

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00186626.</p> <p>Complaint IN00186626- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: December 14 &amp; 15, 2015.</p> <p>Facility number: 000034 Provider number: 155086 AIM number: 100274880</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 2 Medicaid: 48 Other: 2 Total: 52</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Survey Event ID: 97Z111 Exit Date: 12/15/2015 Please consider this Plan of Correction as the facility credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this Plan of Correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This Plan of Correction reflects a desire to continuously enhance the quality of care and services provided to our residents, and it is submitted solely as a requirement of the provisions of Federal and State law. If there are any further questions or concerns, please feel free to contact me at 574-295-0096. Facility respectfully requests a paper compliance review of his survey</p> <p>Respectfully, Kevin Baker, HFA</p>	
------------------------	--	--------	--	--

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0250 SS=D Bldg. 00	<p>Quality Review completed by 14454 on December 22, 2015.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident was monitored for psychosocial affects following a verbal exchange with another resident for 1 of 3 residents reviewed for behavior monitoring. (Resident B)</p> <p>Finding includes:</p> <p>On 12/14/15 at 11:03 A.M., an interview was conducted with Resident B. Resident B indicated that she felt bullied by another resident's "cussing her up and down a tree." He tells me to get out of my wheelchair and walk (cuss word). I called the police but they told me because I lived here in the facility they could not help me. Resident B indicated the facility should work with Resident C to resolve the problem.</p> <p>On 12/14/15 at 11:15 A.M., the clinical record for Resident B was reviewed.</p>	F 0250	<p>F 250 483.15(g)(1) Provision of Medically Related Social Service Corrective Action: The policy and procedure for following up and reviewing behaviors that occur in the facility has been reviewed and revised to ensure appropriate monitoring of residents for psycho-social affects following inappropriate behaviors. Identifying others at risk: A complete audit of all residents' records was completed to review behaviors and identify any residents that had not been properly followup for documented behaviors. Nursing notes, Care plans, behavior log, behavior notes, 24 hour reports, and clinical meeting notes were all reviewed. Preventative measures in place: The IDT team will review all behaviors at clinical morning meeting. Items to be reviewed shall include the behavior log, 24 hour report, and nursing documentation. Social Services</p>	01/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  12/15/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Resident B was admitted on 5/27/15. The diagnoses included, but not limited to, cerebral palsy, post traumatic stress syndrome, personality disorder, bipolar disorder and depression borderline.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 10/6/15, indicated a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact.</p> <p>A care plan, dated 12/3/15 and revised on 12/14/15, indicated, "...[Name of Resident B] exhibited behavior of being antagonistic towards other residents by deliberately being in the area of others that she does not like...Goal: Will not provoker behaviors from other residents thru next review...Administer medications as ordered while observing for the effectiveness &amp; side effects...Document behaviors on tracking sheet...Redirect/educate her rights/responsibilities and rights of others as needed...Refer to [name of mental health facility] as needed...Remove from area as needed...."</p> <p>On 12/4/15 at 11:30 A.M., the clinical record for Resident C was reviewed. Resident C was readmitted on 10/9/15. The diagnoses included, but not limited to, depression, history of alcohol abuse, history of cerebrovascular accident,</p>		<p>and Licensed Nurses will be re-educated on the 72 behavior follow up policy. The Social Service Director and/or designee will monitor the behaviors of residents B &amp; C weekly by conducting interviews with residents for any inappropriate interactions or concerns between the residents. Monitoring of the 24 hour report for behaviors of residents B &amp; C will be done at morning meeting and any behaviors will be followed up per policy. The Behavior Management Team will monitor and review all behaviors bi-weekly for proper follow up, review and interventions. The Behavior Management Team will audit behavior tracking follow up which shall include 24 hour report, nursing notes, care plans and behavior log and behavior notes, any negative outcomes will result in extension of audit by 1 month. If audit shows 100% compliance audit will be discontinued. Quality assurance program in place: All Audits findings will be reviewed monthly at QA Committee meeting, additional action plan will be put into place to address negative outcomes. Compliance: 1/8/16</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>coronary artery disease and hypertension.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 12/8/15, indicated a Brief Interview for Mental Status (BIMS) of 10, moderately cognitively impaired.</p> <p>A care plan, initiated on 10/15/15 and revised on 12/2/15, indicated, "...[Name of Resident C] has history [sic] of exhibiting verbally abusive behaviors by yelling about his roommate needing to take a shower/needing to change his clothes/wash his clothes, verbally abusive and name calling towards staff...12/2/15 verbally abusive and name calling towards another resident...Goal: Will have fewer than 3 episodes/per day/week of yelling at others through the review date...separate from other resident as needed...inform him of his being inappropriate...allow him to voice his side of the incident...."</p> <p>On 12/14/15 at 2:15 P.M., an interview was conducted with the Assistant Director of Nurses (ADON). The ADON indicated, on 12/2/15, Resident B indicated Resident C had cussed her out. The ADON indicated Resident C has exchanged words with Resident B in the past and Resident B has a history of aggravating Resident C purposefully. She further indicated that Resident B has told</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>others she goes up to the lounge where he sits to aggravate Resident C but did not name the person or persons she allegedly told this to.</p> <p>On 12/14/15 at 2:25 P.M., a Potential Resident Abuse Report Form, dated 12/2/15 at 4:30 P.M., and provided by the Administrator, was reviewed. The Potential Resident Abuse form indicated, "... Location: Front TV Lounge... Mental/Verbal Abuse...Residents involved: [name of Resident B and C]...Alleged Perpetrators: [name of Resident C]...Witnesses: [name of Resident D]...Was/is there an injury/adverse affect?: Yes, [Resident B] reports feelings of anxiousness after [sic] event with [sic] request for Ativan [medication used to treat anxiety] prn [as needed]...Interview with Resident B...Just before 4:30 P. M., Resident reports she proceeded to Unit 3 to cook for CNA [certified nursing assistant] upon passing Front TV [television] Lounge she greeted Resident D with "Hey", Resident C was seated next to Resident D and offered "Hello" but he said it sarcastically so I ignored him, before I was passed Front TV Lounge Resident C stated " M---- F--- - B----" I responded with M---- F---- B---- to. I continued towards Unit 3 and met Admissions Director at Unit 3 desk and talked with [sic] her for about 20 mins</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>[minutes] and then went back to unit 2. As I passed Front TV Lounge again headed to Unit 2 Resident C stated " why don't you get out of that w/c [wheelchair] and walk you B----. I notified Unit 2 nurse about the event...Interview with Resident C...I was up watching TV minding my business and she came up here just to irritate me. She knows I come up here about 5 o'clock every night and she said she like to irritate me to someone. I stay away from her and that B---- doesn't need to come up here where I try to sit at night. I called her a F---- B-- -- when she went by because she is a F--- - B----. She knows what she's doing and she does it cause she knows I don't like her and she wants to get me in trouble. I try to stay away from her. She knows she irritates me...Interview with Resident D... Resident B passed us in Front TV Lounge approx [approximately] 4pm and she said "Hi" to me and then Resident C said "Hey" to her but it was kind of sarcastic. Resident C said something to Resident B but I'm not sure what it was but it was cussing at her and Resident B basically said "F--- Y--" back to him. After that she just went on her way. She really didn't stop she just kept going. It's not good between them, they don't get along...."</p> <p>On 12/14/15 at 2:35 P.M., an interview</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>was conducted with the Administrator. The Administrator indicated a similar incident had transpired between Resident B and C in August of 2015. The Administrator indicated that the incident which occurred on 12/2/15 was a continued behavior from the incident that occurred in August of 2015. The Administrator went on to further indicate that Resident B and C had at one time been good friends but had a falling out related to DVD's (digital video disc). Since the falling out Resident C has been moved to the opposite hall at the farthest end close to the front of the building, as he used to be a neighbor to Resident B. Resident C likes to sleep during the day and go up to the lounge in the front to watch TV in the evening. Resident B likes to go up to the TV lounge during that time and it often antagonizes Resident C.</p> <p>On 12/15/15 at 10:43 A.M., an interview was conducted with the Program Director of the Dementia unit and sometimes Interim Social Worker. The Program Director indicated that she was acting as interim Social Worker on 12/2/15, when the incident between Resident B and C occurred. The Program Director went on to describe that she received a call from the ADON and was asked to return to the facility to investigate a verbal conflict</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>between Resident B and C. She indicated she proceeded to investigate and interviewed Resident's B, C and D, after doing so she reported her findings to the Administrator and Director of Nurses. It was then reviewed in the morning meeting and determined to be a behavior. The Program Director indicated the facility would report the incident if there was potential for psychosocial harm but in this case it was determined to be a behavior because it had also occurred in the summer and the resident recognized she has ineffective coping mechanisms that are care planned related to her childhood, so the social worker would follow up with the behavior monitoring.</p> <p>On 12/15/15 at 2:00 P.M., an interview with the Social Worker was conducted. The Social Worker indicated that she did not follow up with either resident for 72 hours as she should have. She further indicated that both residents seemed fine, their behaviors were being tracked, each had been placed on 1:1 monitoring and there had been no further verbal exchanges between them. The social worker indicated Resident C tends to sleep during the day and tries to stay away from her side of the building because he does not want any problems. The Social Worker indicated she should have investigated to see if this was abuse,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/15/2015	
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>let the Administrator know, review the charting and plans of care, and follow up with them for the next few days to ensure they both were alright.</p> <p>On 12/15/15 at 2:15 P. M., the social service progress notes were reviewed for Resident B and C. The social service progress notes lacked documentation of follow up for the incident that occurred on 12/2/15.</p> <p>On 12/15/15 at 2:30 P.M., the current Interdisciplinary Team Process policy, dated 10/2010, and provided by the Administrator on 12/14/15 was reviewed. The policy indicated, "... Review of behaviors...4. Behaviors Residents who exhibit inappropriate behaviors should be reviewed daily during the clinical meeting. Review the clinical record, the behavior tracking sheet documentation, the care plan, and the CNA/Resident Care assignment sheet. Be sure that an assessment was completed at the time of the behavior and immediate intervention was implemented. An IDT [interdisciplinary team] intervention note should be written at this time in the clinical record...."</p> <p>3.1-34(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/15/2015
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	