMA 5 did			· Health Services Directo	or/	
	not compare the me	edications pulled from the cart			Designee to complete daily		
	to the MAR.				medication administration aud	lit to	
					ensure medication compliance	9	
	Resident S's curren	t physician orders indicated			· Health Services Directo	or/	
	the resident was to	receive Acetaminophen 325			Designee to complete clinical		
	mg 2 tablets daily.				morning meeting agenda revie	ew	
					and follow up related to new		
	A clinical record re	eview was completed on			orders, new admission review		
	8/24/2022 at 1:15 F	P.M. Resident N's diagnoses			· Health Services Directo	or/	
	included, but were	not limited to: hypertension,			Designee to review daily staffi	ng	
	atrial fibrillation, pa	ain and congestive heart failure.			schedules to ensure licensed		
					nurse staffing levels are		
	Resident N's curren	nt physician orders, dated from			appropriate		
	2/25/2022 to 7/22/2	2022, included the following			<ul> <li>Health Services Directo</li> </ul>	r.	
	medication orders:				Designee to complete medica	tion	
	Lyrica (nerve pain	medication) 25 mg 1 tablet three			administration observation au	dits	
	times a day.				· Audit to be completed		
	· ·	) 20 ml (milliliters) twice a day.			weekly x 4 then monthly x 6 to	)	
	Albuterol Sulfate (b	breathing aid) 2.5 mg/3 ml via			ensure compliance		
	nebulizer every 6 h				· Results of the audits wi	ll be	
		noking cessation) 24 hr/14 mg			reviewed in QA and plan will b	ре	
	apply 1 patch daily				adapted or adjusted as neede	d to	
		pray suspension 1 spray both			maintain compliance		
	nostrils twice a day						
	Fentanyl (narcotic pain patch) patch 12 mcq every						
	12 hours.						
	The MAR ( Medication Administration Record)						
		ough 8/31/2022, indicated the					
	following medication	ons were not administered to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	<u> </u>		(X3) DATE SURVEY COMPLETED 08/26/2022		
	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION yl pain patch, Nicotine patch,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	Fluticasone nasal sp Lyrica, and the Alb	oray, Lactulose solution, uterol Neb solution.					
	_	ew, on 8/24/2022 at 11:23 A.M., d she was not receiving her					
	8/24/2022 at 3:58 P included, but were a	view was completed on  M. Resident Q's diagnoses not limited to: anxiety,					
	hypertension, insomnia, pain and depression.  Resident Q's current physician orders, dated 8/17/2022, indicated new orders to: discontinue the Cymbalta (anti depressant) 30 mg twice a day						
	order and start Cym	abalta 30 mg every day x 14 e the order. Increase Zoloft					
	8/31/2022, lacked the Cymbalta and or the	dated 8/1/2022 through the documentation to show the e Zoloft had been given since received on 8/17/2022.					
	_	ew, on 8/25/2022 at 1:50 P.M., up to the front office and aiting for his noon					
	8/25/2022 at 2:59 P included, but were a	view was completed on .M. Resident W's diagnoses not limited to: depression, idism, pain, and bipolar.					
	indicated Resident	l's order, dated 8/17/2022, W was to receive Norco 5/325 m, and 1 tablet every 6 hours r pain.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X:  A. BUILDING 00  B. WING				SURVEY ETED /2022
	PROVIDER OR SUPPLIER			17650 0	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)	NTE.	(X5) COMPLETION DATE
	_	ndicated Resident W had not pain pill from 8/17/2022					
	Medication Record Hydrocodone pills 8 8/18/2022. An entry	dual Resident Control Sheet indicated there were 15 sent to the facility on was made, on 8/21/2022 at ag that only 1 Hydrocodone pill red.					
	_	y, on 8/25/2022 at 2:45 P.M., esident W only received the time on 8/21/2022.					
	8/5/2022 at 9:05 A.	review was completed on  M. Resident LL's diagnoses not limited to: diabetes, heart nd pain.					
	2:22 P.M., the staff	ous interview, on 8/25/2022 at person indicated Resident LL of not getting their pain					
	Record), dated 8/1/2 indicated on 8/15/2 documented as refu documentation to sl the patch. The MAI	Medication Administration 2022 through 8/31/2022, 022 the Lidocaine 5% pad was sed. The back page lacked the now the resident had refused R lacked any initials indicating nistered from 8/16/22 through					
	10:57 A.M., with Q Lidocain patches w label on it. 5. Duri conducted on 8/20/2	t was observed on 8/26/2022 at MA 6. She provided a box of ith Resident W's pharmacy ng the initial tour of the facility, 2022 between 9:45 A.M 11:30 yee 18, the Admissions					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  08/26/2022	
	PROVIDER OR SUPPLIEF		17650	ADDRESS, CITY, STATE, ZIP COD 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 B: CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		D was observed to get himself	TAG	DEFICIENCY)	DATE
		d ambulate with a walker to			
		f his room. Employee 18			
	indicated Resident	D was alert and oriented.			
		for Resident D was reviewed			
		0 P.M. Resident D was			
		lity with diagnoses included,			
		diabetes mellitus type 2, depressive disorder, cerebella			
	stroke symptoms ar	•			
	stroke symptoms at	id anxiety disorder.			
	The current physici	an's orders for Resident D			
		nitiated on 5/15/2022, for the			
	resident to receive (	Ozempic 4 mg/ml injections			
	once a week for dia	betes. Review of the			
	medication adminis	tration record for Resident D			
	indicated he had on	ly received the Ozempic			
		n August from the 1st through			
		Medication Administration			
		ilable for review. The June			
		stration Record did not have			
	_	ses of the Ozempic medication			
	given.				
	_	on 8/25/2022 with Resident			
		also served as the facility's			
	1	e indicated no staff had			
		dent D's refusals nor of the			
	· ·	lity to administer the Ozempic			
		She indicated Resident D had receiving the injections timely.			
		receiving the injections timely.  Vas concerned the resident was			
		edication as ordered and her			
		ng noted and transcribed			
	timely and correctly. She indicated she had rewritten medication and insulin orders on				
	8/18/2022 because the medication aides had				
		were no insulin orders for a			
		sident D even though they			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIEI	8		17650 G	DDRESS, CITY, STATE, ZIP COD ENERATIONS DR BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU		e resident's admission orders in		TAG			DATE
	on 8/24/2022 at 1:1 receiving his Ozem no licensed nurse a medication. He incomposed to come of the medication but the injection. In addid not always receively. He indicate oral pain medication did not receive any A.M. He indicated reduced to crawling pain.	w with Resident D, conducted 5 P.M., he indicated he was not upic injection because there was vailable to administer the dicated the nurse, LPN 1 was every Monday to administer often did not show up to give dition, Resident D indicated he give his pain medications and he was supposed to get his on twice a day but yesterday he pain medication until 2:00 the was in so much pain he was g on the floor and crying in					
	8/18/2022 the physical pain medication, H (milligram) from or of the medication at Resident D for Augresident did not receive at Hydrocodone, nor of Gabapentin on 8 orders, dated 7/22/2 physician indicated receive a Fentanyl There was no document of the physician indicated receive at Fentanyl There was no document.	dician's orders indicated on ician had increased his oral ydrocodone 5/325 mg mee a day to twice a day. Review dministration record for gust 2022 confirmed the eive his morning dose of did he receive any of his doses /22/2022. Review of physician 2022 and signed by the Resident D was also to patch 12 mg every 72 hours. The mentation the resident had nedication patches at all in					
	6/2/2022 for the resoccupational theraporder was not noted	vere physician orders, dated sident to receive physical and by due to his back pain. The d by a nurse. 6. During a sistration observation on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIEI	?	17650 (	ADDRESS, CITY, STATE, ZIP CO GENERATIONS DR I BEND, IN 46635	)D	
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Medication Aide) 3 giving Resident H : 1 Oxycod/apap 5-3 observed taking the cup into the dining 3, having never tak signed the Control indicating she had and the medication.  In an interview at the indicated the Resid Oxycod/apap to the his breakfast. QMA the resident actually.  On 8/26/22 at 8:20 Resident H's medicated that time. The Ph 1/08/21, indicated at TAB 5-325 MG - F [each] - PO [by monoton TABLET BY MOU Review of Resident Control Medication through 8/26/22 indicated and ally Quantity Rem Review of the of the column on the Resident Control Medication 8/12/22 to 8/26/22, full Oxycod/apap T "ONE-HALF," as on 8/24/22 at 11:00 indicated nursing stresident's take their	A.M., with QMA (Qualified as the QMA was observed a small white paper pill cup with 25mg tablet. Resident H was coxycod/apap in the paper pill room and out of sight of QMA en the medication. QMA 3 Medication Record Sheet given 1 Oxycod/apap 5-325 Mg had been administered.  That time with QMA 3, the QMA ent H preferred to take the edining room and have it with a 3 indicated she did not watch by take the medication.  A.M., QMA 2 provided all records which were reviewed an order for, "OXYCOD/APAP BID [2 times daily] - 0.5 EA uth] - TAKE ONE-HALF JTH TWICE DAILY."  It H's Individual Resident an Record Sheets dated 8/11/22 dicated, "Oxycod/apap Tab e-half tablet by mouth twice maining: 30 EA,"  The Dosage Documentation dent H's Individual Resident and Record Sheet, indicated from the Resident had been given 1 as 5-325, rather than ordered by the physician.  O A.M., an interview with LPN 1 taff should always watch the emedication since the life-administer their medications.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/26/	ETED	
	PROVIDER OR SUPPLIER	8		17650 G	DDRESS, CITY, STATE, ZIP COD GENERATIONS DR 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on 8/25/22 at 9:00 at to the facility on 5/0 the facility on 6/20/included, but were themiplegia, anxiety. The physician's ord period included but mg tablet by mouth 0.5 mg by mouth 2 mg tablet 1 time da.  Review of the Medi (MAR), dated 6/01/Resident C did not following dates and 6/07/22 morning an 6/19/22 evening 6/01/22 through 6/2 administered.  Resident C did not following dates and 6/09/22 morning 6/13/22 morning 6/13/22 morning 6/13/22 morning 6/15/22 morning 6/06/22 morning 6/06/22 morning 6/06/22 morning 6/10/22 morning 6/10/22 morning 6/10/22 morning 6/14/22 morning 6/14/24	ers during the admission were not limited to Baclofen 5 3 times daily, Lorazepam tablet times daily, and Cetirizine 10 ily. ication Administration Record (22 to 6/20/22, indicated receive Baclophen on the l times: id evening (20/22, no doses were receive Lorazepam on the l times:  receive Cetirizine on the l times:  receive Cetirizine on the l times:					
	included but were n	included but were not limited to chronic					

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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	_	08/26	/2022
NAME OF A			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		17650 C	GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION lary disease (COPD), heart	+	TAG	DEFICIENCE!		DATE
	failure, diabetes, an						
	lanuic, diabetes, an	id emonie pani.					
	The current physici	ian's orders included, but were					
		othyroxin (thyroid hormone					
	replacement) 200 mg tablet by mouth 1 time daily,						
	Methoprol (heart failure)Suc 25 mg extended						
	release tablet by mouth 1 time daily, Montelukast						
	(allergies/asthma) 10 mg tablet by mouth 1 time						
	daily, Trazodone (antidepressant) 325mg tablet by						
	mouth at bedtime, Vitamin D3 2000 unit capsule by						
	mouth 1 time daily, Clonazepam (antianxiety) 0.5						
	mg tablet by mouth 2 times daily, Acetaminophen						
	(pain) 500 mg tablet by mouth 3 times daily, Bethanechol (urinary retention) 10 mg tablet by						
	· ·	ry retention) 10 mg tablet by daily, Hydromorphone (narcotic					
		olet by mouth 3 times daily, and					
		ection 100/ML per sliding scale					
		or blood sugar readings which					
	-	of 150-200 to give 1 unit.					
		2					
	Review of the Med	ication Administration Record					
	(MAR), dated 7/1/2	22 to 7/25/22, indicated:					
		receive Levothyroxin on the					
	following dates and	l times:					
	8/13/22 morning						
		receive Metoprol on the					
	following dates and	times:					
	8/13/22 morning						
	8/22/22 morning Resident G did not	receive Montelukast on the					
	following dates and						
	8/22/22 morning	· miles.					
		receive Trazodone on the					
	following dates and						
	8/23/22 bedtime						
	Resident G did not receive Vitamin D3 on the						
	following dates and	l times:					
	8/22/22 morning						
	Resident G did not	receive Clonazepam on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMP			TE SURVEY PLETED P6/2022	
	PROVIDER OR SUPPLIEI	·	17650 (	ADDRESS, CITY, STATE, ZIP CO GENERATIONS DR I BEND, IN 46635	DD	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	following dates and 8/2/22 through 8/10 8/17/22, and 8/22/2 8/22/22 morning at Resident G did not following dates and 8/22/22 morning, he There was no documedication omission. On 8/23/2022 at 2: provided the policy Medications", dater policy was the one The policy indicate thoroughly with some dication cart and Sheet. The Medicate each time the medications discontresident's medication labels made of medication labels made of medication name, and expirated dispensing pharman number. 4. Read the Read the label where from the medication in the medication in the medication should be supposed to the state of the s	receive Acetaminophen on the I times: 0/22 and 8/12/22 through 22 Noon ad evening receive Bethanechol on the I times: unch, and evening mentation explaining the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
R 0243 Bldg. 00	in the individual 's records that indica (A) time; (B) name of medic (C) dosage (if app (D) name or initial administering the 9. During the initial on 8/20/2022 between the Admission Dire was observed to get and ambulate with a his room. Employer alert and oriented.  The clinical record on 8/24/2022 at 2:0 admitted to the faci but not limited to: chronic pain, major stroke symptoms are the current physici included an order, resident to receive to once a week for dia medication administindicated he had on injection one time if the 24 of August. Administration Record did not have	Deficiency administering the locument the administration a medication and treatment ate the: cation or treatment; licable); and s of the person drug or treatment. tour of the facility, conducted ten 9:45 A.M 11:30 A.M., with ctor, Employee 18, Resident D thimself up out of his bed a walker to the doorway area of the 18 indicated Resident D was for Resident D was lity with diagnoses, including diabetes mellitus type 2, depressive disorder, cerebella	R 0243	R 243 Health Services – MAI not signed  What corrective action(s) whose accomplished for those residents found to have been affected by the deficient practice.  MD was notified of residents F,L,N,P,Q,C,G and medication administration omissions  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be	rill n D

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		08/26/	/2022
				CENTER	A DODDEGG CHTM CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP COD		
WOODD	IDOE \				GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	H 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 O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of the ordered med	ications documented as having			taken.		
	been administered.	The ordered insulin was not			· All residents to the facili	ity	
	documented as give	en on the medication			have the potential to be affect	ed	
	administration reco	rds.			by alleged deficient practice		
					MAR to Cart audit to be		
	The May blood glu	cose tracking forms for			completed by Pharmacy		
	Resident D for the Humolog insulin had only one				representative/ designee		
	before breakfast blood sugar level and insulin				· Clinical Meeting agenda	a	
	documented on 5/20/2022.				initiated to include reviewing a	II	
	documented on 3/20/2022.				new medication orders to ensu	ure	
	During an interview on 8/25/2022 with Resident				accuracy, EMAR review for		
	D's physician, who also served as the facility's				missing and refused medication	ons,	
	medical director, she indicated no staff had				new admission reviews to ens		
	notified her of Resident D's refusals nor of the				all admission orders transcribe	ed	
	inability of the facility to administer the Ozempic				accurately		
	injections timely.	She indicated Resident D had			Staffing patterns review	ed	
	told her he was not	receiving the injections timely.			with facility to ensure that		
	She indicated she v	vas concerned the resident was			Licensed staff is on duty to		
	not receiving his m	edication as ordered and her			administer injections if necess	ary	
	orders were not bei	ng noted and transcribed			· IDT team to complete		
	timely and correctly	y. She indicated she had			resident interviews to determine	ne	
	rewritten medication	n and insulin orders on			any further medication or		
	8/18/2022 because	the medication aides had			treatment concerns, pain		
	informed her there	were no insulin orders for a			concerns or any additional		
	sliding scale for Re	sident D even though they			medical needs		
	were included in th	e resident's admission orders in			<ul> <li>Administrator and Healt</li> </ul>	h	
	May.				Services Director to meet with		
					Medical Director to review nev	V	
	During an interview	with Resident D, conducted			order process, staff to be		
	on 8/24/2022 at 1:1	5 P.M., he indicated he was not			educated		
	receiving his Ozem	pic injection because there was					
	no licensed nurse a	vailable to administer the					
	medication. He inc	licated the nurse "Joe" LPN 1			What measures will be put in	ito	
		me every Monday to			place or what systemic		
	administer the medication but often did not show				changes the facility will make	е	
	up to give the injection.				to ensure that the deficient		
					practice does not recur;		
		nt D indicated he did not			· All Nurses and QMAs ir	1	
		pain medications timely. He			serviced on Medication		
	indicated he was su	pposed to get his oral pain			administration with return		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		08/26/	2022
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			GENERATIONS DR		
WOODB	IDGE VILLAGE						
WOODK	IDGE VILLAGE			30011	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medication twice a	day but yesterday he did not			demonstration and emphasis	on	
	receive any pain m	edication until 2:00 A.M. He			comparing medications to EM	AR,	
	indicated he was in	so much pain he was reduced			documentations of medication	i .	
	to crawling on the	floor and crying in pain.			refusals and PRN medications	3	
					<ul> <li>All nurses and QMAS ir</li> </ul>	1	
	Review of the phys	sician's orders indicated on			serviced proper on Oral, Inha	ler,	
	8/18/2022 the physician had increased his oral				and nasal spray administration	n	
	pain medication, Hydrocodone 5/325 from once a				· All nurses educated on		
	day to twice a day. Review of the medication				admission process with emph	asis	
	administration record for Resident D for August				on admission order verification	n,	
	2022 confirmed the resident did not receive his				new admission checklist provi	ded	
	morning dose of Hydrocodone, nor did he receive				as tool for floor staff		
	any of his doses of Gabapentin on 8/22/2022.				<ul> <li>All nurses and QMAs to</li> </ul>	be	
	Review of physician orders, dated 7/22/2022 and				educated on new physician or	der	
	signed by the phys	ician indicated Resident D was			process and procedure		
	also to receive a Fe	entanyl patch 12 mg every 72			· All nurses and QMAs in	1	
	hours. There was a	no documentation the resident			serviced on PRN medication		
	had received the pa	in medication patches at all in			administration policy with		
	August 2022.				emphasis on documentation in	n the	
					MAR and the Narcotic count s	heet	
	In addition, there v	vere physician orders, dated			· IDT educated on use of	:	
		sident to receive physical and			clinical meeting agenda and for	ollow	
	occupational therap	by due to his back pain. The			up		
	order was not noted	d by a nurse.			· Health Service		
					Director/Designee to complete	÷	
		15 P.M., the Administrator			medication pass observations	with	
		titled, "Staff Administered			staff to ensure compliance		
	Medications", date	d 12/8/2011, and indicated the					
		currently used by the facility.			How the corrective action(s)		
	The policy indicate	ed" 1. Wash you hands			will be monitored to ensure	he	
	thoroughly with so	ap and water. 2. Unlock the			deficient practice will not		
	medication cart and	d read the resident's Medication			recur, i.e., what quality		
		tion Sheets must be reviewed			assurance program will be p	ut	
		cations are administered to			into place; and		
	make certain that c	hanges have not been made or			· Health Services Directo	or/	
	medications discontinued. 3. Remove the				Designee to complete daily		
	resident's medication	on container/package. All			medication administration aud	lit to	
	medication labels r	nust include: resident's name,			ensure medication compliance	Э	
	name of medication	n, dose, directions, physician's			Health Services Director	or/	
	name, and expiration date of medication,				Designee to complete clinical		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
			B. W	ING		08/26/	2022
				CTD FET A	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
MOODE					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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dispensing pharmac	ey name and prescription			morning meeting agenda revie	ew	
	number. 4. Read the	e label on each bottle/packet.			and follow up related to new		
	Read the label when	n removing the bottle/packet			orders, new admission review		
	from the med cart and compare it with the				Health Services Directo		
		on Sheet. If there is a			Designee to review daily staffi		
		lirectors between the label and			schedules to ensure licensed	J	
	an individual Medication Sheet verify against the				nurse staffing levels are		
		make sure the Medication			appropriate		
		ects the physician order			Health Services Directo	r.	
	<b>1</b>				Designee to complete medica		
	On 8/24/2022 at 2:15 P.M. the Administrator				administration observation aud		
	provided the policy titled, "Preparation for				including narcotic monitoring		
	Medication Administration - Controlled				· Audit to be completed		
	Medications", undated, and indicated the policy				weekly x 4 then monthly x 6 to	)	
		ly used by the facility. The			ensure compliance		
		d. When a controlled			· Results of the audits wil	ll be	
		nistered, the licensed nurse			reviewed in QA and plan will b		
		nedication immediately enters			adapted or adjusted as neede		
	-	nation on the accountability			maintain compliance		
	_	time of administration. 2)					
	· ·	ed. 3) Signature of the nurse					
		ose, completed after the					
	medication is actual	-					
	On 8/24/2022 at 2:1	5 P.M., the Administrator					
		titled, "Controlled Substance					
		0/2018, and indicated the					
	-	currently used by the facility.					
		d"D. A controlled substance					
		rd is prepared by the					
		For all Schedule II, III, IV and V					
		ollowing information is					
		ecountability form upon					
		ot of a controlled substance or					
		substance from the emergency					
		resident, if applicable. 2)					
	Prescription number, if applicable. 3) Name,						
	_	e form of medication. 4) Date					
	-	ty received. 6) Name of person					
		on supply. E. At each shift					
	13001 ving incurcation	in supprije D. The odon shift					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/26/2022	
	PROVIDER OR SUPPLIE	R	17650	ADDRESS, CITY, STATE, ZIP CO GENERATIONS DR 1 BEND, IN 46635	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	
TAG	change, or when k inventory of all co refrigerated items nurses and is docu This Residential T	eys are transferred, a physical ntrolled substances, including is conducted by two licensed	TAG		DATE	
	7.The clinical record for Resident C was reviewed on 8/25/22 at 9:00 A.M. Resident C was admitted to the facility on 5/02/22 and was discharge from the facility on 6/20/22. Admitting diagnoses included but were not limited to stroke, hemiplegia, anxiety, and pain.					
	period included bu	ders during the admission at were not limited to Baclofen 5 h 3 times daily, Lorazepam tablet times daily, and Cetirizine 10 aily.				
	(MAR), dated 6/02 Resident C did not following dates an 6/07/22 morning a 6/19/22 evening 6/01/22 through 6/ administered.	nd evening 20/22, no doses were receive Lorazepam on the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
			B. WI	NG	_	08/26	/2022
NAME OF F	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
WOODB	IDGE VILLAGE				GENERATIONS DR		
WOODK	IDGE VILLAGE			30016	BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION receive Cetirizine on the		TAG	DEI IOEERO I		DATE
	following dates and						
	6/03/22 morning						
	6/06/22 morning						
	6/10/22 morning						
	6/14/22 morning						
	There was no documentation explaining the						
	medication omissions listed above.						
	8. The clinical record for Resident G was reviewed						
	on 8/25/22 at 9:25 A.M. Resident G was originally						
	admitted to the facility with diagnoses that						
	included but were not limited to Chronic						
	Obstructive Pulmonary Disease (COPD), heart						
	failure, diabetes, an	d chronic pain.					
	The current physici	an's orders included but were					
		thyroxin 200 mg tablet by					
		, Methoprol Suc 325mg					
		blet by mouth 1 time daily,					
	Montelukast 10 mg	tablet by mouth 1 time daily,					
	_	tablet by mouth at bedtime,					
		nit capsule by mouth 1 time					
		0.5 mg tablet by mouth 2 times					
		nen 500 mg tablet by mouth 3					
		echol 10 mg tablet by mouth  Iydromorphone 2 mg tablet by					
	· ·	y, and Humalog kwik injection					
		s scale three times daily for					
		gs which included readings of					
	150-200 to give 1 u	,					
		ication Administration Record					
		22 to 7/25/22, indicated					
	following dates and	receive Levothyroxin on the					
	8/13/22 morning	· mnes.					
	_	receive Metoprol on the					
	following dates and						
	8/13/22 morning						
	1						I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í			COMPLETED 08/26/2022	
NAME OF F	PROVIDER OR SUPPLIEF	2		EET ADDRESS, CITY, STATE, ZIP COD		
WOODR	IDGE VILLAGE			OUTH BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	3 DEFICIENCE		DATE
	8/22/22 morning Resident G did not	receive Montelukast on the				
	following dates and					
	8/22/22 morning	times.				
		receive Trazodone on the				
	following dates and					
	8/23/22 bedtime					
		receive Vitamin D3 on the				1
	following dates and	times:				
	8/22/22 morning					
	Resident G did not receive Clonazepam on the					
	following dates and times:					
	8/22/22 morning					
	Resident G did not receive Acetaminophen on the					
	following dates and times:					
	_	0/22 and 8/12/22 through				
	8/17/22, and 8/22/2					
	8/22/22 morning an	_				
		receive Bethanechol on the				
	following dates and					
	8/22/22 morning, lu					
	medication omissio	mentation explaining the				
	medication omissio	ns fisted above.				
	On 8/24/22 at 11:00	A.M. an interview with LPN 1				
		aff should document all				
	medication adminis	tration on the Medication				
		ord. Any omissions of				
		tration should be documented				
		Administration Record and the				
	physician should be	e notified.				
	Rosed on magard re	view, observation and				
		ty failed to document in the				
		cating a medication had been				
		of 23 residents reviewed for				
		lents F, L, N, P, Q, C, G, and D)				1
	meateanons. (itesic	1, 2, 11, 1, ×, 0, 0, unu D)				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00  B. WING		COMPLETED 08/26/2022		
	PROVIDER OR SUPPLIER	2		17650 0	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	TE	(X5) COMPLETION DATE
	8/25/2022 at 3:48 P included, but were rediabetes, Parkinson disorder.  A current MAR (M Record), dated 8/20 not receive the follor Invega injection 23 medications were n 8/22/2022: Aspirin units daily, Mag Ox Mono Macr 100 mg a day, Carbamazepi Novolog sliding sca 2. A clinical record 8/25/2022 at 4:05 P included, but were depression, bipolar,  The following medias received on 8/22 a day, Lamotrigine 1000 mg in the ever 2:00 P.M. On 8/23/were not documented aily, Divalpoediaily, Amantadine 325 mg daily, Mettoprol 50 mg daily.  3. A clinical record 8/24/2022 at 1:15 Pincluded, but were recorded but were recorded but were recorded.	review was completed on .M Resident F's diagnoses not limited to: epilepsy, bipolar, 's disease and schizoaffective edication Administration 22, indicated Resident F did owing medications: 8/15/2022 4/1.5. All of the following ot documented as received on 81 mg daily, Lantus insulin 15 cide 400 mg daily, Nitrofuran g daily, Benztropine 2 mg twice ne 200 mg twice a day, alle three times a day.  Treview was completed on, .M. Resident L's diagnoses not limited to: diabetes, hypertension and anxiety.  The cations were not documented (2022: Gabapentin 600 mg twice 100 mg twice a day, Metformin ning Carbo/Levo 25-100 mg at 2022 the following medications ed as received: Lisinopril 2.5 to 250 mg daily, Aspirin 81 mg 100 mg daily, Ferrous Sulfate formin 1000 mg twice daily, and Tamsulosin 0.4 mg  Treview was completed on .M. Resident N's diagnoses not limited to: hypertension, ain and congestive heart failure.					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	ROVIDER OR SUPPLIER DGE VILLAGE		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR 1 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
	The following medias received on 8/22/2000, Potassium Ch. Warfarin 2 mg daily were not documented through 8/26/2022: Fluticasone nasal sp. ml twice a day, Alb. times a day.  4. A clinical record 8/25/2022 at 9:28 A diagnoses included, asthma, convulsions hemiparesis.  The following medias received on 8/22/2022 at 9:28/2022.	ications were not documented /2022: Furosemide 20 mg at alloride 20 meq daily, and y. The following medications ed as received from 8/1/2022 Nicotine 14 Gm patch daily, bray twice daily, Lactulose 20 uterol Nebulizer treatments 4  review was completed on a.M. Resident P's current but were not limited to: s, atrial fibrillation and left /2022: Metoprol 50 mg twice mg twice daily, Olopatadine			
	Chloride 20 meq tw three times a day wi lunch time and no d 8/26/2022, Anoro I mg daily, Fluticasor mg daily, Metolazor twice a day, Eliquis 500 mg twice daily	wice daily, Potassium rice daily, hydralazine 10 mg ith a line drawn through the locumentation from 8/1/ to Ellipt inhaler daily, Cetirizine 10 me spray daily, Furosemide 40 me 2.5 mg daily, Diltiazem 60 mg 5 mg twice daily, Levetiraceta and Losartan 50 mg twice daily.			
	8/24/2022 at 3:58 P included but were n hypertension, insom The following medias received: Zoloft: mg 8/20 through 8/2				
	6. During an intervi	ew, on 8/24/2022 at 11:23 A.M.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			LDING	00	COMPL 08/26/	ETED	
NAME OF F	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP COD SENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Resident Q indicate medications.	d she was not receiving her					
	8/24/2022 at 3:58 P included but were n	view was completed on .M. Resident Q's diagnoses ot limited to: anxiety, nnia, pain and depression.					
	dated 7/15/2022, increceive a Fentanyl (	t narcotic medication orders, dicated the resident was to narcotic pain) patch 25 meg y one patch every 3 days.					
	Record Sheet for th	dent Control Medication e Fentanyl indicated the eived the Fentanyl patch from (24/2022.					
	Record), dated 8/1/2 indicated Resident 0	Medication Administration 2022 through 8/31/2022, Q had received the Fentanyl m 8/1/2022 to 8/21/2022.					
	8/18/2022, for Resid	f Fentanyl patches, dated dent Q was observed in the 8/26/2022 at 10:04 A.M.					
	dated 8/17/2022, indiscontinue the Cyrtwice a day, and sta 14 days then discon	arcotic medication orders, dicated a new order for: nbalta (anti-depressant) 30 mg rt Cymbalta 30 mg every day x tinue the order, and increase ant) to 50 mg every day					
	8/31/2022, lacked the Cymbalta and or the	dated 8/1/2022 through the documentation to show the e Zoloft had been given since seceived on 8/17/2022.					
	A review of Reside	nt Q's Individual Resident					

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED  08/26/2022
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	(X5) COMPLETION DATE
R 0246 Bldg. 00	Control Medication (anti-anxiety) 0.5 m amount listed on 8/2 remaining. The acture maining. The courselong off after the medicate Resident Q.  A Resident Individual Sheet for Oxycodon three times a day, the at 10:41 A.M. was a medication card had sheet had not been swas administered.  During an interview QMA 3 indicated the and had not been opshould have been signedications.  410 IAC 16.2-5-4(Health Services - In (6) PRN medication a qualified medical authorization by a physician. The QM authorization for each property in the physician not on the authorization to addocumented in the the time and date of the property administered by a Q Aide) were signed of the property and the	Record Sheet for Clonazepam g (milligrams) twice a day, the c3/2022 at 10:40 A.M. was 22 al medication card had 21 pills at sheet had not been signed tion was administered to all Control Medication Record e (narcotic pain) 5/325 mg 1 e amount listed on 8/23/2022 8 pills remaining. The actual 17 pills remaining. The count igned off after the medication , on 8/26/2022 at 10:04 A.M., e Fentanyl box had 5 patches ened, and the narcotics gned off after giving the pe)(6)  Deficiency and the properties of the medication of a fall contacts with a nurse or the premises for liminister PRNs shall be a nursing notes indicating	R 0246	R 2 46- Health Services PRN Medications given by QMA	10/15/2022

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED	
			B. W	ING		08/26/	2022
				_			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					GENERATIONS DR		
WOODR	IDGE VILLAGE			SOUTH	1 BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUBERG WALLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	P).						
	Findings include:						
	A clinical record re	eview was completed on					
		A.M. Resident P's current					
		, but were not limited to:			What corrective action(s) wi	11	
		s, atrial fibrillation and left			be accomplished for those	••	
	hemiparesis.	s, attat normation and lett			residents found to have been	1	
	nemparesis.				affected by the deficient	•	
	A current MAR (M	ledication Administration			practice.		
Record) dated, 8/1 through 8/31/2022, indicated				practice.			
	Resident P had received a PRN (as need)				Resident P had no		
	medication of Acetaminophen (pain reliever) 325				negative effects related to alle	and	
		ne time on the following dates:			_	geu	
		/18, 8/19 and 8/20/2022.			deficient practice		
	0/0, 0/11, 0/13, 0	718, 8/19 and 8/20/2022.					
	On the book side of	f the MAR were the					
		PRN Med. Reason given and			How the facility will identify		
		oted on Nurses's Medication			How the facility will identify other residents having the		
		ge was blank and lacked any				•	
		ay why the as needed			potential to be affected by the	е	
	medication was add	-			same deficient practice and what corrective action will be	_	
		how that an authorization from				<del>)</del>	
		or the as needed medication			taken.	tv	
	was obtained.	or the as needed medication			All residents in the facili	ty	
	was obtained.				have the potential to be affected		
	The Nurses's Notes	, dated 8/6/2022 through			LPNs and QMAs to be in the interest of th	n	
		he documentation to show the			serviced on QMA scope of	11	
	licensed Nurse had				-	N.I.	
	licensed Nurse nad	been notified.			practice with emphasis on PR	IN	
	During an interview	v, on 8/24/2022 at 11:00 A.M.,			administration process		
	_				What magazines will be seed in	140	
		he QMAs are supposed to call			What measures will be put in	ilo	
		give a PRN medication. They back of the MAR or in the			place or what systemic	_	
		back of the MAK or in the			changes the facility will mak	е	
	progress notes.				to ensure that the deficient		
	D	0/24/2022 4 11 10 4 35			practice does not recur;		
	-	v, on 8/24/2022 at 11:10 A.M.,			LPNs and QMAs to be	n	
		sing, indicated PRN (as			serviced on QMA scope of		
	needed) medication	ns- all need to be cleared by him			practice with emphasis on PR	N	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		08/26/2022	
			<u> </u>	_	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8		Γ ADDRESS, CITY, STATE, ZIP COD		
				GENERATIONS DR		
WOODRI	DGE VILLAGE		SOUT	TH BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVINCIAN AND CONTROL		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	and then he would t	tell the QMA to document it		administration process		
		nt the follow up. He indicated		· Health Service Director	to	
		d 1 call from July 3rd 2020 to		review PRN medication usage		
	-	nd the QMA's had not been		using the clinical morning		
	calling him for PRN			meeting agenda		
				mooning agonaa		
	On 8/25/22 at 1:00	P.M., the Administrator		How the corrective action(s)		
	provided a form titl	ed QUALIFIED MEDICATION		will be monitored to ensure	the	
	AIDE Scope of Prac	ctice which indicatied, "The		deficient practice will not		
	following tasks are	within the scope of practice for		recur, i.e., what quality		
	the QMA unless pro	ohibited by facility policy:		assurance program will be p	ut	
	(11) Administer pre	eviously ordered pro re nata		into place; and		
	(PRN) [as needed]	only if authorization is				
	obtained from the fa	acility's licensed nurse on duty		i. Health Servio	ces	
	or on call. If author	ization is obtained, the QMA		Director/Designee to complete	e l	
	must do the followi	ng: (A) Document in the		PRN medication audit to ensu	re	
	resident record sym	ptoms indicating the need for		that all PRN medications rece	ived	
	the medication and	time the symptoms occurred.		appropriate nurse follow up		
	(B) Document in th	e residnt record that the				
	facility's licensed m	urse was contacted, symptoms		ii. Audit to be		
	were described, and	l permission was granted to		completed weekly x 4 then		
	administer the medi	ication, including the time of		monthly x 6 to ensure complia	ınce	
	contact"					
				iii. Results of the		
	This Federal Tag is	related to Complaint		audits will be reviewed in QA	and	
	IN00387635 and IN	100380236.		plan will be adapted or adjuste	ed as	
				needed to maintain compliand	;e	
D 0070						
R 0273	410 IAC 16.2-5-5.	• •				
		nal Services - Deficiency				
Bldg. 00		ation and serving areas				
	•	n residents ' units) are				
		ordance with state and				
		id safe food handling				
	standards, includi	•				
		on and interview, the facility	R 0273	R 273 Food and Nutritional	10/15/2022	
		ppropriate temperatures for the		Services temperature logs,		
	_	ator, label open containers,		labeling containers,		
	_	ets were clean and intact, and				
	utensils were not ur	ncovered for 1 out of 1 kitchen				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIER	3	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	inspected.			What corrective action(s) w	
	•			be accomplished for those	
Finding includes:			residents found to have bee	n	
	8			affected by the deficient	
	During the tour of t	the kitchen on 8/23/2022, with		practice.	
	_	er at 9:05 A.M. to 9:30 A.M.,		process.	
		opening the walk-in freezer as		· Freezer door gasket	
	-	of ice on the torn gasket, ice		repaired	
	_	, outside the temperature read 8		<u> </u>	
		ide thermometer read 28		· Freezer defrosted and	new
		n the inside was not running.		thermometer installed	
The walk-in refrigerator had an opened plastic					
	package covered with foil and pepperoni both			· Fan Reported and	
	undated. The Reach	n-in refrigerator had an outside		operating properly at this time	<b>;</b>
	temperature of 46 d	legrees and no thermometer			
	inside, contents of j	elly were stored in a metal		· Refrigerator items clea	ned
	container covered v	vith foil, 3/4 jug of barbeque		and all items labeled and date	ed
	_	1 3 bundles of American		appropriately	
		ped in plastic wrap all undated,			
	serving utensils in a	a plastic bin on a lower shelf		· Refrigerator and Freez	er
	uncovered.			logs initiated	
	During an interviev	v on 8/23/2022 at 9:30 A.M., the		· Utensil cleaned and st	ored
		idicated that the freezers		appropriately	
	, , ,	have been below 0, the		'' '	
	_	cheese, jelly, and barbeque			
		been labeled with an open			
		efrigerators temperature should		How the facility will identify	
		degrees and serving utensils		other residents having the	
	should have been co	overed.		potential to be affected by the	ne
				same deficient practice and	
	On 8/23/2022 at 2:4	45 P.M., the Administrator		what corrective action will b	e
		itled, "3. Equipment:		taken.	
	_	ezer Temperature Policy: It is		· All residents have the	
		le safe food that is stored at		potential to be affected by alle	eged
		tures at all times. All food		deficient practice	
	_	e in the safe zone and will be		· Deep clean of the kitch	en
		ourse of each shift utilizing the		was completed	
	_	ezer Temperature log.		· Audit completed and al	I
	Procedure: a. The	Dining Services Director will		food labeled and dated as	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	PROVIDER OR SUPPLIEI IDGE VILLAGE	R	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	ON (X5) BE COMPLETION DATE
	the course 0 each sie each refrigerator are thermometer install ensure the followin degrees Fahrenheit 0 degrees Fahrenheit reading in the Refrilog. d. Any signification reported to the Din management"	I staff member responsible in hift to check the temperature of ad/or freezer b. Utilizing the led in the equipment, check to gg: i. Refrigerator's must be 41 or below. ii. Freezer's must be bit or below, c. Enter each igerator & Freezer Temperature ant fluctuations should be ing services Director or 115 A.M. polices requested for orage was requested but not be survey exit.		appropriate Dishwasher temp loginitiated Kitchen cleaning schinitiated What measures will be purplace or what systemic changes the facility will measure that the deficient practice does not recur; Dietary Manager educate on Refrigerator and freezer log and kitchen cleaning schedus Dietary staff educate Refrigerator and freezer tend kitchen cleaning schedus Dietary staff educate Food labeling and Storage infection control requirement the kitchen Dietary staff educate storage of utensils Dietary Manger to condaily kitchen environmental sanitation rounds  How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and Administrator. Design complete Kitchen sanitation rounds to ensure compliance cleanliness and infection con practices including food stollabeling, temperature check and utensil storage	eduled  t into  ake  at  cated ctemp hedule d on mp log luled d on and nts for  d  cmplete l and  (s) re the  e put  nee to n ce with outrol crage,

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING B. WING		COMPLETED 08/26/2022		
	ROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	(X5) COMPLETION DATE
				Audit to be completed weekly x 4 then monthly x 6 to ensure compliance     Results of the audits will reviewed in QA and plan will be adapted or adjusted as needed maintain compliance	ll be pe
R 0275 Bldg. 00	(h) Diet orders sha by the physician a requires.	nal Services - Deficiency all be reviewed and revised s the resident 's condition			
	failed to ensure ther	iew and interviews, the facility e were diet orders, signed by of 23 Residents. (Resident	R 0275	R 275- Food and Nutritional Services- Diet Orders signed	10/15/2022
	reviewed on 8/23/20 was admitted to the including but not lin pressure ulcers of th	rd for Resident M was 22 at 3:30 P.M. Resident M facility with diagnoses, nited to, epilepsy, non e skin, glaucoma, chronic		What corrective action(s) wi be accomplished for those residents found to have been affected by the deficient practice.  Residents M, D,F,L and P had diet orders reviewe	n
	Review of the currer Resident M indicate During an interview Care Coordinator, co A.M. he indicated h orders for Resident indicated he would be queried on 8/24/202 8/25/2022 at 3:00 P.	nt physician orders for d there was no diet order. with QMA 2, the Residential onducted on 8/24/2022 at 11:00 e did not know where the diet M were located but he 'look" for them. QMA 2 was 2 at 3:00 P.M., again on M. and on 8/26/2022 at 10:00 no diet order located for		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.  All residents in the facility have the potential to be affect by alleged deficient practice Whole House audit	e ity

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. W	B. WING 08/26/2022			2022
				CTREET	ADDRESS OF A TE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP COD		
WOODD					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	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2. The clinical reco	ord for Resident D was reviewed			completed to verify diet accura	асу	
	on 8/24/2022 at 10:	00 A.M. Resident D was			and physician signature	Ĭ	
	admitted to the faci	lity on 5/9/2022 with					
	diagnoses, includin	g but not limited to diabetes			What measures will be put in	to	
	mellitus and hyperl	ipidemia. The admission			place or what systemic		
	physician orders for	r Resident D did not include an			changes the facility will make	Э	
	order for the resider	nt's diet. QMA 2, the			to ensure that the deficient		
	Residential Care Co	pordinator was interviewed on			practice does not recur;		
	8/24/2022 at 11:00	A.M. regarding the resident's			o IDT team provided education	on on	
	diet order. He indie	cated he would look for the			new admission reviews to incl	ude	
	order. The diet ord	er was requested again on			verification of Diet Order		
	8/24/2022 at 3:00 P.M., on 8/25/2022 at 11:00 A.M.				o Licensed educated on		
	and 3:00 P.M. and	on 8/26/2022 at 11:00 A.M. and			admission checklist to include		
	no diet order was located for Resident D.3. A				verification of Diet Order		
	clinical record revie	ew was completed on 8/25/2022			o IDT will review diet orders		
	at 3:48 P.M. Reside	ent F's diagnoses included, but			during semi annual assessments		
	were not limited to:	epilepsy, bipolar, diabetes,			and during service plan review		
	Parkinson's disease	and schizoaffective disorder.					
					How the corrective action(s)		
		ian orders, dated 9/15/2021,			will be monitored to ensure t	he	
		and no more recent physician			deficient practice will not		
	orders were noted of	on the medical record.			recur, i.e., what quality		
					assurance program will be p	ut	
		:47 A.M., Resident F's current			into place; and		
		ere requested, but none were					
	provided on 8/25/22	2 or 8/26/2022.			i. Health Servic	e	
					Director to complete Audit to		
		review was completed on,			ensure Diet orders are in place	9	
		.M. Resident L's diagnoses			and have been signed by the		
		not limited to: diabetes,			physician		
	depression, bipolar,	hypertension and anxiety.					
	B 11 . T. 1				ii. Audit to be		
		ian orders, dated 2020, lacked			completed weekly x 4 then		
		er and no more recent			monthly x 6 to ensure complia	nce	
		ere noted on the medical					
	record.				iii. Results of the		
	0 0/05/0000 : 11	40 A M D '1 / II			audits will be reviewed in QA a		
		:48 A.M., Resident L's current			plan will be adapted or adjuste		
		ere requested, but none were			needed to maintain complianc	e	
	provided on 8/25/22	2 or 8/26/2022.					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R 0299 Bldg. 00	5. A clinical record 8/25/2022 at 9:28 A diagnoses included, asthma, convulsions hemiparesis.  Resident P's physic lacked any type of ophysician orders we record.  On 8/25/2022 at 11 physician orders we provided on 8/25 or A policy was requereviewing but one with the state Resident IN00387635.  410 IAC 16.2-5-6(Pharmaceutical S (3) The medication recommendations physician, if necessin accordance with Based on record revialled to ensure medical pharmacist for 10 of (Residents C, D, F, Findings include:	review was completed on a.M. Resident P's current but were not limited to: s, atrial fibrillation and left ian orders, dated 9/15/2021, diet order and no more recent ere noted on the medical et 47 A.M., Resident P's current ere requested, but none were 8/26/2022.  Sted for diet orders and was not provided.  ial finding relates to Complaint c)(3) ervices - Noncompliance	R 0299	R 299 Pharmaceutical Service—No Pharmacy Recommendations  What corrective action(s) with the accomplished for those residents found to have bee affected by the deficient	ces 10/15/2022
	sampled residents, of 8/26/2022, there we	conducted on 8/23/22 - ere no pharmacy medication d for Residents C, D, F, G, H,		practice.  Residents C,D,F,G,H,L,M,N,P and JJ ha	ad

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		08/26/	2022
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			GENERATIONS DR		
WOODP	IDGE VILLAGE				BEND, IN 46635		
WOODK	TOOL VILLAGE		-	33011	, DE14D, II4 40000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	w with QMA 2, the Resident			medications reviewed by		
		on 8/24/2022 at 9:40 A.M., he			pharmacist		
		y had changed pharmacy					
	1 ~	d not think the new pharmacy					
	was conducting routine pharmacy reviews for residents. He indicated he would look for any				Harris de la Carte		
					How the facility will identify		
		e no pharmacy reviews located			other residents having the	_	
	by QMA 2.				potential to be affected by the	е	
	On 8/23/2022 at 2.	15 P.M., the Administrator			same deficient practice and what corrective action will be	•	
	provided the policy				taken.	<del>-</del>	
		', dated 12/28/2008, and			All residents in the facili	tv	
		was the one currently used			have the potential to be affect	•	
		policy indicated " 1. The			by alleged deficient practice		
		riew the drug regimen of each			· Pharmacy contacted an	ıd	
		ery sixty (60) days. 2. A written			review requested of all resider		
	report of individual				that reside in the facility.		
	1 -	along with recommendations			Pharmacy completing reviews	and	
		eutical services will be			will ensure all residents review		
	provided to the Adı	ministrator, or designee. 3. All			over next sixty days		
	pharmacy recomme	endations requiring a			· Pharmacy report/		
	1	vill be brought to the attention			recommendation tracking syst	em	
		physician in a timely manner			implemented		
	,	ess days). 4. If a physician is			· Health Service Director		
	not in agreement w				Administrator to meet with fac	-	
	1	nis will be documented in the			pharmacy consultant to review	<b>V</b>	
	medical record"				Pharmacy recommendations		
	TELL CLASS STATE	. 1 (* 1)			policy		
		rial finding relates to					
	_	37635, IN00380236 and			What measures will be put in	ito	
	IN00382840.				place or what systemic	_	
					changes the facility will mak	е	
					to ensure that the deficient		
					practice does not recur;	on	
					o IDT team provided education	UH	
					pharmacy consultant reviews o Pharmacy to send reports	to	
					Health Services Director and	ıo	
					Administrator after visits and f	ollow	
					up to be given to physician for		
	I				I ar is as all all to bull older for		I

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 08/26/2022
	PROVIDER OR SUPPLIEF	2	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR 1 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)	(X5) COMPLETION DATE
				review o Health Serv ice Director/Designee to maintain Pharmacy review/ report track system	
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; and	the
				i. Health Service Director to complete Audit to ensure that Pharmacy reports recommendation orders are in place and have been reviewed completed and signed by the physician	and
				ii. Audit to be completed weekly x 4 then monthly x 6 to ensure complia	ince
				iii. Results of the audits will be reviewed in QA aplan will be adapted or adjusted needed to maintain compliance.	ed as
R 0300 Bldg. 00	(4) Over-the-coun drugs, and biologi	c)(4) ervices - Deficiency ter medications, prescription cals used in the facility n accordance with currently			

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			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	accepted profession the appropriate accinstructions and the Based on record revinterview, the facility when opened, failed and topical creams, labels in 3 of 3 med (Medication Carts 1). During a medicat 3 medication cart, of QMA 2 (Qualified Medication cart, of QMA 2 (Qualified Medication baserved: An opener patch in it not labeled Albuterol inhaler miname [residents name pharmacy label. A Sepharmacy label. A Sepharmacy label. An Fluticasone nasal special pharmacy label pharmacy la	consideration on the constraint of the constrain		R 300- Pharmacy – Med Storage What corrective action(s) who be accomplished for those residents found to have be affected by the deficient practice.  Medications carts 1, 2 3 were audited and correction made  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will taken.  All residents to the fact have the potential to be affected by alleged deficient practice.  Medication Cart Audit completed and corrections for labeling and storage completed.  What measures will be put in place or what systemic changes the facility will made to ensure that the deficient practice does not recur;  All nurses educated medication storage	ill and he be sility sted ar ed.

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
	PROVIDER OR SUPPLIER	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	On 8/23/2022 at 9:49 A.M., QMA (Qualified Medication Aide) 2 indicated the medications should be labeled, dated when opened and the medications that was held or was refused, is put back in the medication drawer and at the end of the week on Friday they will be returned or destroyed when there can be another witness present.  2. During a medication storage observation on Hall 2, on 8/23/2022 at 10:38 A.M., with QMA 2 the following was observed: 2 loose pills in drawer 2 and 3; An opened bottle of pills with no pharmacy label and or date opened. An opened bottle of Equate not labeled with AM written on the cap. An opened bottle of Sentry Senior vitamins with no label or name. An opened, undated, and not labeled bottle of Omeprazole. A bottle of Atropine eye drops in with the oral medications. Three opened and undated bottles of Miralax. Opened and undated containers of Potassium Chloride, Methadone Syrup, lacteals, and Paratroop nasal spray. Four insulin pens with no pharmacy label. A medication cup with 2 Tylenol tablets with no resident identifiers.  During an interview, on 8/23/2022 at 10:50 A.M., AMA 2 indicated the medications should be labeled, dated when opened, separated by routes and the Tylenol pills should not be in the cart like that. 3. During a medication Storage observation on Hall 1 Medication Cart, at 8:00 A.M., with QMA 3, the following was observed: Assure Prism glucose test strips 50/bottle was opened. The container was not labeled with a resident's name, there was no open date on the container; 1 bottle of opened Refresh Tear Drops with no open or discard date on the bottle.		How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; and  Health Services Direct Designee to complete medica cart audit to ensure storage a labeling of medication cart is appropriate  Audit to be completed weekly x 4 then monthly x 6 the ensure compliance  Results of the audits wereviewed in QA and plan will adapted or adjusted as needed maintain compliance	out  or/ ation and  o  ill be be

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		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/26/2022	
OVIDER OR SUPPLIE	3	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635		
	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
An interview with medications and m labeled with the result be labeled with the be labeled with the On 8/24/2022 at 2: provided the policy the Facility", dated policy was the one The policy indicated dispensed by the placentainer with the pla	QMA 3 at this time indicated all edication supplies should be sident's name and should also open and expiration dates.  15 P.M. the Administrator titled, "Medication Storage in 5/10/2018, and indicated the currently used by the facility. d"C. All medications narmacy are stored in the charmacy label. Orally eations are kept separate from dications and treatments such intments, creams, vaginal medications are stored ity policy"	TAG	DEFICIENCY)	DATE	
Clinical Records - (a) The facility muon each resident. maintained under employee of the fresponsibility. The follows: (1) Complete. (2) Accurately doe (3) Readily acces (4) Systematically Based on observati interview, the facil records were accur sampled residents.	Noncompliance ust maintain clinical records These records must be the supervision of an acility designated with that e records must be as  cumented. sible. organized. on, record review and ity failed to ensure clinical ate and complete for 23 of 23 This potentially affected all 53	R 0349	R 349 – Clinical Records What corrective action(s) who accomplished for those residents found to have bee		
nib Crift Fild caears ICI 4C (Conenfo (C) (C) (Firs	REGULATORY OF An interview with of medications and medications are labeled with the policy defended the policy of the Facility", dated policy was the one of the policy indicated dispensed by the proportion of the policy indicated dispensed by the policy indicated dispensed by the policy indicated dispensed by the proportion of the policy indicated dispensed by the proportion of the policy indicated dispensed by the policy	An interview with QMA 3 at this time indicated all medications and medication supplies should be abeled with the resident's name and should also be labeled with the open and expiration dates.  On 8/24/2022 at 2:15 P.M. the Administrator provided the policy titled, "Medication Storage in the Facility", dated 5/10/2018, and indicated the policy was the one currently used by the facility. The policy indicated"C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Orally administered medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately per facility policy"  This State Residential finding relates to Complaints IN00387635, IN00380236 and IN00382840.  Alto IAC 16.2-5-8.1(a)(1-4)  Clinical Records - Noncompliance  a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that desponsibility. The records must be as ollows:	An interview with QMA 3 at this time indicated all medications and medication supplies should be abeled with the resident's name and should also be labeled with the open and expiration dates.  On 8/24/2022 at 2:15 P.M. the Administrator provided the policy titled, "Medication Storage in the Facility", dated 5/10/2018, and indicated the policy was the one currently used by the facility. The policy indicated"C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately per facility policy"  This State Residential finding relates to Complaints IN00387635, IN00380236 and IN00382840.  Alto IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that esponsibility. The records must be as ollows:  1) Complete. 2) Accurately documented. 3) Readily accessible. 4) Systematically organized. Based on observation, record review and nterview, the facility failed to ensure clinical records were accurate and complete for 23 of 23 sampled residents. This potentially affected all 53	REGULATORY OR LSC IDENTIFYING INFORMATION An interview with QMA 3 at this time indicated all medications and medication supplies should be abeled with the resident's name and should also be labeled with the resident's name and should also be labeled with the open and expiration dates.  On 8/24/2022 at 2:15 P.M. the Administrator provided the policy titled, "Medication Storage in the Facility", dated 5/10/2018, and indicated the policy was the one currently used by the facility. The policy indicated"C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored exparately per facility policy"  This State Residential finding relates to Complaints IN00387635, IN00380236 and IN00382840.  110 IAC 16.2-5-8.1(a)(1-4)  Clinical Records - Noncompliance and The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that esponsibility. The records must be as ollows:  1) Complete. 2) Accurately documented. 3) Readily accessible. 4) Systematically organized. 3ased on observation, record review and netrview, the facility failed to ensure clinical records what corrective action(s) we be accomplished for those residents. This potentially affected all 53	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING			NSTRUCTION  00	(X3) DATE ( COMPL 08/26/	ETED	
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE		1	7650 G	DDRESS, CITY, STATE, ZIP COD SENERATIONS DR BEND, IN 46635		
PREFIX (EACH DEFIC TAG REGULATORY	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
- 8/26/2022, clin missing docume evaluations and medication reviaccurate medical accurate and concurrent diet order.	ey process, conducted on 8/23/22 ical records were noted to be ntation such as current service plans, pharmacy ews, current physician's orders, tion administration records, nplete emergency file information, ers, current resident weight			No residents with report negative outcomes related to clinical records noncompliance		
notes, narcotic of documentation, assessments.	nursing notes, physician progress ount records and immunization including Tuberculin testing and			How the facility will identify other residents having the potential to be affected by th same deficient practice and what corrective action will be		
paper holder in 3 months old an implemented. T Administration	hers were observed in an open the nurse's station that were over d had not been transcribed and there were stacks of Medication Records from June 2022 on the the bookcase holding Resident			taken.  All residents to the facili have the potential to be affected by alleged deficient practice  New Health Service  Director (LPN was on board at facility)  Administrator, Health	ed	
documentation in During an intervention Care Coordinate	harting system had very little mplemented for each resident. riew with QMA 2, the Resident or, he indicated the facility only king on an as needed basis until			Service Director, and Regiona Operator to review staffing patterns, trends and IDT team review delegation of duties as relates to clinical records	to	
8/24/2022 when agreed to come basis. In addition pharmacy took at Records back at even though state floor. QMA 2 is completing narround December 2021 consuming. QM	the as needed nurse, LPN 1 back and work on a consistent on, QMA 2 indicated the current all the Medication Administration ter the month was completed, acks of records were noted on the adicated the facility had stopped otic count sheet records in because it was too time IA 2 indicated he had requested the facility's new corporation and			What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Administrator, Health Service Director, and Regiona Operator to review staffing patterns, trends, and IDT team review delegation of duties as relates to clinical records	e I n to	

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PRINTED: 10/11/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	AT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 08/26/2022
	PROVIDER OR SUPPLIER IDGE VILLAGE		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	(X5) COMPLETION DATE
	had been told they we no assistance was properties. The policy regarding records was requested 8/26/2022. The policinical records was addition, a highlight regulation and a clir provided. There was regarding the facility regarding maintenant clinical records in the This State Residential	were doing "a good job" and rovided.  g the maintenance of clinical ed on 8/25/2022 and icy regarding destruction of provided multiple times. In ed copy of the Residential prical chart content list was as no policy provided by's policy and procedure ince of active and closed ine building.		Electronic Health Record (PCC) training to be reviewed facility staff Education for Facility ston Cheat sheets created for documentation and copies provided to staff Clinical Morning Meetin agenda and follow up initiated Facility Chart Audits to completed by RN or LPN staff resident charts weekly weekly until all resident charts have be reviewed- Chart Reviews will comprehensive and review or service plans, assessments, medications etc. New Admission Checkl to be utilized for floor staff and to complete IDT admission reto capture accurate clinical information  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Chart Audits to be completed by RN or LPN staff resident charts weekly until al resident charts have been reviewed- Chart Reviews will comprehensive and review or service plans, assessments, medications etc. Audit to be completed weekly until current census	rd with aff  g be 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 08/26/2022
	ROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I 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)	(X5) COMPLETION DATE
				reviewed and will be reviewed monthly x 6 to ensure complia Results of the audits wil reviewed in QA and plan will be adapted or adjusted as neede maintain compliance	l be e
R 0356 Bldg. 00	be immediately ac in case of emerger following: (1) The resident 's apartment number date of birth. (2) The resident 's (3) The name and legally authorized (4) The name and resident 's physici (5) The name and family members or contacted in the evideath. (6) Information on (7) A photograph (resident). (8) Copy of advances and the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility in case of the second record review, the facility is approximately approximatel	Noncompliance gency information file shall cessible for each resident, ncy, that contains the s name, sex, room or r, phone number, age, or s hospital preference. phone number of any representative. phone number of the	R 0356	R 356 – Clinical Records What corrective action(s) wi be accomplished for those	10/15/2022
	53 of 53 residents.  Finding includes:  On 8/25/2022 at 10:	quired resident information for  28 A.M., the Administrator cy binders. The binders		residents found to have beer affected by the deficient practice.  No residents with report negative outcomes related to clinical records noncompliance.	ted

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	EMENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/26/2022
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE			17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635	
(X4) I PREF TAG	X (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
	facility. The followmissing: 30 face sheets out 21 of 23 face sheets home preference. 2 of 23 face sheets 8 of 23 lacked a ph 23 of the 23 reside their Advanced Di A policy on emerg requested on 8/25/	lacked the name of the funeral lacked the hospital preference. noto of the resident. Ints lacked a current copy of rectives.  ency resident information was 2022.  w, on 8/25/2022 at 1:12 P.M., the cated he could not provide a		How the facility will identify other residents having the potential to be affected by th same deficient practice and what corrective action will be taken.  All residents to the facility have the potential to be affected by alleged deficient practice  New Health Service Director (LPN was on board at facility)  Administrator, Health Service Director to review staffing patterns, trends and IDT team review delegation of duties as relates to clinical records  What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Administrator, Health Service Director, and Regiona Operator to review staffing patterns, trends, and IDT team review delegation of duties as relates to clinical records  Electronic Health Record (PCC) training to be reviewed facility staff  Education for Facility staff	ty ed the to it to it to it d with

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/26/2022
NAME OF P	ROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP COD	
MOODBI	DGE VILLAGE			GENERATIONS DR H BEND, IN 46635	
WOODRI	DGE VILLAGE		30011	1 DEND, IN 40033	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				on Cheat sheets created for	
				documentation and copies	
				provided to staff	- <b>4</b> :
				Clinical Morning Me	_
				agenda and follow up initia	•
				<ul> <li>Facility Chart Audits completed by RN or LPN s</li> </ul>	•
				resident charts weekly wee	•
				until all resident charts have	- I
				reviewed- Chart Reviews	
				comprehensive and review	v orders,
				service plans, assessment	•
				medications, emergency c	ontact,
				photos etc.	
				New Admission Che	ecklist
				to be utilized for floor staff	
				to complete IDT admission	
				to capture accurate clinica	I
				information	
				How the corrective action	n(s)
				will be monitored to ensu	` '
				deficient practice will not	:
				recur, i.e., what quality	
				assurance program will b	e put
				into place; and	
				· Chart Audits to be	
				completed by RN or LPN s	•
				resident charts weekly unt resident charts have been	II dII
				reviewed- Chart Reviews	will be
				comprehensive and review	
				service plans, assessment	•
				medications etc.	,
				· Audit to be complete	ed
				weekly until current census	•
				reviewed and will be review	•
				monthly x 6 to ensure com	
				· Results of the audits	•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/26/2022			ETED		
					PPPPA CONT. CO.	00/20/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR		
WOODRI	DGE VILLAGE				I BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG R 0406 Bldg. 00	410 IAC 16.2-5-12 Infection Control - (a) The facility mu an infection contro provide a safe, sa environment and t			TAG	reviewed in QA and plan will be adapted or adjusted as needer maintain compliance		DATE
	interview, the facility control measures we maintained to ensur was provided to pre This deficient practions of 53 of 53 residents we Finding includes:  Upon entrance to the A.M., only one staff wearing a face mash including the Admir face masks and wer residents in close properties.	on, record review and ty failed to ensure infection ere implemented and e a safe, sanitary environment event infection transmission. Sice had the potential to affect who reside in the facility.  The facility, on 8/23/22 at 9:30 f member was noted to be exampled. All other staff members enistrator, were not wearing the noted to be interacting with the account of the facility.  The facility of the	R 0	406	F 406- Infection Control – COVID, Mask Use, COVID etc What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice.  No residents were affect QMA 2 is no longer employed at the facility  How the facility will identify other residents having the potential to be affected by th same deficient practice and what corrective action will be	i n cted	10/15/2022

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	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE S COMPL 08/26/	ETED
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE				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
	the facility was not policy and procedu indicated they were (Centers for Diseas Administrator indic COVID 19 policy variety staff were doing regard to the survey part of the survey par	currently following their own re regarding COVID-19. He is following the current CDC are Control) guidelines. The stated the facilities current was not reflective of what the garding wearing masks.  Process, conducted through 26/22, QMA 2, the Resident and the staff member designated the Infection Control system times for a copy of the COVID and the list records. The QMA are documentation in a folder but and documentation regarding a for review. When queried, the thought a dietary employee COVID a month or two ago. He proved testing positive for off work for 5-7 days and then if the they could come back to any resident with signs and or any resident with signs any resident with signs any resident with signs any resident with signs any			taken.  All residents to the facility have the potential to be affected by alleged deficient practice.  Health Services Director boarded and is responsible for COVID 19-line listings, tracking monitoring etc.  Infection control Surveillance initiated.  COVID Vaccination Audition completed for all residents and staff.  COVID vaccination tracking system implemented.  COIVD monitoring order initiated in PCC.  Infection control praction reviewed in orientation and duroutine in servicing.  Audit of all staff.  TB/Tuberculin testing to be completed as noted in R 121.  TB tracking system initiated staff. TB tracking system to be maintained with documentation with.  Facility staff educated on The tracking system, 1st, 2nd step and annual PPD requirements staff.  What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  All nurses educated on COVID monitoring, reporting, and covered the covered to the covered the covered to the covered the covered to the c	ed r on r g, dit d rs es ring d for e n 6 for	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER A. BUILDING 00  B. WING				(X3) DATE COMPL <b>08/26</b> /	ETED
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE		•	17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR 1 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
140	infection to the "Standard Standard Sta				isolation practices etc.  All staff in service on Pf Mask use in the facility  Upon orientation with all new hires, Administrator/ designation will complete New Hire checkly to ensure that employee has completed all required aspects orientation including PPD testing/screening / Vaccination Records and infection control training  Health Services Director boarded and is responsible for COVID 19-line listings, tracking monitoring etc.  Infection control Surveillance initiated  COVID Vaccination Audit completed for all residents and staff  COVID vaccination traces system implemented  COIVD monitoring order initiated in PCC  Infection control practice reviewed in orientation and duroutine in servicing  Audit of all staff TB/Tuberculin testing to be completed as noted in R 121  TB tracking system initiated for staf  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place; and	PE/ I gnee ist s of n ron r g, dit d king rs es uring	

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PRINTED: 10/11/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING  B. WING	COMPLETED 08/26/2022
NAME OF PROVIDER OR SUPPLIER  WOODRIDGE VILLAGE  STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTEYING INFORMATION  administered and he would come to the building to provide the test. When asked for any documented TB Mantoux test performed in the past year, QMA 2 indicate the documentation was in a folder and that he had lost the folder. There was no documentation located in the clinical records or employee files regarding the required tuberculin skin testing.  Review of the facilities policy and procedure regarding COVID 19 indicated it had not been updated since May 28, 2020. In addition, review of the facilities policy and procedure, titled " Surveillance for Infections" included the following: "3. Infections that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment. b. Available processes's and procedures that prevent or reduce the spread of the infection. c. Clinically significant morbidity or mortality associated with infection (e.g. Pneumonia, UTI's C. Difficile) and d. Pathogens associated with serious outbreaks. (e.g. invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza)5. Nursing staff.  This State Residential finding relates to Complaint IN00387635.	DATE  COMPLETION DATE  D

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (2)	(X3) DATE SURVEY  COMPLETED  08/26/2022				
	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  ACH DEFICIENCY MUST BE PRECEDED BY FULL  GULATORY OR LSC IDENTIFYING INFORMATION  BY PREFIX  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
R 0408 Bldg. 00	chest x-ray complements prior to act Based on record reversal failed to ensure a club to admission for 1 club past year in a sample. Findings include:  The clinical record on 8/24/2022 at 10: admitted to the faci diagnoses, including mellitus and hyperla physical form confadmission to the fact xray documented of diagnostic center for During an interview Care Coordinator of indicated a physicial had provided the predocumentation for 1 unaware of the lack	Noncompliance shall have a diagnostic eted no more than six (6) dmission. View and interviews, the facility nest x-ray was completed prior of 2 residents admitted in the de of 23.  for Resident D was reviewed 00 A.M. Resident D was lity on 5/9/2022 with g but not limited to diabetes ipidemia. There was a copy of impleted prior to the resident's cility, but there was no chest in the form or on a separate	R 0408	F 408- Infection Control CXR fresidents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affect Resident D had CXR completed, and MD was notified.  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.  All residents to the facility have the potential to be affected by alleged deficient practice PPD/ CXR audit complete for residents at the facility PPD testing/ CXR or screening scheduled for all identified residents What measures will be put into	ed d d d d d d d d d d d d d d d d d d			

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022
NAME (	OF PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR	
WOO	ORIDGE VILLAGE			H BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
	REGULATOR TO	LES ADEATH THIS BY ORWATION		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; IDT team educated on preadmission requirements of prior to admission Nursing staff in service PPD testing/ Screening IDT educated on use of admission review tool to ensure CXR was obtained and PPD winitiated. Audit of all staff TB/Tuberculin testing to be completed for residents in the facility TB tracking system initiated for resident tracking. tracking system to be maintain by Health Service Director/Designee  How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; and Health Services Director/Designee to audit new admissions to the facility to ensure that PPD/ CXR/ Screenings have been complete as required Results of the audits will reviewed in QA and plan will be adapted or adjusted as neede maintain compliance	e CXR on FIDT re vas  TB ned  the ut  W eted II be ne

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	(X3) DATE SURVEY  COMPLETED  08/26/2022	
	PROVIDER OR SUPPLIER		17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE BY 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 APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
R 0410 Bldg. 00	completed within th				
	forty-eight (48) to so result shall be reconsideration with the by whom administed (f) For residents who documented negation result during the promonths, the baseling should employ the first step is negative performed within on after the first test. To testing will depend with tuberculosis.  (g) All residents who indured the state of the sta	eventy-two (72) hours. The orded in millimeters of date given, date read, and dered and read.			
	have a chest x-ray laboratory examina a diagnosis. Based on record revifailed to ensure tube	and other physical and stions in order to complete ew and interview, the facility reulin skin testing was	R 0410	F 410- Infection Control PPD/CXR	10/15/2022
	23 sampleted resider K, L, M N, P, Q, S, HH, KK and JJ)	nission and annually for 23 of ats. (Resident B, C, D, F, G, H, Γ, V, W, BB, CC, DD, FF, GG,		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	
	Findings include:  During the survey, c	onducted on 8/23/22 -		· No residents were affec	ted

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPL		ETED		
			B. W			08/26/		
							-	
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
				17650 GENERATIONS DR				
WOODR	IDGE VILLAGE			SOUTE	H BEND, IN 46635			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDERIC DI AM OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	8/26/2022, the clini	ical records for Residents B, C,			· Residents			
	· ·	1, N, P, Q, S, T, V, W, BB, CC,			B,C,D,F,G,H,K,L,M,N,P,Q,S,T	.V.		
		KK and JJ) were reviewed.			W,BB,CC,DD,FF,GG,HH,KK a			
		mentaiton in the clinical reords			JJ had PPD screening/ Testing			
	regarding tuberculi				completed as appropriate	5		
	8 8	8						
	During an interview	w with QMA 2, the Resident						
	-	conducted on 8/25/2022 at 3:00			How the facility will identify			
		all of the facility resident			other residents having the			
	· ·	ing documentation was in a			potential to be affected by th	e		
		not locate the folder. He			same deficient practice and	•		
		(as needed) nurse LPN 1 would			what corrective action will be	<u>.</u>		
		g to perform the testing when			taken.	•		
		ow of the need. The folder was			· All residents to the facili	itv		
		ys of the survey but was never			have the potential to be affected	•		
	located and provide	•			by alleged deficient practice	<b>J</b> u		
	iocaica ana provide	34 0) (11112.			PPD/ CXR audit comple	eted.		
	Review of the facil	ity policy and procedure, titled,			for residents at the facility	nou		
		ing", provided by the			· PPD testing/ CXR or			
		/25/2022 at 9:30 A.M., indicated			screening scheduled for all			
		ncluded: "2. A tuberculin			identified residents			
	-	ompleted within three (3)			lacrimoa regiaerite			
		admission or upon admission			What measures will be put in	ito		
	-	ght (48) to seventy-two (72)			place or what systemic			
	-	hall be recorded in millimeters			changes the facility will make	Δ		
		the date give, date read and by			to ensure that the deficient			
		l and read. 3. Residents who			practice does not recur;			
		umented neggative tuberculin			· IDT team educated on			
		ng the preceding twelve (12)			preadmission requirements of	CXR		
		te tuberculin skin testing			prior to admission	• • • • • • • • • • • • • • • • • • • •		
		two-step method"			Nursing staff in service	on		
		<b>r</b>			PPD testing/ Screening	011		
					· IDT educated on use of	IDT		
					admission review tool to ensur			
					CXR was obtained and PPD v			
					initiated.			
					· Audit of all staff			
					TB/Tuberculin testing to be			
					completed for residents in the			
					facility			
				lacility		I		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2022	
NAME OF PROVIDER OR SUPPLIER  WOODRIDGE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 17650 GENERATIONS DR SOUTH BEND, IN 46635				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE	
				TB tracking system initiated for resident tracking. Tracking system to be maintain by Health Service Director/Designee		
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place; and § Health Services Director/Designee complete Paudit to ensure that PPD/ CXI Screenings have been complete as required  Results of the audits will reviewed in QA and plan will be adapted or adjusted as needed maintain compliance	ut PD R/ sted I be e	
R 0414	410 IAC 16.2-5-1					
Bldg. 00	(k) The facility mเ hands after each	st require staff to wash their direct resident contact for ing is indicated by accepted				
	failed to follow star	on and interview, the facility ndards of care during a stration observation. (QMA 5)	R 0414	F 414- Infection Control QMA Medication Pass 1. What corrective action( will be accomplished for thos	s)	
	Finding includes:			residents found to have beer affected by the deficient		
	During an Adminis	stration of Medication		practice.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE		URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
			B. WI	ING		08/26/2022	
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8					
WOODRIDGE VILLAGE			17650 GENERATIONS DR SOUTH BEND, IN 46635				
WOODRIDGE VILLAGE				30016	1 BEND, IN 40035		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY 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
	observation, on 8/1	6/2022 from to 8:05 A.M. to					
	8:45 A.M., the follo	owing was observed:			· QMA 5 was educated of	on	
					medication administration prio	· · · · · · · · · · · · · · · · · · ·	
	1. QMA 5 retrieved	medication packets from the		retuening to the floor to pass			
	medication cart for	Resident BB. QMA tried to			medications		
		ith her hands, but they did not					
		ed the corner of the pill packet					
	· ·	pped the packet open and					
		the medication cup. QMA 5					
		er 6 packets with her teeth and					
		the medication cup, with 1 pill					
		of the medication cart. QMA 5			2. How the facility will		
	-	cked up the pill and placed it			identify other residents havi	ng	
	into the medication				the potential to be affected b	-	
		edications to the resident. The			the same deficient practice a	ınd	
	QMA did not any c	omplete of hand hygiene.			what corrective action will be	е	
					taken.		
		8:15 A.M., QMA 5 retrieved the			· All residents to the facil	•	
	-	for Resident P. When ripping			have the potential to be affect	ed	
		packet a pill fell onto the floor.			by alleged deficient practice		
		off the floor bare handed and			· All Nurses and QMAs		
		the medication cup. She then			educated on Medication		
		naining packets one at a time			administration with emphasis	on	
	-	cations into the medication			handwashing		
	-	red the medications to Resident					
	-	complete any type of hand			3. What measures will be	_	
	hygiene.				put into place or what syster		
	2 44 0 20 4 34 03	A445 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			changes the facility will make	е	
		MA 5 retrieved medications for			to ensure that the deficient		
		an ungloved hand, she			practice does not recur;		
	-	the package and placed the pill			All Nurses and QMAs ir serviced on Medication	1	
	on top of the package on the medication cart.  QMA 5 administered the medications to the						
		ed the medications to the eted no hand hygiene.			administration with return	on	
	resident and comple	eted no nand hygiene.			demonstration and emphasis		
	/ A+ 8.22 A M ON	MA 5 removed Resident CC's			comparing medications to EM		
		ne cart. She dropped a pill on			documentations of medication		
		on cart, and with an ungloved			refusals and PRN medications	•	
	•				· Health Service		
		pill and placed it into the			Director/Designee to complete		
	medication cup. QN	AA 5 did not complete any	ı		medication pass observations	with	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	<u> </u>		(X3) DATE SURVEY COMPLETED 08/26/2022	
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE			17650	ADDRESS, CITY, STATE, ZIP COD GENERATIONS DR H BEND, IN 46635			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  type of hand hygiene.  During an interview, on 8/23/2022 at 8:45 A.M., QMA 5 indicated she should not have used her mouth to open the pill packets and may be used scissors instead. She indicated the medications should not have been picked up off the floor and given and should not have given the pills dropped on the medication cart, and she should have washed her hands and or used hand gel in between the residents.  On 8/23/2022 at 2:15 P.M. the Administrator provided a policy titled," Staff Administered Medication", dated 3/1/2010, and indicated the policy was the one currently used by the facility. The policy indicated"1. Wash your hands throughly with soap and water 5 Use a paper medicine cup, not your hands"			staff to ensure compliance  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place; and  Health Services Director Designee to complete daily medication administration and ensure medication compliance Health Services Director Designee to complete medica administration observation and to ensure proper infection comprocess in place Audit to be completed weekly x 4 then monthly x 6 to ensure compliance Results of the audits wi reviewed in QA and plan will to adapted or adjusted as neede maintain compliance	ity ut  r/ it to e r. tion dits trol		

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