STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Residential Licensure Survey and to the Investigation of Complaints IN00387635, IN00382840, and IN00380236, completed on 8/26/2022. This visit was in conjunction with the Investigation of Complaint IN00393551. Complaint IN00387635 - Not Corrected Complaint IN00382840 - Not Corrected Complaint IN00380236 - Not Corrected Survey dates: October 27, 28 and 31, 2022 and Novemeber 1 and 2, 2022 Facility number: 001148 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/10/22.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the physician when medications were not administered to 2 of 5 residents review for medication administration, Residents (Resident D and Resident H). Findings include: 1.On 10/31/22 at 1:19 P.M., Resident D's Clinical Record was reviewed and indicated the resident's current diagnoses included, but were not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. The current physician's orders for Resident D included an order, initiated on 7/22/22, for the resident to receive 1 mg of Ozempic (a medication to lower blood sugar) 4 mg/ml injections once a week for diabetes. Review of the October Medication Administration Record (MAR) for Resident D, indicated he received the Ozempic injection on 10/7,10/14, and 10/21/22, but did not receive the ordered medication on 10/28/22. On the back side of the MAR were the instructions for: D. Drug not given. Indicate reason in Nurse's Medication Note. The back page lacked any documentation to say why the blood sugar medication was not given. On 10/31/22 at 11:35 A.M., an interview with Resident D's physician indicated the resident was not getting his Ozempic every week as ordered, and the facility was not notifying her of missed medication administrations for any of her patients. On 10/31/22 at 1:19 P.M., an interview with the	R 0036	**R 036- Resident Rights- Refusals, Med Omissions** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**· The Physician was notified of residents D, and resident H of medications not administered. **2. 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 have the potential to be affected by deficient practice. · HSD/ designee will audit resident EMAR daily each shift x 2 weeks, then once monthly. Results of audit will be reviewed with Health Service Director to ensure all adequate notifications have been addressed. **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;** · New nursing staff, Licensed staff and QMA's will be in-serviced on QMA's Scope of Practice, Staff Administered Medication	12/15/2022

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	Licenced Practical Nurse (LPN), indicated Resident D's Ozempic was not charted as given on 10/28/22 and did not know if the medication was not given or if the Qualified Medication Aide (QMA) forgot to sign it as administered. Licenced Practical Nurse indicated he did not know if the physician was notified of medications that were not administered and further indicated the QMAs did not always notify him when medications were not administered. 2. On 10/31/22 at 1:30 P.M., Resident H's Clinical Record was reviewed and indicated the resident's current diagnoses included, but were not limited to: epilepsy, depression, and anxiety. The current physician's orders for Resident H included an order, initiated on 5/11/18, for the resident to receive 1 Phenytoin EX (extended release) 100 mg capsule 3 times daily for seizures. Review of the October Medication Administration Record (MAR) for Resident H, indicated he but did not receive the lunch dose of the ordered medication on 10/17/22. The Nurses Medication Notes of the Medication Administration Record lacked any documentation to say why the seizure medication was not given. On 11/2/22 at 11;00 A.M., the Administrator provided the policy titled, "RESIDENTIAL CARE POLICIES AND PROCEDURES STAFF ADMINISTERED MEDICATION," dated 3/01/2010, and indicated it was the current facility policy. The policy indicated, "...Record on the resident's Medication Sheet...Medication taken Time medication was taken Other specific information...Use the Medication Sheets that the community requires according to State		emphasis on Physician notification and medication documentation. **4.** - How the corrective action(s) will be monitored to ensure the deficient practice will not **recur, i.e., what quality assurance program will be put into place; and** · Upon orientation with new licensed nursing staff, training will be provided regarding QMA's Scope of Practice, Job Description, and Staff Administered Medication. · Health services Director/Designee to complete Medication administration audit daily each shift weekly x 2 weeks then twice monthly 6 months. In clinical meeting reviewing, medication and treatment refusals, medication and lab omissions and ensure physician notification was completed · Health Services Director or designee will monitor audit tool weekly x 4 then monthly with Health Services Review Schedule Audit tool for 6 months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	

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	regulation..Draw a circle around the square and initial it when the resident is observed not taking an ordered medication. Indicate on the back of the Medication Sheet the date, time and reason the medication was not taken..." This deficiency was cited on 8/26/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure physician ordered medications were administered per order for 2 of 5 records reviewed medication administration, (Resident D and Resident H). Findings include: On 10/31/22 at 1:19 P.M., Resident D's Clinical Record was reviewed and indicated the resident's current diagnoses included, but were not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. The current physician's orders for Resident D included an order, initiated on 7/22/22, for the resident to receive 1 mg of Ozempic (a medication	R 0243	**R 243 Health Services** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **· Physician was notified of Resident D and Resident H medication administration ordered medications were administered per order.** **2. 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**	12/15/2022

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	to lower blood sugar) 4 mg/ml injections once a week for diabetes. Review of the October Medication Administration Record (MAR) for Resident D, indicated he received the Ozempic injection on 10/7,10/14, and 10/21/22, but did not receive the ordered medication on 10/28/22. On the back side of the MAR were the instructions for:"... D. Drug not given. Indicate reason in Nurse's Medication Note...." The back page lacked any documentation to say why the blood sugar medication was not given. On 10/31/22 at 11:35 A.M., an interview with Resident D's physician indicated the resident was not getting his Ozempic every week as ordered, and the facility was not notifying her of missed medication administrations. On 10/31/22 at 1:19 P.M., an interview with the Licenced Practical Nurse (LPN), indicated Resident D's Ozempic was not charted as given on 10/28/22 and did not know if the medication was not given or if the Qualified Medication Aide (QMA) forgot to sign it as administered. On 10/31/22 at 1:30 P.M., Resident H's Clinical Record was reviewed and indicated the resident's current diagnoses included, but were not limited to: epilepsy, depression, and anxiety. The current physician's orders for Resident H included an order, initiated on 5/11/18, for the resident to receive 1 Phenytoin EX (extended release) 100 mg capsule 3 times daily for seizures. Review of the October Medication Administration Record (MAR) for Resident H, indicated he but did not receive the lunch dose of the ordered medication on 10/17/22.		**facility have the potential to be affected by alleged deficient practice· Clinical Meeting agenda initiated to include reviewing all new medication orders to ensure accuracy, HSD/designee review EMAR daily each shift x 2 weeks then daily x 3 months for missing and refused medications, new admission reviews to ensure all admission orders transcribed accurately · IDT team to complete resident interviews to determine any further medication or treatment concerns, pain concerns or any additional medical needs · Administrator and Health Services Director to meet to review new order process, staff to be educated** **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; · All Nurses and QMAs in serviced on Medication administration with return demonstration and emphasis on comparing medications to EMAR, documentations of medication, or refusals and PRN medications · All nurses educated on Staff Administered Medications, Nurse Medication notes· All nurses and QMAs to be educated on physician order**	

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	The Nurses Medication Notes of the Medication Administration Record lacked any documentation to say why the seizure medication was not given. On 11/2/2022 at 11:00 A.M., the Administrator provided the policy titled, "Staff Administered Medications", dated 12/8/2011, and indicated the policy was the one currently used by the facility. The policy indicated, "... The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made or medications discontinued...." This deficiency was cited on 8/26/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		**process and procedure of Medication administered per order.** **· IDT educated on use of clinical meeting agenda and follow up.· Health Service Director/Designee to complete medication pass observations with staff to ensure compliance once weekly x 4 then once monthly x 6 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and· Health Services Director/ Designee to complete daily medication administration audit x2 weeks each shift then twice monthly to ensure medication compliance· Health Services Director/ Designee to complete clinical morning meeting agenda review and follow up related to new orders, new admission review** **· Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance**	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate			

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	authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by QMA (Qualified Medication Aide) staff were signed off by a licensed nurse for 1 of 5 residents reviewed for medications, (Resident D). Finding includes: A clinical record review was completed on 10/31/2022 at 1:19 P.M. Resident D's current diagnoses included, but were not limited to: diabetes mellitus type 2, chronic pain, major depressive disorder, cerebella stroke symptoms and anxiety disorder. A current MAR (Medication Administration Record) dated, 10/01/22 through 10/31/2022, indicated Resident D had received a PRN (as need) medication of Hydroco/APAP (pain reliever) 5-325 mg (milligrams) one tablet one time, from QMA 4 on the following dates: 10/1, 10/8, 10/12, 10/13, 10/14, 10/15, 10/19, 10/27 and 10/28/2022. Resident D had the same medication from QMA 7 on 10/10, 10/16, and 10/21/2022. On the back side of the MAR were the instructions for:"... d. PRN Med. Reason given and results should be noted on Nurses's Medication Notes...." The back page lacked any documentation to say why the as needed medication was administered on 10/1, 10/10, 10/14, 10/16, 10/19, 10/21 and 10/28/22. There was no the documentation to show that an authorization from	R 0246	R 246- Health Services PRN Medications given by QMA 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D physician and LPN were notified related to alleged deficient practice **2. 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 affected · LPNs and QMAs to be in serviced on QMA scope of practice with emphasis on PRN administration process **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;** · LPNs and QMAs to be in serviced on QMA scope of practice with emphasis on PRN administration process · Health Service	12/15/2022

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	a Licensed Nurse for the as needed medication was obtained on 10/1, 10/8,10/10, 10/12, 10/13, 10/14, 10/15, 10/16, 10/19, 10/2110/2, and 10/28/2022. During an interview on 10/31/22 at 1:19 P.M., Licence Practical Nurse (LPN) indicated the QMAs did not obtain permission to give Hydroco/APAP 5-325 mg to Resident D on any of the dates listed above. During an interview, on 10/31/22 at 3:48 P.M.., the Administrator indicated the QMAs were supposed to notify the LPN before they administered a PRN medication and the notification was to be noted on the Medication Administration Record. On 11/2/22 at 11:00 A.M., the Administrator provided a form titled QUALIFIED MEDICATION AIDE Scope of Practice which indicated, "The following tasks are within the scope of practice for the QMA unless prohibited by facility policy:... (11) Administer previously ordered pro re nata (PRN) [as needed] only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact..." This deficiency was cited on 8/26/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		Director/Designee to review PRN medication usage using audit tool daily each shift x 2 weeks then once daily x 3 months. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Health Services Director/Designee to complete PRN medication audit to ensure that all PRN medications received appropriate nurse follow up Audit of PRN medication to be completed daily each shift x 2 weeks then once daily x 3 months to ensure compliance Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance	