STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00172568. Complaint IN00172568 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: May 11, 12, 13, 14, 15, 18 and 19, 2015 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 4 Medicaid: 50 Other: 3 Total: 57 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Survey Event ID: W6Y111 Exit Date: 05.19.2015 Please consider this Plan of Correction as the facilitycredible allegation of compliance. ThisPlan of Correction constitutes a written allegation of substantial complianceunder Federal Medicare requirements. Submission of this Plan of Correction is not an admission that adeficiency exists or that the facility agrees they were cited correctly. This Plan of Correction reflects a desire tocontinuously enhance the quality of care and services provided to ourresidents, and it is submitted solely as a requirement of the provisions ofFederal and State law. If there are anyfurther questions or concerns, please feel free to contact me at 574-295-0096. Respectfully, Kevin Baker, HFA	

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 determined that other safegaurds 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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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 0156 SS=B Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral			

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 05/19/2015
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
	and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation, record review and interviews, the facility failed to ensure a Notice of Medicare Provider Non-Coverage was provided timely for 3 residents in a sample of 3 who had a change in coverage. (Resident #35, #51, and #64) Findings include: 1. The Notice of Medicare Provider Non-Coverage form for Resident #65 was provided by the Business Office Manager, Employee #16, on 5/14/15 at 9:00 A.M. The form indicated the resident's last day of Medicare skilled coverage was 01/05/15. The notice was not signed by the resident or his representative. During an interview on 5/14/15 at 3:10 P.M., the Business Office Manager, Employee #16 indicated she dated a copy of the form as mailed on 01/02/15 but there was no proof the letter had been mailed, the address and name of to whom the letter was mailed. She indicated the resident's family visited frequently and after the coverage changed the resident was placed on Hospice and she did not know why they were not approached to	F 0156	F156 483.10(b)(5)-(10) Notice of Rights, Rules, Services, Charges Corrective action: The Business Office Manager has reviewed the notification inchange of coverage policy, the policy has been amended with information aboutthe change in coverage notification being included in the admissionprocess. Identifying others at risk: The Business Office Manager has conducted an audit of allcurrent residents to determine if any other residents have been affected. Preventative measures in place: The Business Office Manager will review all change ofservice notices to ensure timely notification of resident or family of thechange. Social Services will be educatedon the policy for notification of change of service. Business Office Managerwill audit all change of service notifications monthly to ensure timeliness ofnotification, if audit shows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes.	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	sign the form in a timely manner. 2. The Notice of Medicare Provider Non-Coverage form for Resident #35 was provided by the Business Office Manager, Employee #16, on 5/14/15 at 9:00 A.M. The form indicated the resident's last day of Medicare skilled coverage was 03/09/15. The form was signed by the resident's representative on 03/08/15. During an interview on 5/14/15 at 3:10 P.M., Employee #16 indicated she thought she had discussed the change in coverage for Resident #35 on 03/04/15, but the family had not signed the form until 03/08/15, one day before the change in coverage. 3. The Notice of Medicare Provider Non-Coverage form for Resident #51 was provided by the Business Office Manager, Employee #16, on 5/14/15 at 9:00 A.M. The form indicated the resident's last day of skilled Medicare coverage was 01/12/15. The notice was not signed by the resident's representative. During an interview on 5/14/15 at 3:10 P.M., Employee #16 indicated she had given a notice and mailed a letter to the resident's representative on 01/07/15, but the letter was returned as she mailed it to the wrong address. She indicated		Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	recently she had obtained the correct address and re-mailed the form in April 2015 and had not yet received any response. She produced a copy of the front of the returned envelope and the address on the envelope did not have a state identified or a zip code and was stamped "return to sender Not deliverable as addressed...." The facility policy and procedure titled "SNF [Skilled Nursing Facility] - Beneficiary Notice Requirements," undated, was provided by the Administrator on 05/15/15 at 2:30 P.M., The policy and procedure indicated a skilled nursing liability notice was to be provided when the resident's Medicare part A skilled services were to end. The form did not indicate the time frame for the notice but the Administrator had written 48 hours notice on the policy. 3.1-4(f)(3)			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify a resident's physician of two prescribed medications that were not given related to not having a supply of the medication to administer. This deficient practice affected 1 of 5 residents who met the criteria for unnecessary medications. (Resident #20) Finding includes:	F 0157	F157 483.10(b)(11) Notify of Change Corrective action: Resident #20's physician was notified, medication wasdiscontinued related to nonuse per physician order Identifying others at risk: DON or designee will audit all medication administrationrecords to ensure no other resident has been affected.	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	The clinical record for Resident #20 was reviewed on 5/19/15 at 10:00 A.M. Resident #20 was admitted, on 04-21-15, with diagnoses including, but not limited to, dementia, major depression, generalized anxiety, osteoporosis, hyperlipidemia and insomnia. A physicians order, dated 04-21-14, indicated "Fexofenadine HCL[hydrochloride] [an allergy medication] 180 mg [milligrams] Take 1 Tab [tablet] by mouth daily at 8 AM...." A second physicians order, dated 5/13/15, indicated "...Restoril [a sleep aid medication] 15 mg QHS [every night at bedtime] (Insomnia) at 8 PM...." Resident #20's Medication Administration Record for May 2015, for the Fexofenadine medication indicated the medication had not been given for the following dates: 5/14/15, 5/15/15, 5/16/15, 5/17/15 and 5/18/15. Resident #20's Medication Administration Record for May 2015, regarding the Restoril medication indicated initials with a circle around them for the following dates: 5/14/15, 5/15/15 and 5/16/15. The record indicated the following: "5/14/15 Fexofenadine not available pharmacy		Preventative measures in place: Licensed Nursing staff will be educated on the policy andprocedure of notification of physician when a resident has not received propermedication per policy. DON or designee will audit medication administrationrecord one time weekly for three months to ensure compliance, if audit shows100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	notified...5/15/15 Fexofenadine awaiting delivery...5/16/15 Fexofenadine pharmacy pending delivery...5/17/15 Fexofenadine pharmacy aware...5/18/15 Fexofenadine pharmacy aware...." "...5/14/15 Restoril 15 mg unavailable pharmacy notified...." The Nurses Notes, from 5/14/15 at 1300 (1:00 P.M.) through 5/18/15 at 0400 (4:00 A.M.) lacked documentation to indicate Resident #20's physician had been notified that the resident had not received her Fexofenadine and Restoril due to lack of availability During an interview, on 5/19/15 at 9:54 A.M., LPN #36 indicated the Fexofenadine had been delivered the night before and she administered the medication with her morning med pass to Resident #20. LPN #36 further indicated the Restoril had not been delivered and she did not know if the physician had been notified that the medications were not given related to lack of availability from the pharmacy. During an interview, on 5/19/15 at 11:00 A.M., the Director of Nurses indicated she was not aware the Fexofenadrine and Restoril had not been given due to lack of supply she then proceeded to call the pharmacy and was told the Fexofenadine			

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 05/19/2015
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
	was reordered on 5/17/15, and it was delivered 5/18/15, and the Restoril had not been sent because they were waiting on the physicians signed prescription. (Restoril is a medication that requires a physician's signed prescription before it can be filled or refilled). The Director of Nurses further indicated she did not know if Resident #20's physician had been notified that she had not received her Fexofedarine and Restoril. During an interview, on 5/19/15 at 11:48 A.M., LPN #36 indicated Resident #20's doctor had been notified of the need for a signed prescription for the pharmacy to fill the Restoril order and it would be sent to the facility that evening with the delivery. She further indicated she did not know what happened with the Fexofenadine and did not know if the doctor had been notified. 3.1-5(a)(3)			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interviews, the facility failed to ensure 3 of 5 allegations of abuse were thoroughly investigated and 1 of 6 allegations of abuse was reported timely to the State agency. In addition, the facility failed to ensure follow their policy and procedure to protect residents from further abuse	F 0225	F225 483.13(c)(1)(ii)-(iii),(c)(2)-(4) Investigate/Report Allegations/Individuals Corrective action: Residents #45,#29,#48,and #59 were interviewed per abusepolicy and reported to ISDH during the annual survey. Identifying others at risk:	06/12/2015

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 05/19/2015
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
	while an investigation was in process for 1 of 6 allegations. (Resident #45, #29, #28, #48 and #59) Findings include: During an interview, on 05/12/15 at 9:35 A.M., Resident #28 indicated about a month ago a CNA, Employee #53, had handled her roughly and had been verbally threatening. She indicated she reported the incident and she thought the facility had fired the aide because she had not seen her since. She indicated she could not recall the name of the CNA that had been rough or the name of the staff member to whom she had reported the allegation. During an interview, on 05/12/15 at 10:24 A.M., Resident #48 indicated two CNAs had been rough and shoved her in the shower room. She could not provide any other details regarding the abuse allegation. During an interview, 05/12/15 at 10:32 A.M., alert and oriented Resident #45, indicated a shower aide, CNA #50 had a bad attitude and was too rough when giving showers. She indicated the CNA said "mean" things to her and would get mad at her while giving care. She indicated she reported the abuse and the		Social Services has conducted interviews of residents to askif they have experienced any abuse by staff or peers that has not been reportedto the administrator. Any additionalabuse identified will be reported and investigated per policy. Preventative measures in place: Staff will be educated on the abuse policy, what constitutesabuse, what is the difference between a grievance and abuse reporting, how torecognize abuse, and proper reporting of abuse. Post education training will be done to assess understanding. Social Service or designee will conductweekly audit of grievance log for 3 months to ensure policy is being followed,if audit shows 100% compliance audit will be discontinued. Social Service or designee will conductrandom resident interviews weekly for 3 months to ask if they have experiencedany abuse by staff or peers that has not been reported. If audit shows 100% compliance audit will bediscontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	rough handling improved but CNA #50's attitude did not improve. During an interview, on 05/12/15 at 3:00 P.M., Resident #59 indicated a staff nurse, Employee #20, had called him an "idiot" and had yelled at him. He indicated the Dementia Coordinator, Employee #54 had assisted him with completing a written grievance form. He indicated the only response to the grievance form had been when the facility had attempted to issue him an involuntary discharge form. He indicated Employee #54 still worked second shift in the facility and continued to antagonize him and upset him. During an interview, on 05/13/15 at 10:50 A.M., Resident #29 indicated a staff member was "just nasty" to her while giving care. Resident #29 indicated she thought the staff member worked the evening shift and she was uncertain of her name. During an interview, on 05/14/2015 11:28 A.M., the Administrator indicated he only had one investigation, which involved Resident #59 and former employee, CNA #55 and provided the investigation for review. The complaint investigation involving			

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 05/19/2015
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
	Resident #59 and CNA #55 indicated on 03/14/15 at approximately 8:00 A.M., CNA #55 was overheard yelling at Resident #59. During an Interview, on 05/14/15 at 10:45 A.M., RN #56 indicated she had overhead CNA #55 being verbally abusive to Resident #59. She indicated she intervened by asking the CNA #55 to leave the room and was going to report the abuse to the Director of Nursing (DON) and the Administrator but by the time she had spoken with Resident #59, CNA #55 was on the telephone reporting herself to the DON. During an interview, on 05/15/2015 at 2:26 P.M., the Administrator indicated he was not in the building on 03/14/15 when the allegation regarding Resident #59 and CNA #55 occurred. He was telephoned regarding the incident on 03/14/15, around 9:00 A.M. The CNA was removed from resident room, took a break and was reassigned to a different part of the building. The Administrator indicated other CNAs leave the room when getting frustrated with Resident #59 and we did not realize the severity of the verbal altercation until we got statements. When the Administrator spoke to the nurse, RN #56, the severity of the abuse was not communicated to			

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 05/19/2015
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
	the Administrator. The Administrator indicated the abuse was reported late because the administrative staff were trying to "work through the issues" and with the weekend it just slipped through and got reported late. There was no reason given for not suspending staff member while the investigation was completed. Several staff members statements were taken to confirm the abuse and the CNA #55 was later terminated from employment. There were no statement from other alert and oriented residents regarding the incident or their experience with CNA #55. In addition, the Administrator indicated he had initiated abuse investigation forms for Residents #48, 45, 28, and 29 on 05/14/15, when he was first notified of the allegations. The investigation form for Resident #45 indicated about 3-4 months ago CNA #53 was short and rude to her during a shower. She indicated the staff member had given her some instructions and when she did not hear the instructions the staff member was rude and hurt her feelings. A Resident Concern form, dated 02/02/15, indicated Resident #45 had reported to the Social Service Director, Employee #12 that she was upset with a CNA regarding her shower. She indicated she felt like the aide "hurried" her. The Director of			

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 05/19/2015
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
	Nursing had followed up with the concern and the resident indicated the CNA #53 had gotten upset with her because she took too long to remove her socks and also spoke to her loudly. Resident #45 indicated she did not want this CNA to give her a shower. The Resolution portion of the form indicated the DON had spoken with the aide regarding rushing Resident #45 which caused the resident anxiety and made the resident not want to complete the activity. There was no where on the form where the name of the resident was identified. There was no where on the form where other residents were interviewed regarding their treatment by the shower aide. The allegation was not reported and it was unclear if CNA #63 was the same staff member involved in the incident documented on 02/02/15. The Resident Abuse Investigation form for Resident #29 indicated the night shift is "rude." There was no other information reported by the resident. The form indicated other than interviewing Resident #29 regarding her concern, no other residents were interviewed regarding possible concerns with the night shift. There was no other investigation completed regarding this allegation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	The Resident Abuse Investigation form for Resident #28 indicated she reported a "big black CNA" was rude to her. She was unable to remember any further information but indicated the CNA was gone by the next day. There was no other investigation completed regarding this allegation. The facility's Abuse investigation policy and procedure, dated as revised in 2011, and provided by the Administrator, on 05/11/15 at 10:30 A.M., indicated the following: "...1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or designee, will appoint a member of management to investigate the alleged incident. 2. The individual conducting the investigation will, at a minimum: ...e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident f. Interview the resident's roommate, family members, and visitors g. Interview other residents to whom the accused employee proves care or services.... 5. Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	the investigation have been reviewed by the Administrator... 9. Allegations of abuse are to be reported to ISDH [Indiana State Department of Health] and local law enforcement within 2 hours...." 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to implement their policy to ensure 3 of 5 allegations of abuse were thoroughly investigated and 1 of 6 allegations of abuse was reported timely to the State agency. In addition, the facility failed to follow their policy and procedure to protect residents from further abuse while an investigation was in process for 1 of 6 allegations. (Resident # 45, #29, #28, #49 and #59) Findings include:	F 0226	F226 483.13(c) Develop/implement abuse/Neglect, etc policies Corrective action: Residents #45,#29,#48,and #59 were interviewed per abusepolicy and reported to ISDH during the annual survey. Identifying others at risk: Social Services has conducted interviews of residents to askif they have experienced any abuse by staff or peers that has not been reportedto the administrator. Any additionalabuse identified will be reported and investigated per policy. Preventative measures in	06/12/2015

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 05/19/2015
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
	During an interview, on 05/12/15 at 9:35 A.M., Resident #28 indicated about a month ago a CNA, Employee #53, had handled her roughly and had been verbally threatening. She indicated she reported the incident and she thought the facility had fired the aide because she had not seen her since. She indicated she could not recall the name of the CNA that had been rough or the name of the staff member to whom she had reported the allegation. During an interview, on 05/12/15 at 10:24 A.M., Resident #48 indicated two CNAs had been rough and shoved her in the shower room. She could not provide any other details regarding the abuse allegation. During an interview, 05/12/15 at 10:32 A.M., alert and oriented Resident #45, indicated a shower aide, CNA #50 had a bad attitude and was too rough when giving showers. She indicated the CNA said "mean" things to her and would get mad at her while giving care. She indicated she reported the abuse and the rough handling improved but CNA #50's attitude did not improve. During an interview, on 05/12/15 at 3:00 P.M., Resident #59 indicated a staff nurse, Employee #20, had called him an		place: Staff will be educated on the abuse policy, what constitutesabuse, what is the difference between a grievance and abuse reporting, how torecognize abuse, and proper reporting of abuse. Post education training will be done to assess understanding. Social Service or designee will conductweekly audit of grievance log for 3 months to ensure policy is being followed,if audit shows 100% compliance audit will be discontinued. Social Service or designee will conductrandom resident interviews weekly for 3 months to ask if they have experiencedany abuse by staff or peers that has not been reported. If audit shows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	"idiot" and had yelled at him. He indicated the Dementia Coordinator, Employee #54 had assisted him with completing a written grievance form. He indicated the only response to the grievance form had been when the facility had attempted to issue him an involuntary discharge form. He indicated Employee #54 still worked second shift in the facility and continued to antagonize him and upset him. During an interview, on 05/13/15 at 10:50 A.M., Resident #29 indicated a staff member was "just nasty" to her while giving care. Resident #29 indicated she thought the staff member worked the evening shift and she was uncertain of her name. During an interview, on 05/14/2015 11:28 A.M., Administrator indicated he only had one investigation, which involved Resident #59 and former employee, CNA #55. The complaint investigation involving Resident #59 and CNA #55 indicated on 03/14/15 at approximately 8:00 A.M., CNA #55 was overheard yelling at Resident #59. During an interview, on 05/14/15 at 10:45 A.M., RN #56 indicated she had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	overhead CNA #55 being verbally abusive to Resident #59. She indicated she intervened, asked the CNA to leave the room and was going to report the abuse to the Director of Nursing and the Administrator but when she by the time she had spoken with Resident #59, CNA #55 was on the telephone reporting herself to the DON. During an interview, on 05/15/2015 at 2:26 P.M., the Administrator indicated he was not in the building on 03/14/15 when the allegation regarding Resident #59 and CNA #55 occurred. He was telephoned regarding the incident on 03/14/15 around 9:00 A.M. The CNA was removed from resident room, took a break and was reassigned to a different part of the building. The Administrator indicated other CNAs leave the room when getting frustrated with Resident #59 and we did not realize the severity of the verbal altercation until we got statements. When the Administrator spoke to the nurse, RN #56, the severity of the abuse was not communicated to the Administrator. The Administrator indicated the abuse was reported late because the administrative staff were trying to "work through the issues" and with the weekend it just slipped through and got reported late. There was no reason given for not suspending the staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	member while the investigation was completed. Several staff members statements were taken to confirm the abuse and the CNA was later terminated from employment. There were no statement from other alert and oriented residents regarding the incident or their experience with CNA #55. In addition, the Administrator indicated he had initiated abuse investigation forms for Residents #48, 45, 28, and 29 on 05/14/15. The investigation form for Resident #45 indicated about 3-4 months ago CNA #53 was short and rude to her during a shower. She indicated the staff member had given her some instructions and when she did not hear the instructions the staff member was rude and hurt her feelings. A Resident Concern form, dated 02/02/15 indicated Resident #45 had reported to the Social Service Director, Employee #12 that she was upset with a CNA regarding her shower. She indicated she felt like the aide "hurried" her. The Director of Nursing had followed up with the concern and the resident indicated the CNA had gotten upset with her because she took too long to remove her socks and also spoke to her loudly. Resident #45 indicated she did not want this CNA to give her a shower. The Resolution portion of the form indicated the DON			

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 05/19/2015
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
	had spoken with the aide regarding rushing Resident #45 which caused the resident anxiety and made the resident not want to complete the activity. There was no where on the form where the name of the resident was identified. There was no where on the form where other residents were interviewed regarding their treatment by the shower aide. The allegation was no reported and it was unclear if CNA #63 was the same staff member involved in the incident documented on 02/02/15. The Resident Abuse Investigation form for Resident #29 indicated the night shift is "rude." There was no other information reported by the resident. The form indicated other than interviewing Resident #29 regarding her concern, no other residents were interviewed regarding possible concerns with the night shift. There was no other investigation completed regarding this allegation. The Resident Abuse Investigation form for Resident #28 indicated she reported a "big black CNA" was rude to her. She was unable to remember any further information but indicated the CNA was gone by the next day. There was no other investigation completed regarding this allegation.			

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 05/19/2015
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
	The facility's Abuse investigation policy and procedure, dated as revised in 2011, and provided by the Administrator on 05/11/15 at 10:30 A.M., indicated the following: "...1. Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the administrator, or designee, will appoint a member of management to investigate the alleged incident. 2. The individual conducting the investigation will, at a minimum: ...e. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident f. Interview the resident's roommate, family members, and visitors g. Interview other residents to whom the accused employee proves care or services.... 5. Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of the investigation have been reviewed by the Administrator... 9. Allegations of abuse are to be reported to ISDH [Indiana State Depart of Health] and local law enforcement within 2 hours...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	3.1-28(a)			
F 0250 SS=D Bldg. 00	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 observation, record review and interviews, the facility failed to ensure medically related social services was provided for 2 of 3 residents reviewed for social service needs. Telephone access and timely discharge assistance was not provided for Resident #26 and timely assistance applying for State provided financial insurance was not provided for Resident #59. Findings include: 1. During an interview, conducted on 05/12/15 at 11:30 A.M., alert and oriented Resident #59 indicated he had been to a physician's office for an appointment and the physician had ordered therapy and the facility had not provided the therapy. He indicated he had taken his copy of the "paperwork" from the physician to the therapy department and they had indicated "they did not know anything about it." He also indicated he had voiced an allegation of	F 0250	F250 483.15(g) Provision of medically related social service Corrective action: Resident # 59's physician was contacted to clarify desirefor continued therapy services. Resident#59 was screened by therapy for need of service. A new application for Medicaidfor resident #59 will be submitted. Resident #26 was made aware of the available cell phone for resident useif not able to leave. Social Service has met with resident #26 and family tocontinue the process of relocating resident closer to family. Identifying others at risk: Business Office Manager will conduct audit of all residentsfinancial records to ensure accurate payer information compliance and that noother residents have been affected. Social Service will audit all dischargecare plans for progress towards discharge goals. Any other residents identified	06/12/2015

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 05/19/2015
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
	abuse regarding a nurse. He indicated he did not have a satisfactory response to the allegation and was instead given an involuntary discharge form. He indicated the State Ombudsman had came to the facility and the discharge form was "voided." During a discussion with the Administrator regarding Resident #59's allegation of abuse, conducted on 05/14/15 at 2:30 P.M., he indicated Resident #59 was a "charity" case and the facility was not being paid for his stay. He indicated the resident had been denied Medicaid coverage and was no longer eligible for nursing home care. The clinical record for Resident #59 was reviewed on 05/14/15 at 9:00 A.M. Resident #59 was admitted to the facility on 05/23/14 with diagnoses, including but not limited to, history of alcohol abuse, history of multiple facial fractures and tibial/fibial fracture from pedestrian versus car, fracture of the left lamina at C (Cervical) 7, scoliosis, nicotine dependence, history of testicular cancer with left orchiectomy, and gastric esophageal reflux disease. The Indiana Pre-Admission Screening Program Assessment Determination, completed on 05/16/14, indicated the		as unable toleave their rooms will be informed of the availability of cell phone forpersonal use. Preventative measures in place: Social Service and Business Office Manager will be educatedon the Medicaid process. Additionalinformation about requesting help with the filing of Medicaid will be includedin the admission process. Business Office Manager will audit all new admissionsfor Medicaid application process monthly for three months, if audit shows 100%compliance audit will be discontinued. SocialServices will monitor weekly for three months the availability of and properfunction of cell phone for resident use, if audit shows 100% compliance auditwill be discontinued. Staff will be educated on where the resident cell is keptand that it is available for resident use. Residents will be educated at nextResident Council meeting of the availability of cell phone. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	resident could enter the facility and was eligible to stay until 07/23/14. The application for Long-Term care services form, completed on 05/16/14, indicated the resident was to apply for Medicaid on admission. During an interview, on 05/14/2015 at 10:00 A.M., the SSD (Social Service Director), Employee #12, indicated the Business Office Manager, Employee #16 had submitted a Medicaid application for Resident #59 but he was denied Medicaid coverage. She also indicated Employee #16 helped him apply for disability but he was also denied coverage. She indicated no one had attempted to reapply for either program for him. She indicated she had contacted the R-Cap (Residential Care Assistance Program) program director with the State but never got a return call from the person. During an interview, on 05/14/15 at 10:30 A.M., the Business Office Manager, Employee #16, indicated she had not applied for Medicaid for Resident #59 because she was under the impression the acute care center had already applied for this resident prior to his admission to the facility. She indicated she had assisted the resident to apply for disability but he did not qualify. She was not sure why the resident was			

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 05/19/2015
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
	denied coverage and she indicated there was a new law and a resident who was under (a required age) who required nursing home Medicaid coverage also had to qualify for the State's disability program before they were eligible for Medicaid. A copy of the resident's application for Social Security Disability indicated the State office had attempted to verify the information in August 2014. Other Medicaid denial forms indicated the applications had been submitted in March of 2014, prior to the resident's accident and subsequent admission to the long term care facility. It was unclear why the proper Medicaid application had not been filed upon the resident's admission to the facility in June 2014. 2. During an interview, on 5/12/15 at 2:45 P.M., alert and oriented Resident #26, indicated he had been in isolation in his room and had not been allowed to come out of his room for up to 4 - 5 months. He indicated the facility did not have a portable telephone and he was not given telephone access during that time. He indicated his family lived a distance from the facility and could not visit often and telephone contact was important to him.			

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 05/19/2015
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
	In addition, the resident indicated he desired to be transferred to a facility closer to where his family was located. He indicated he had spoken with the Social Service Director and voiced his request in December but he did not think she was even working on assisting him with a discharge. The clinical record for Resident #26 was reviewed on 05/14/2015 at 9:26 A.M. Resident #26 was admitted to the facility on 06/02/14, and readmitted on 11/29/14, with diagnoses, including but not limited to quadriplegia, tracheostomy, motor vehicle accident, dysphasia, chronic airway obstruction, major depressive disorder, contraction of the joints, convulsions, diabetes, chronic respiratory failure, obesity, and history of mixed drug abuse and history of alcohol abuse. The physician's orders indicated Resident #26 was in contact isolation, from 03/28/15 - 05/01/15, and was on antibiotics. During an interview, conducted on 05/14/15 at 9:38 A.M., with LPN #17, who worked on the unit on which Resident #26 resided, indicated if a resident received a phone call she would have to bring the resident up to the nurse's station to talk on the phone. She			

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 05/19/2015
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
	indicated the phone at the nurse's station was the only phone available. She confirmed if the resident was in isolation they would not have access to a telephone. She indicated the resident's family's could pay for a land line to be placed in their room or provide them with a cell phone. During an interview, on 05/14/15 at 10:00 A.M., the SSD, Employee #12, indicated due to Resident #26's isolation and need to have telephone access, a cell phone for the facility was purchased sometime after the first of the year. She indicated the cell phone was kept in the Social Service office and staff could call her if she was out of the building to gain access to the phone. The SSD confirmed with the DON (Director of Nursing) that the resident was in isolation and not out of his room from sometime in November or December 2014 until just recently. During an interview, on 05/15/2015 at 9:37 A.M., CNA #57, a shower aide who was working on the unit on which Resident #26 resided, indicated if a person on 300 unit could not come to the phone, she would have to take a message. She was unaware of the facility cell phone. During an interview on 05/18/15 at 11:07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	A.M., Resident #26 indicated someone had informed him the facility had purchased a cell phone he could use but other staff had never known or gotten the facility cell phone for him to utilize. A social service note, completed on 06/09/14, by Employee #12, indicated Resident #26 desired to relocate closer to his family but at the time of admission no other facility close to his family would accept him. Social service notes on the following dates also indicated the resident had expressed a desire to relocate closer to his family on: 06/16/14, 06/28/14, 07/28/14, 09/06/14, 09/13/14, 12/24/14 and 3/23/15. A social service note, dated 04/04/15, indicated the following: "...family is supportive and has been unable to visit as much as they would like. He and his family wishes he was closer- waiting for him to be out of isolation and will pursue contacting other facilities in their area...." During an interview, on 05/14/15 at 10:00 A.M., the SSD, Employee #12, indicated she had given Resident #26's family a list of facilities in their area when they visited last in May 2015. She indicated she had not contacted other facilities to assess Resident #26 because prior to his admission other facilities would not accept him, then he was in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	isolation so she did not contact any facility, and now she was waiting on the family to let her know which facility they had chosen. 3.1-34(a)			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;			

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 05/19/2015
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
	Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, record review and interviews, the facility failed to accurately assess the dental status for 1 of 3 residents reviewed for dental status. (Resident #23) Finding includes: During an interview on 5/12/15 at 9:54 A.M., Resident #23 indicated he only has 1 tooth on the bottom gum and it was decayed. He further indicated he had an upper denture plate and had never had a lower denture plate. The resident also indicated he would like to see the dentist and have a lower denture plate made. On 5/12/15 at 9:55 A.M., an observation of Resident #23 indicated he had an upper denture in place but no lower denture and had only 1 tooth on the bottom gum, which was decayed. The clinical record for Resident #23 was reviewed, on 5/14/15 at 10:32 A.M. Resident #23 was admitted to the facility on 2/28/14 with diagnoses included but were not limited to: diabetes mellitus	F 0272	F272 483.20(b)(1) Comprehensive Assessment Corrective action: A corrected MDS has been submitted for resident #23 Identifying others at risk: DON or designee will complete an audit of all currentresidents for accuracy of oral care assessments. Any assessment found to be incorrect werecorrected and resubmitted as per RAI protocol. Preventative measures in place: Licensed nursing will be educated on completing proper oralassessment. An audit of each completedannual, sig change or quarterly assessment will be evaluated for accuracywithin 7 days of the MDS completion date in accordance with the resident's RAI–Obra assessment schedule by the medical records nurse or designee. At the end of the quarter, the results of theaudit will be tallied and reported to the QA committee a percentage of 85% orabove will result in periodic random audits over the next quarter, less than85% of compliance will result in another quarter of full audits. DON ordesignee will audit oral assessments monthly for three months for accuracy, ifaudit shows	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	type II, bipolar disorder, depressive disorder, lower limb amputation, morbid obesity and hypertension. An admission nursing assessment, dated 2/28/14, indicated Resident #23 has upper and lower dentures and ate well with teeth/dentures. A quarterly nursing assessment, dated 2/25/15, indicated Resident #23 had upper and lower dentures. An annual Minimum Data Set (MDS) assessment, dated 2/25/15, indicated under the oral/dental status section check all that apply: A. Broken or loosely fitting full or partial denture. B. No natural teeth or tooth fragment(s) (edentulous) C. Abnormal mouth tissue. D. Obvious or likely cavity or broken natural teeth. F. Mouth or facial pain, discomfort or difficulty chewing. G. Unable to examine. Z. None of the above were present. The box beside Z was check marked. During an interview on 5/18/15 at 2:14 P.M., the MDS Coordinator, RN #2, indicated the last quarterly nursing assessment was completed for Resident #23 on 2/25/15. She further indicated she went by the information marked on the quarterly nursing assessment and since		100% compliance audit will be discontinued. Quality assurance program in place: All Audit findingswill be reviewed monthly at QA Committee meeting, additional action plan willbe put into place to address negative outcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	the assessment was marked that the resident had upper and lower dentures she thought that is what he had. On 5/19/15 at 1:45 P.M., the current policy titled "Admission and Quarterly Nursing Assessment" was received from the MDS Coordinator. The policy indicated indicated "...The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission and quarterly for the purposes of managing the resident, initiating and updating the care plan...5. Our assessment includes the following: a. physical condition...." 3.1-31(c)(9)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on observations, record review and interviews, the facility failed to ensure a care plan was revised to include the resident's refusal of care related to bathing for 1 of 3 residents reviewed for activities of daily living needs. (Resident #29) Finding includes: During an interview with Resident #29, conducted on 05/13/15 at 10:50 A.M., Resident #29's hair was noted to be oily. Resident #29 was observed on 05/18/2015 at 9:40 A.M. ambulating herself with a walker in the hall. Her hair appeared wet and stringy. She was asked if she had just had a shower and she replied "No, not today." Closer observation indicated it was just very oily. The clinical record for Resident #29 was reviewed on 05/14/15 at 10:35 A.M. Resident #29 was admitted to the facility, on 06/26/14, with diagnoses, including but not limited to, diabetes, lack of	F 0280	F280 483.20(d)(3) Right to participate in planning care Corrective action: Resident # 29 care plan for activities of daily living hasbeen revised to included resident's behavior of refusal of care related tobathing and or shampooing of hair. Identifying others at risk: All residents shower sheets were reviewed by DON. DON or designeewill complete an audit of all residents that are known to refuse showering orhair washing to ensure resident care plans are accurate and behavior sheetsaddress refusal of showering or hair washing. All care plans for these residents were revised. Preventative measures in place: Al care plans will be reviewed with a change in condition orquarterly. Any residents that refuseshowers or any form of bathing, a copy of the shower sheet will be given tosocial services to ensure the behavior books are updated. Social Service will initial sheet and returnto DON for placement in the shower book as evidence of process being completed.DON or designee will conduct audit of all resident shower sheets three times weeklyfor thirty	06/12/2015

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 05/19/2015
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
	coordination, dementia, GERD (Gastroesophageal Reflux Disease), hypertension, neuropathy, cerebral vascular accident acute systolic heart failure, hypertension, renal failure, seizure disorder and restless leg syndrome. The quarterly MDS (Minimum data set) assessment, completed on 04/07/15, indicated Resident #29 required limited staff assistance of one for dressing, personal hygiene and bathing needs. The CNA (Certified Nursing Assistant) Weekly Bath Checklist, from 02/02/15 - 05/18/15, indicated the resident had received 6 showers. The resident had refused a majority of her bathing/showering opportunities. The last documented shower received by Resident #29 was on 04/23/15, almost one month prior. During an interview on 05/19/15 at 10:45 A.M., the Director of Nursing indicated Resident #29 refused her showers and other care frequently and there was a care plan regarding this issue for Resident #29. Review of the current care plan and interview with LPN #19, on 05/19/15 at 2:00 P.M., indicated Resident #29 had a		days and then monthly for six months, if audit shows 100% complianceaudit will be discontinued. Nursingstaff has been educated on completing the behavior sheet when resident refusesbathing or hair washing. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	behavior tracking form in the "Behavior" book but the form was not individualized regarding which behaviors the facility was tracking for Resident #29 and the form was blank indicating Resident #29 had not had any behaviors. In addition, LPN #19 indicated there was no current care plan regarding refusal of care for Resident #29. LPN #19 indicated she was surprised and unaware that Resident #29 refused her showers so often. On 5/19/15 at 2:00 P.M., LPN #20, who was just getting ready to work the second shift on 05/19/15, indicated she was aware of Resident #29's refusal of showering. 3.1-35(d)(2)(B)			
F 0282 SS=E Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to follow the care plan regarding nutrition was followed and fortified foods were served to 1 of 3 residents reviewed for nutrition. (Resident #35) The facility also failed to ensure a physician's order regarding the	F 0282	F282 483.20(k)(3)(ii) Services by qualified persons/per care plan Corrective action: Resident #20's physician has been contacted and Restoril hasbeen discontinued per physician order related to nonuse. Resident # 35's	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	need for physical therapy was followed for 1 of 4 residents reviewed for rehabilitation needs. (Resident #59) The facility further failed to ensure the physician orders were followed regarding allergy/sleeping medications and the AIMS assessment was completed for 1 of 5 residents reviewed for unnecessary medications (Resident #20). Findings include: 1. The clinical record for Resident #35 was reviewed on 05/15/2015 10:06 A.M. Resident #35 was admitted to the facility on 12/19/14 with diagnoses, including but not limited to, dementia, hypothyroidism, history of acute kidney failure, history of urinary tract infection, diverticulitis and vascular dementia with delusions. Her current diet orders for May 2015 were for NAS (No Added Sweets), fortified foods with all meals. The resident's weight on 12/19/14 was 180 pounds. Her weight on 05/07/15 was 152 pounds. A Nutrition Risk Assessment, completed 01/02/15, indicated the resident at the time, weighed 169 pounds and her BMI (Body Mass Index) was 25.6.		tray card has been correctedto include fortified food. Resident #59's physician was contacted to clarifydesire for continued therapy services. Resident #59 was screened by therapy for need of service. AllTray cards with fortified foods have been updated with corrected information Identifying others at risk: All resident AIMs assessments were audited for accuracy bysocial service. All Resident MAR's wereaudited for missing medications by the DON. The Registered Dietitian will auditall diets for fortified foods, clarifying orders to indicate what foods are tobe fortified and when those fortified foods are to be served. Preventative measures in place: Dietary Manager or designee will audit weekly for threemonths residents receiving fortified foods to ensure order and tray card arecorrect, if audit shows 100% compliance audit will be discontinued. Nursing has modified its practice to recordon the 24 hour report any missing medication in addition to reporting topharmacy. Licensed Nursing staff will beeducated on policy for transcribing physician orders. DON or designee will review documents /orders received from outside physicians to ensure proper transcription to MARor TAR weekly for one month and then monthly for two months, if audit shows100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	A weight note, on 03/26/15, indicated the weights were 158.6, 162.4, 164.4 and 161.8 pounds. The note indicated the resident had recently been ordered Lasix, had meal intakes of 25 - 100 percent with no chewing or swallowing issues, and received Med pass 120 ml (milliliter) three times a day. A care plan regarding the resident's risk for weight loss, initiated on 01/07/15, and current through 07/10/15, included the following interventions: assist resident to finish meal, allow resident to feed self as participates, assist to finish the meal to improve intake, bring resident to the dining room, set up as needed, nurse to evaluate program periodically, serve diet at ordered, and NAR (Nutrition at Risk) program as indicated. The goal was for the resident to not have a weight loss of 5%or greater thru next review. Another Nutrition at Risk plan of care, indicated on 01/02/15, and current through 06/15, indicated the resident was to have a NAS diet, received fortified cereal and fortified potatoes at lunch and dinner since 04/09/15, med pass 120 ml TID (three times daily) was added on 02/05/15. Other interventions included refer to RD (Registered Dietician) prn (as needed), staff assist PRN (as needed),		compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	weigh per NAR, monitored record meal intake daily, notify family, physician, RD of significant weight change, labs as ordered, and meds as ordered. Resident #35 was observed on 05/15/15 at the noon meal, from 11:30 A.M. - 12:30 P.M. for a meal observation. She received a taco with several toppings and fried ice cream. She did not have any fortified potatoes. Resident #35 was observed on 05/18/2015 11:45 A.M., seated in the dining room at a table. She had an 8 ounce glass of red colored juice 2/3 of the way full. She was also given a cup of coffee. She was able to give herself her drinks. At 12:01 P.M., she was given a small glass of medication pass shake by the nurse. At 12:10 P.M., the resident was served mashed potatoes, gravy, chicken breast, zucchini and tomatoes. Resident #35's ticket indicated the resident was to receive a NAS diet. No fortified foods was on the meal ticket. Resident #35's lunch tray was observed on 05/19/2015 at 12:02 P.M. She had a bacon wrapped beef patty, lyonaise potatoes, zucchini and tomatoes and a brownie dessert. She did not have fortified potatoes on her plate and her meal ticket indicated she was to receive			

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 05/19/2015
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
	regular NAS diet. Fortified foods was not on the ticket. During an interview on 05/19/2015 2:25 P.M., the Food Service Director indicated Resident #35 was supposed to have been served a regular diet with fortified foods but it had not been on her ticket (meal) and he was notified today of the issue. He indicated he was correcting the issue. He did not know why the fortified foods was not printing on her ticket or how long that had occurred. He indicated he was to receive a pink slip when there was a diet change but he could not look up to see if he received the slip because he gave them all to the dietician who was not in the building until 05/21/15. 2. During an interview, conducted on 05/12/15 at 11:30 A.M., alert and oriented Resident #59 indicated he had been to a physician's office for an appointment and the physician had ordered therapy and the facility had not provided the therapy. He indicated he had taken his copy of the "paperwork" from the physician to the therapy department and they had indicated "they did not know anything about it." The clinical record for Resident #59 was reviewed on 05/14/15 at 9:00 A.M. Resident #59 was admitted to the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	on 05/23/15 with diagnoses, including but not limited to, history of alcohol abuse, history of multiple facial fractures and tibial/fibial fracture from pedestrian versus car, fracture of the left lamina at C (Cervical) 7, scoleosis, nicotine dependence, history of testicular cancer with left orchiectomy and gastric esophageal reflux disease. A nurse's note, dated 03/30/15 at 12:00 P.M., indicated the following: "Resident returned from appt. [appointment]. N.O. [new order] PT [physical therapy] for gait training, less w/c [wheelchair] time daily. Naprosyn [an anti-inflammatory pain medication] 400 mg [milligrams] BID [twice a day] po [by mouth] with food." The physician's orders, for March 2015 through May 2015, indicated a copy of the Naprosyn order from the orthopaedic physician's office, dated 03/30/15, was present but there was no order for the physical therapy in the medical record. During an interview on 05/18/2015 at 9:52 A.M., the Occupational Therapist, Employee #18, indicated a discussion was held with the resident at the time of the order and it was decided he would not get therapy based on his previous history of refusing to comply with therapy in the past. She indicated in the past, 2014, he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	had received therapy and had progressed from a wheelchair to a cane but refused to get up out of his wheelchair and ambulate. She indicated the previous physical therapist, who was working at the facility in March 2015, did not make any evaluation or note regarding the reason therapy was not initiated. She indicated nursing should have written a discontinue therapy order. During an interview on 05/18/2015 10:09 A.M., the ADON (Assistant Director of Nursing) indicated as she looked through every section of the chart she could not find any documentation of a therapy evaluation, discussion regarding therapy, or an order to discontinue therapy, except the nursing note entry, on 03/30/15, regarding therapy. The ADON indicated she had checked with the DON (Director of Nursing) regarding clarification and the DON had indicated therapy had evaluated the resident but the therapy was not conducted due to the resident's refusal. She did not know where the orders were for the therapy or the physician order to discontinue the therapy. A physician's report from the Orthopaedic surgeon, dated 03/30/15, indicated the following statement: "...At this point, we feel that he should work			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	with physical therapy where he is living for gait training, propriception, and stay out of the wheelchair. Gave him a prescription for Naprosyn one p.o. bid (two times daily) with food and will order a CT [cat scan] of his right tibia to see how well he is healing. We will have him come back in six weeks for re-evaluation and go over the CT." The facility had obtained a copy of the office visit on 05/18/15 when it was requested. 3. The clinical record for Resident #20 was reviewed on 5/19/15 at 10:00 A.M., Resident #20 was admitted, on 04/21/14, with diagnoses including, but not limited to, dementia, major depression, generalized anxiety, osteoporosis, hyperlipidemia and insomnia. A physicians order, dated 04/21/14, indicated "...Fexofenadine HCL[hydrochloride] [an allergy medication] 180 mg [milligrams] Take 1 Tab [tablet] by mouth daily at 8 A.M...." A second physicians order, dated 5/13/15, indicated "...Restoril [a medication to aid sleep] 15 mg QHS [every night at bedtime] (Insomnia) at 8 P.M...." Resident #20's Fexofenadine Medication Administration Record indicated this medication had not been given for the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	following dates: 5/14/15, 5/15/15, 5/16/15, 5/17/15 and 5/18/15. Resident #20's Restoril Medication Administration Record indicated this medication had not been given for the following dates: 5/14/15, 5/15/15 and 5/16/15. The Medication Administration Records indicated the reason why the medications were not given as the following: "... 5/14/15 Fexofenadine not available pharmacy notified...5/15/15 Fexofenadine awaiting delivery...5/16/15 Fexofenadine pharmacy pending delivery...5/17/15 Fexofenadine pharmacy aware...5/18/15 Fexofenadine pharmacy aware...." "...5/14/15 Restoril 15 mg unavailable pharmacy notified...." During an interview on 5/19/15 at 9:54 A.M., LPN #36 indicated the Fexofenadine had been delivered the night before and she administered the medication with her morning med pass. LPN #36 further indicated the Restoril had not been delivered. During an interview on 5/19/15 at 11:00 A.M., the Director of Nurses indicated she was not aware the Fexofenadrine and Restoril had not been given due to lack of supply she then proceeded to call the			

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 05/19/2015
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
	pharmacy and was told the Fexofenadine was reordered on 5/17/15 and it was delivered 5/18/15 and the Restoril had not been sent because they were waiting on the physicians signed prescription. (Restoril is a medication that requires a physician's signed prescription before it can be filled or refilled). 4 .The clinical record for Resident #20 was reviewed on 5/19/15 at 10:00 A.M., Resident #20 was admitted, on 4/21/15, with diagnoses including, but not limited to, dementia, mixed-type vascular/Alzheimer's dementia with delusions and behavioral issues, major depression, generalized anxiety, osteoporosis, hyperlipidemia and insomnia. A physician's order, dated 3/5/15, indicated " Olanzapine [an antipsychotic medication] Tab [tablet] 10 mg [milligrams] take 1 tablet by mouth every night at bedtime. Dx;[diagnosis] vascular dementia with delusions...." A care plan initiated on 4/6/15, indicated: "... Focus: [Resident's name] uses anti-psychotic medications r/t dementia with delusions...Goal: She will remain free of drug related complications, including movement disorder, discomfort, hypotension, gait			

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 05/19/2015
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
	disturbance, constipation/ impaction or behavioral impairment through review date...Revision on 4/6/15...Target Date: 7/8/15... Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness...Consult with pharmacy, MD to consider dosage reduction when clinically appropriate...Document observed behaviors on behavior management log...Monitor/record/report t MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles,shaking), frequent falls, refusal to eat, difficult swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person...." A "Quarterly Nursing Assessment" dated 4/13/15, lacked documentation to indicate the last page of the assessment titled " Abnormal Involuntary Movement Scale [AIMS]" had been completed. On 5/19/15 at 1:30 P.M., an interview was conducted with the MDS [Minimum Data Set] Coordinator. The MDS Coordinator indicated the nurses complete the AIMS assessment with			

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	quarterly assessments and if there is a medication increase the Social Worker completes it. On 5/19/15 at 1:35 P.M., an interview was conducted with Medical Records Director. The Medical Records Director indicated that the Social Worker had been looking for an AIMS for Resident #20 but could not find a current one. On 5/19/15 at 2:15 P.M., a current policy titled " Admission and Quarterly Nursing Assessment", provided by the MDS Coordinator and dated 10/2010, was reviewed. The policy indicated, "6. This admission and quarterly assessment tool also includes the following supplemental assessments:...i. AIMS if resident is receiving antipsychotic medications...." 3.1-5(a)(3)			
F 0311 SS=D Bldg. 00	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, record review and interviews, the facility failed to ensure interventions were implemented to assist 1 of 3 residents reviewed for activities of	F 0311	F311 483.25(a)(2) Treatment / services to improvement / maintain ADL's	06/12/2015

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 05/19/2015
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
	daily living, competed hair care. (Resident #29) Finding includes: During an observation, on 05/13/15 at 10:50 A.M., Resident #29's hair was noted to be oily looking. Resident #29 was observed on 05/18/2015 at 9:40 A.M. ambulating herself with a walker in the hallway. Her hair appeared wet and stringy. She was asked if she had just had a shower and she replied "No, not today." Closer observation indicated it was just very oily. The clinical record for Resident #29 was reviewed on 05/14/15 at 10:35 A.M. Resident #29 was admitted to the facility, on 06/26/14, with diagnosis, including but not limited to, diabetes, lack of coordination, dementia, GERD (Gastroesophageal Reflux Disease), hypertension, neuropathy, cerebral vascular accident acute systolic heart failure, hypertension, renal failure, seizure disorder and restless leg syndrome. The quarterly MDS (Minimum data set) assessment, completed on 04/07/15, indicated Resident #29 required limited		Corrective action: Resident # 29 care plan for activities of daily living hasbeen revised to included resident's behavior of refusal of care related tobathing and or shampooing of hair. Identifying others at risk: All residents shower sheets were reviewed by DON. DON ordesignee will complete an audit of all residents that are known to refuse showeringor hair washing to ensure resident care plans are accurate and behavior sheetsaddress refusal of showering or hair washing. All care plans for these residents were revised. Preventative measures in place: Al care plans will be reviewed with a change in condition orquarterly. Any residents that refuseshowers or any form of bathing, a copy of the shower sheet will be given tosocial services to ensure the behavior books are updated. Social Service will initial sheet and returnto DON for placement in the shower book as evidence of process being completed.DON or designee will conduct audit of all resident shower sheets three timesweekly for thirty days and then monthly for six months, if audit shows 100%compliance audit will be discontinued. Nursingstaff has been educated on completing the behavior sheet when resident refusesbathing or hair washing. Quality assurance program in place: All Audit findings will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	staff assistance of one for dressing, personal hygiene and bathing needs. The CNA Weekly Bath Checklist, from 02/02/15 - 05/18/15, indicated the resident had received 6 showers. The resident had refused a majority of her bathing/showering opportunities. The last documented shower received by Resident #29 was on 04/23/15, almost one month prior. During an interview, on 05/19/15 at 10:45 A.M., the Director of Nursing indicated Resident #29 refused her showers and other care frequently and there was a care plan regarding this issue for Resident #29. Review of the current care plan and interview with LPN #19, on 05/19/15 at 2:00 P.M., indicated Resident #29 had a behavior tracking form in the "Behavior" book but the form was not individualized regarding which behaviors the facility was tracking for Resident #29 and the form was blank indicating Resident #29 had not had any behaviors. In addition, LPN #19 indicated there was no current care plan regarding refusal of care for Resident #29. LPN #19 indicated she was surprised and unaware that Resident #29 refused her showers so often.		monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	During an interview on 5/19/15 at 2:00 P.M., LPN #20, who was just getting ready to work the second shift on 05/19/15, indicated she was aware of Resident #29's refusal of showering. 3.1-38(a)(2)(A)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interviews, the facility failed to ensure nail care was provided for 1 of 3 residents reviewed for activities of daily living. (Resident #51) Finding includes: The clinical record for Resident #51 was reviewed on 05/14/2015 at 2:18 P.M. Resident #61 was initially admitted to the facility on 06/04/14, and readmitted to the facility on 11/11/14, with diagnosis, including but not limited to vascular dementia, diabetes, depressive disorder, lack of coordination, abnormality of gait, hypertension, chronic kidney disease, hypertrophy of the prostate without	F 0312	F312 483.25(a)(3) ADL Care provided for dependent resident Corrective action: Resident #51, nails were cut and cleaned. Care plan updated to reflect need to assistwith ADL care of finger nails. Identifying others at risk: Nursing staff will conduct audit of all residents throughtheir showering schedule and record on shower sheet if nail care is needed forany resident. Resident will be monitored during meal times and activities forany need of additional grooming of nails. Preventative measures in place: Nursing staff was educated on the need to provide ADL careof	06/12/2015

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 05/19/2015
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
	ureterthal obstruction, chronic kidney disease, obesity, dementia with delusions, congestive heart failure and urinary retention. Resident #51 was observed, on 05/12/15 at 1:50 P.M., seated in his wheelchair. His fingernails were noted to long and there was orange colored debris underneath the fingers on his right hand. Resident #51 was observed, on 05/19/2015 at 9:55 A.M., seated in his wheelchair asleep. His fingernails were still long, extending past his fingertips. The most recent MDS (Minimum Data Set) assessment, completed 02/13/15, indicated the resident was severely cognitively impaired and required the extensive physical assistance of staff for dressing and personal hygiene needs and required bathing assistance of one staff member. The care plan for Resident #51, current through 08/19/15, indicated the resident had an ADL (activity of daily living) performance deficit related to dementia, limited mobility and confusion. The interventions for bathing, personal hygiene/oral care and dressing indicated the resident required one staff participation for each task.		fingernails. Nursing Staff waseducated on completing the behavior sheet for refusal of care. Any resident that refuses nail care will bedocumented on the shower sheet. A copy of the shower sheet will be given toSocial Service to ensure the behavior book and care plan is updated. Social Service will initial and return to DONfor placement in the shower book as evidence of process being completed. DON or designee will audit shower sheetsthree times weekly for thirty days and then monthly for six months, if auditshows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	The CNA weekly Bath Checklist forms, from 03/04/15 - 05/02/15, indicated Resident #51's fingernails had been cleaned but had not been cut during the time frame. During an interview, on 05/19/15 at 10:30 A.M., the Director of Nursing indicated the nurse's were supposed to trim the fingernails of diabetic residents. She indicated she could not locate the policy regarding trimming fingernails of male residents and she did not remember the set frequency. 3.1-38(a)(3)(E)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the resident environment was free of hazards and hazardous chemicals on 1 of 4 nursing units. This affected 1 of 30 residents observed. (Resident #1)	F 0323	F323 483.25(h) Free of accident hazard / supervision /devices Corrective action: Resident #1's personal care items were removed from thebathroom and properly stored in resident's	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	Finding includes: On 5/12/15 at 10:04 A.M., an observation of Room #113 indicated Resident #1 had 1 bottle of deodorant spray, 1 bottle of body wash and 1 small can of shaving cream left at the handwashing sink in the restroom. On 5/18/15, from 10:20 A.M. to 10:47 A.M., an environmental tour was conducted with the Maintenance Supervisor and the Interim Housekeeping Supervisor. At 10:22 A.M., an observation of Room #113 restroom indicated 1 bottle of anti-perspirant/deodorant spray, 1 bottle of body wash, and 1 small can of shaving cream were left at the handwashing sink in the resident's restroom. During an interview on 5/18/15 at 10:23 A.M., the Maintenance Supervisor indicated personal care items should be bagged up and put away. Resident #1, identified as cognitively impaired, was observed to propel his wheelchair in and out of his room during all days of the survey. On 5/18/15 at 11:05 A.M., an interview was conducted with the Director of		room per policy Identifying others at risk: All resident rooms were inspected for proper storage ofpersonal care items per policy. Preventative measures in place: Nursing staff was educated on the policy for storage ofresident personal care items. DON ordesignee will audit resident rooms for proper storage of personal care itemsweekly for three months, if audit shows 100% compliance audit will bediscontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	Nurses. The Director of Nurses indicated there is only one person that uses that bathroom but the personal care items should be bagged up and put away. She further indicated she had no policy regarding the labeling and storage of personal care items. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interviews, the facility failed to ensure a medical symptom of delusions was monitored for 1 of 5 residents reviewed for unnecessary medications (Resident #51). In addition, the facility failed to ensure an AIMs (Abnormal Involuntary Movement) assessment was completed timely to monitor for adverse side effects for 2 of 5 residents reviewed for unnecessary medications (Resident #20 and #25) Findings include: 1. The clinical record for Resident #51 was reviewed on 05/14/2015 2:18 P.M. Resident #51 was initially admitted to the facility on 06/04/14, and readmitted to the facility on 11/11/14, with diagnoses, including but not limited to, vascular dementia, diabetes, depressive disorder, lack of coordination, abnormality of gait, hypertension, chronic kidney disease, hypertrophy of the prostate without ureterthal obstruction, chronic kidney disease, obesity, dementia with delusions, congestive heart failure and urinary retention. The current physician's orders for medications for May 2015, included	F 0329	F329 483.25(1) Drug regimen is free from unnecessary drugs Corrective action: Resident #51's behavior documentation record has beenupdated to reflect the medical symptom of delusions to be monitored. Resident's#20 and #25 have had AIMs assessments completed. Identifying others at risk: Social Service has completed an audit of all residents toassure AIM's assessments have been completed. Social Service has completed anaudit for any other residents with the diagnosis of delirium to verfy thattheir behavior record reflect this diagnosis. Social Service will audit all PO's forms for any new diagnosis ofdelirium that may need to be updated. Preventative measures in place: Social Service will audit AIM's assessment for accuracy onetime weekly for thirty days then monthly for three months, if audit shows 100%compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	antipsychotic medication, Risperidone 1 mg (milligram) at bedtime and 0.5 mg in the mornings for agitation and delusions. The behavior tracking form for April and May 2015 for Resident #51 indicated staff were monitoring the resident for the following behaviors: biting, yelling, refusal of care, throwing things, trying to get out of bed, cussing, inappropriate touching of staff, and lowering self to the floor. During an interview, on 05/19/2015 at 10:46 A.M., the Social Service Director (SSD), indicated Resident #51 was admitted to the facility, on 06/04/14, on Seroquel. He was sent to an acute care facility and readmitted, on 06/12/14, on Risperdal .5 mg BID (twice a day). The resident was sent to another psychiatric facility in November 2014, and readmitted on Risperdal 0.5 mg in AM and 1 mg in PM. The medication was given for delusions and agitations. The SSD indicated the resident's delusions were thinking other people did not like him and were out to get him. When shown the April/May 2015 behavior tracking form she indicated delusions should be monitored but were not being monitored on the form. 2. On 5/18/15 at 2:57 P.M., record review was conducted for Resident #25. The			

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 05/19/2015
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
	resident's diagnoses included but were not limited to "...depression, dementia with delusional features, anxiety, panic disorder with agoraphobia and insomnia with sleep apnea...." The resident's medication regimen included the anti anxiety medication, Lorazepam 0.5 mg (milligrams) to be given daily at bedtime, ordered on 4/16/15. Prozac 20 mg to to be given daily at bedtime as an anti depressant, ordered on 3/12/15. An antipsychotic Zyprexa 5 mg every morning and 15 mg every night at bedtime for vascular dementia with depressed mood, ordered on 1/13/15. An Abnormal Involuntary Movement Scale (AIMS), dated 8/11/14, indicated Scoring Codes: 0=None. The AIMS assessment indicated a score of 0. A Quarterly Nursing Assessment, dated 11/10/14, indicated the AIMS assessment was not completed. A care plan, initiated on 11/12/14 and revised on 2/11/15, indicated the problem: (Resident name) takes an antipsychotic medication (Zyprexa for dementia with delusions) & has a potential for side effects related to the use of the antipsychotic medication.			

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 05/19/2015
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
	Interventions included but were not limited to "...Complete FALL RISK and AIMS assessments per facility protocol...Observe for changes in mental and physical functioning and inform physician as warranted...Will administer medications as ordered while observing for the effectiveness and side effects: Sedation, drowsiness, dry mouth, constipation, blurred vision, extra pyramidal reaction, weight gain, edema, postural hypotension, sweating and loss of appetite...." During an interview on 5/19/15 at 1:27 P.M., the Social Service Director indicated the AIMS assessment should be done with the quarterly nursing assessment. She further indicated the last AIMS assessment that she found for Resident #25 was on 8/11/14. On 5/19/15 at 1:45 P.M., the current policy titled "Antipsychotic Medication Use" received from RN #2 indicated "...12. Monitoring for side effects will be documented daily on the medication administration records (MAR). The resident will also be assessed for abnormal involuntary movements using the AIMS assessment tool at least every 6 months...." On 5/19/15 at 1:50 P.M., the current			

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 05/19/2015
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
	policy titled "Admission and Quarterly Nursing Assessment" received from RN #2 indicated "...The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission and quarterly...6. This admission and quarterly assessment tool also includes the following supplemental assessments:...i. AIMS if resident is receiving antipsychotic medications...." 3. The clinical record for Resident #20 was reviewed on 5/19/15 at 10:00 A.M. The resident was admitted, on 4/21/15, with diagnoses including, but not limited to, dementia, mixed-type vascular/Alzheimer's dementia with delusions and behavioral issues, major depression, generalized anxiety, osteoporosis, hyperlipidemia and insomnia. A physician's order, dated 3/5/15, indicated " Olanzapine [an antipsychotic medication] Tab [tablet] 10 mg take 1 tablet by mouth every night at bedtime. Dx:[diagnosis] vascular dementia with delusions...." A care plan initiated on 4/6/15, indicated: "... Focus: (Resident's name) uses anti-psychotic medications r/t dementia with delusions...Goal: She will remain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/ impaction or behavioral impairment through review date...Revision on 4/6/15...Target Date: 7/8/15... Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness...Consult with pharmacy, MD to consider dosage reduction when clinically appropriate...Document observed behaviors on behavior management log...Monitor/record/report t MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles,shaking), frequent falls, refusal to eat, difficult swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person...." A "Quarterly Nursing Assessment," dated 4/13/15, lacked documentation to indicate the last page of the assessment titled "Abnormal Involuntary Movement Scale (AIMS)" had been completed. On 5/19/15 at 1:30 P.M., an interview			

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 05/19/2015
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
	was conducted with the MDS [Minimum Data Set] Coordinator. The MDS Coordinator indicated the nurses complete the AIMS assessment with quarterly assessments and if there is a medication increase the Social Worker completes it. On 5/19/15 at 1:35 P.M., an interview was conducted with Medical Records Director. The Medical Records Director indicated that the Social Worker had been looking for an AIMS for Resident #20 but could not find a current one. On 5/19/15 at 2:15 P.M., a current policy titled " Admission and Quarterly Nursing Assessment", provided by the MDS Coordinator and dated 10/2010, was reviewed. The policy indicated, "... The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission and quarterly for the purposes of managing the resident, initiating and updating the care plan, and completing required assessment instruments, including the MDS 3.0...6. This admission and quarterly assessment tool also includes the following supplemental assessments:...i. AIMS if resident is receiving antipsychotic medications...."			

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 05/19/2015
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
	3.1-48(a)(3)			
F 0364 SS=D Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interviews, the facility failed to ensure food was served at the proper temperature at point of service. This had the potential to affect 3 of 4 residents reviewed for food palatability who reside on the 100 and 300 halls. (Resident #26, Resident #45 and Resident #59) Findings include: On 5/11/15 at 11:55 A.M., an observation during the noon meal service Cook #1 picked an electrical cord up off of the kitchen floor and plugged in the plate warmer. He indicated he normally turns the plate warmer on at least 30 minutes prior to the meal service but had forgotten. During an interview on 5/12/15 at 10:33 A.M., Resident #45 indicated she ate in her room and the food is always cold. She further indicated the plates are never hot.	F 0364	F364 483.35(d)(1)-(2) Nutritive value/appearance, palatable temp Corrective action: Facility has purchased a new plate warmer to replace olderunit Identifying others at risk: All residents have been interviewed and asked about foodtemperatures and palatability. Any resident not happy with food temperaturewill be addressed. Preventative measures in place: Dietary staff was educated on proper temping and holding offood for nutritive value, flavor, and appearance. Dietary Manager or designeewill audit three times weekly for three months random meals serves on all unitsfor proper temping and holding of food, if audit shows 100% compliance auditwill be discontinued. Dietary Manager ordesignee will audit two times weekly for three months resident satisfaction offood temps and palatability of food, if audit shows 100% compliance audit willbe	06/12/2015

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	During an interview on 5/12/15 at 2:41 P.M., Resident #26 indicated he ate in his room and the food is usually not hot. During an interview on 5/12/15 at 3:00 P.M., Resident #59 indicated he ate in his room and the food was always cold. He further indicated the plate was not always hot and the plastic insulated cover for the top of the plate was never on correctly. On 5/14/15 at 11:45 A.M., an observation indicated the lunch trays were to be delivered at 11:45 A.M. on the 300 hallway. The trays arrived at 12:05 P.M., and the last tray on the cart was for Resident #26 and was delivered at 12:10 P.M. The Dietary Manager checked the temperature of the tray for Resident #26 at 12:15 P.M. The temperature of the ham was 114 degrees Fahrenheit (F) and the potatoes and cooked cabbage were 114 degrees (F). On 5/14/15 at 12:20 P.M., an observation indicated the lunch trays were to be delivered at 12:20 P.M. on the 100 hallway. The trays arrived at 12:20 P.M. The Dietary Manager checked the temperature of the food for Resident #45 at 12:25 P.M. The temperature of the potatoes was 121 degrees (F) and the cooked cabbage was 124.5 degrees (F).		discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	At 12:30 P.M. the Dietary Manager checked the temperature of the food for Resident #59. The temperature of the potatoes was 114 degrees (F) and the cooked cabbage was 125.1 degrees (F). During an interview on 5/18/15 at 9:50 A.M., the Dietary Manager indicated the hot food at the point of delivery should be at least 140 degrees (F). On 5/18/15 at 1:45 P.M., record review of the current policy titled "Holding Temperatures" received from the Dietary Manager indicated "...Potentially hazardous food; hot and cold holding (a) except during preparation, cooking, or cooling...potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above...." 3.1-21(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and	F 0371	F371 483.35(i)	06/12/2015

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 05/19/2015
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
	interviews, the facility failed to ensure food was stored, served and prepared in a sanitary manner in 1 of 1 kitchen and 3 of 3 nourishment refrigerators. This potentially affected 56 of 56 residents who consumed food in the facility. In addition, the facility failed to distribute and serve food under sanitary conditions in 1 of 3 dining rooms. This had the potential to affect 17 of 17 residents that received meals in the dining room on the dementia unit. (Employee #25 and Employee #26) Findings include: 1. On 5/11/15 from 10:20 A.M.-10:45 A.M., the initial kitchen tour was conducted with the Dietary Manager and the following was observed: The microwave oven had dried food substances inside of it and the Kitchen Aid mixer had dried batter on it. Review of the sanitizing solution flow sheet for the dishwasher indicated the chemical solution testing was not documented for the breakfast and lunch meals on May 7th, 8th and 9th 2015. During an interview at that time with the Dietary Manager, he indicated the dishwasher was a low temperature dish machine and the chemical should test at least 200 parts per million (ppm) he further indicated the		Food Procure, Store / prepare / serve – sanitary Corrective action: Equipment identified was immediately sanitized per cleaningpolicy. Undated items were discarded andwere replaced with properly dated items. Refrigerator that was not at appropriate temperature was replaced. Identifying others at risk: All refrigerators were inspected for proper function andproper dating and food storage. Preventative measures in place: Dietary staff was educated on proper sanitation ofequipment. Dietary Manager or designeewill audit weekly for three months sanitation of equipment and cleaning logs,if audit shows 100% compliance audit will be discontinued. Dietary staff was educated on accuratelydocumenting the low temperature sanitizing solution. Dietary Manager or designee audit sanitizingsolution log for accuracy three times a week for three months, if audit shows100% compliance audit will be discontinued. Dietary staff has been educated on proper gloving for handling of foodin a sanitary manner. Dietary Manager ordesignee will audit random meal preparations three times weekly for threemonths, if audit shows 100% compliance audit will be discontinued. All staffwill be educated on proper hand washing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	flow sheet should be filled in for every meal each day. On 5/11/15 from 11:20 A.M.-11:40 A.M., the following was observed in the kitchen during the noon meal service: At 11:25 A.M., Cook #1 was observed to wash his hands and donn clean gloves on both hands. He then prepared pureed carrots in the robot coupe (a food processor). After he finished the carrots he placed them in a saucepan and turned the stove burner on with his gloved hands. He then walked over to the steam table and with the same contaminated gloved hands, removed 5 country fried steaks from the steam table and proceeded to tear the steaks into small pieces with his hands and placed in the robot coupe to prepare a puree. He turned the robot coupe on with his gloved hands. After the puree was completed, he removed his gloves which revealed a Band-Aid covering the tip of his left index finger. He was not observed to wash his hands and placed a clean pair of gloves on both hands to check the temperature of the carrot puree on the stove top. He then with his gloved hands, opened 3 different drawers to retrieve a scoop for serving at the steam table. With the same gloved hands, he scooped the pureed meat with a spatula into a sauce		policy and procedure. DON or designee will audit staff for properadherence to the hand washing policy and procedure two times weekly for thirtydays and then weekly for three months, if audit shows 100% compliance auditwill be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	pan, placed it on the stove top, turned the burner on and then began to check the temperature of the foods on the steam table with his contaminated gloved hands. At 11:55 A.M., Cook #1 was observed without washing his hands to donn clean gloves and pick up an electrical cord off of the floor and plug it into the outlet in the wall to turn on the plate warmer. After he picked the plug up off of the floor with his gloved hands, he touched the top of the clean plates seated in the plate warmer. At 12:15 P.M., Cook #1 without changing his gloves or washing his hands was observed to remove 5 country fried steaks from the steam table with his gloved hands. He then tore the steaks into small pieces with his contaminated gloved hands and placed the meat pieces into the robot coupe (a food processor) to make the mechanical soft meat. He was then observed to return to the steam table with the same gloves on, wipe his gloves on the front of his apron and then continued to serve food from the steam table. On 5/18/15 from 9:15 A.M.-9:25 A.M., an observation of the nourishment refrigerators on the nursing units was			

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 05/19/2015
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
	conducted and the following was observed: At 9:15 A.M., on the 200 unit, 3 cheese sandwiches were observed in Ziploc bags in the nourishment refrigerator. All of the cheese sandwiches were undated. At 9:20 A.M., on the 400 unit, 1 cheese sandwich in a Ziploc bag was undated and the temperature of the refrigerator was 50 degrees. An interview at that time, with the Assistant Director of nursing indicated the refrigerator temp should be 41 degrees or lower. At 9:25 A.M., on the 300 unit, 3 cheese sandwiches were in Ziploc bags and were undated. On 5/18/15 at 9:30 A.M., a second kitchen tour was conducted with the Dietary Manager and the following was observed: A Kitchen Aid mixer was observed on the counter top covered with plastic. The Dietary Manager removed the plastic cover, the mixer had dried batter on it and was put away as clean. An interview at that time, with the Dietary Manager, indicated the mixer should have been cleaned before being put away.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	During an interview, on 5/18/15 at 9:45 A.M., the Dietary Manger indicated gloves should be changed after every task, kitchen equipment should be cleaned before being stored and food should be dated and labeled before being placed in the refrigerator. A form titled "Midnight Nurse Document Daily Fridge/Freezer Temperature Log" received from the Assistant Director of Nursing, on 5/18/15 at 9:50 A.M., indicated "...Unit 4 fridge in pantry...keep foods at or below 41 degrees Fahrenheit (F) in the refrigerator...NOTE: If temperatures are not within the above range (40 degrees refrigerator notify maintenance or place on the maintenance request log...." On 5/18/15 at 1:45 P.M., the current policy titled "Recording of Dish machine Temperatures," received from the Dietary Manager, indicated "...6. The concentration of the sanitary solution during the rinse cycle is 200 ppm with quaternary ammonium. This is used on low temperature dish machines...8. "Dish machine Temperature Log" a. To ensure that the wash and rinse temperatures are properly monitored and controlled, a log must be completed by those who are directly involved in the dishwashing process. Entries must be made for each			

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 05/19/2015
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
	day...f. Record ppm on low temperature machines...." On 5/18/15 at 2:00 P.M., the current policy titled "Blender," received from the Dietary Manager, indicated "...Sanitation of equipment...6. Wash base with sanitizing solution and clean cloth...." On 5/18/15 at 2:05 P.M., the current policy titled "Glove Use," received from the Dietary Manager, indicated "...(a) If used, single-use gloves shall be: (1) used for only (1) task...." 2. On 5/11/15 at 12:19 P.M., CNA #25 was observed washing her hands for 4 seconds and then passing a dining room tray to a resident. She was then observed taking a tray to another resident and touching the back of the the resident's chair. CNA #25 was observed returning to the sink and washed her hands for 5 seconds before taking a tray to yet another resident. On 5/11/15 at 12:24 P.M., CNA #26 was observed washing her hands for 8 seconds and picking up a tray off the cart and placing the tray in front of Resident #38 and cutting his food. CNA #26 returned to the sink and was observed washing her hands for 9 seconds before getting another tray from the cart.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	On 5/13/15 at 11:05 A.M., the Director of Nursing provided a policy titled "Hand washing", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...6. Lather all areas of the hands and wrists rubbing vigorously for 20 seconds...." 3.1-21(i)(2)			
F 0406 SS=D Bldg. 00	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on record review and interviews, the facility failed to ensure physical therapy was provided as ordered for 1 of 4 residents reviewed for rehabilitation. (Resident #59) Finding includes:	F 0406	F406 483.45(a) Provide / obtain specialized rehab services Corrective action: Resident #59 was screen by therapy for the need ofrehabilitation services Identifying others at risk: DON or designee will audit all physician orders forcompliance with orders for rehabilitation services	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	During an interview, on 05/12/15 at 11:30 A.M., alert and oriented Resident #59 indicated he had been to a physician's office for an appointment and the physician had ordered therapy and the facility had not provided the therapy. He indicated he had taken his copy of the "paperwork" from the physician to the therapy department and they had indicated "they did not know anything about it." The clinical record for Resident #59 was reviewed on 05/14/15 at 9:00 A.M. Resident #59 was admitted to the facility on 05/23/15 with diagnoses, including but not limited to, history of alcohol abuse, history of multiple facial fractures and tibial/fibial fracture from pedestrian versus car, fracture of the left lamina at C[Cervical] 7, scoliosis, nicotine dependence, history of testicular cancer with left orchiectomy, and gastric esophageal reflux disease. A nurse's note, dated 03/30/15 at 12:00 P.M., indicated the following: "Resident returned from appt. [appointment]. N.O. [new order] PT [physical therapy] for gait training, less w/c [wheelchair] time daily. Naprosyn [an anti-inflammatory pain medication] 400 mg BID [twice a day] po [by mouth] with food."		Preventative measures in place: DON or designee will audit weekly for three months all newphysician orders indicating rehabilitation services are indicated, if auditshows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	The physician orders for March 2015 through May 2015, indicated a copy of the Naprosyn order from the orthopaedic physician's office, dated 03/30/15, was present but there was no order for the physical therapy in the medical record. During an interview, on 05/18/2015 at 9:52 A.M., the Occupational therapist, #18 indicated a discussion was held with the resident at the time of the order and it was decided he would not get therapy based on his previous history of refusing to comply with therapy in the past. She indicated in the past, 2014, he had received therapy and had progressed from a wheelchair to a cane but refused to get up out of his wheelchair and ambulate. She indicated the previous physical therapist, who was working at the facility in March 2015, did not make any evaluation or note regarding the reason therapy was not initiated. She indicated nursing should have written a discontinue therapy order. During an interview, on 5/18/2015 10:09 A.M., the Assistant Director of Nursing (ADON) indicated as she looked through every section of the chart she could not find any documentation of any therapy evaluation, discussion regarding therapy, or order or discontinue of order, except the nursing note entry on 03/30/15,			

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	regarding therapy. The ADON indicated she had checked with the DON regarding clarification and the Director of Nursing had indicated therapy had evaluated the resident but the therapy was not conducted due to the resident's refusal. She did not know where the orders were for the therapy or the physician order to discontinue the therapy. A physician's report from the Orthopaedic surgeon, dated 03/30/15, indicated the following statement: "...At this point, we feel that he should work with physical therapy where he is living for gait training, propriception, and stay out of the wheelchair. Gave him a prescription for Naprosyn one p.o. [by mouth] b.i.d. [twice a day] with food and will order a CT [cat scan] of his right tibia to see how well he is healing. We will have him come back in six weeks for re-evaluation and go over the CT." There was no documentation of the statement until the facility had obtained a copy of the office visit on 05/18/15 when it was requested. 3.1-23(a)(1)			
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.			
	Based on observation, record review and interviews, the facility failed to facilitate dental services in a timely manner for 1 of 3 residents reviewed for dental status. (Resident #23) Findings include: During an interview on 5/12/15 at 9:54 A.M., Resident #23 indicated he only has 1 tooth on the bottom gum and it is decayed. He further indicated he has an upper denture plate and has never had a lower denture plate. The resident also indicated he would like to see the dentist and have a lower denture plate made. On 5/12/15 at 9:55 A.M., an observation of Resident #23 indicated he had an upper denture in place but no lower denture and had only 1 tooth on the bottom gum which was decayed. On 5/14/15 at 10:32 A.M., record review indicated Resident #23 was admitted to	F 0412	F412 483.55(b) Routine / emergency dental services Corrective action: Resident #23 was added to the dentist referral for next dateof service scheduled to be provided Identifying others at risk: Social Service will audit all residents that have declinedservices or are not using services for accuracy and to verify choice. Preventative measures in place: Facility will revise the admission intake form to betterreflect the acceptance of onsite dental services and prior servicesprovided. Admissions will audit monthlyfor three months the new admission dental indicator for completion, if auditshows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	06/12/2015

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 05/19/2015
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
	the facility on 2/28/14 with diagnoses included but were not limited to "...diabetes mellitus type II, bipolar disorder, depressive disorder, lower limb amputation, morbid obesity and hypertension...." A form titled "Notification of Medicaid Benefits," dated 2/28/14, indicated "...Dental: Having Medicaid entitles you to $600.00 dollars of the following dental services annually: cleanings, exams, problem focused exams, clinically necessary x-rays, fillings, dentures every 6 years, dentures, partials, relines and dental prosthetic repairs require a consent and prior approval from Medicaid...." The form was signed by Resident #23 on 2/28/14, that he accepts dental services. During an interview on 5/18/15 at 11:17 A.M., the Director of Nursing indicated the resident was scheduled to be seen by the visiting dental clinic during a past admission in January of 2013, but the dental clinic called and canceled the appointment, when the dental clinic came in April of 2013, the resident had been discharged. The DON further indicated the resident has an appointment now to see the dentist on 6/4/15. During an interview on 5/18/15 at 2:25 P.M., the Social Service Director (SSD)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	indicated Resident #23 signed a consent form upon admission on 2/28/14, to see the dentist. The SSD further indicated after the consent form is signed someone in medical records should fax the form to the company that arranges the dental, vision and audiology appointments. After the company receives the faxed consent form from the resident they fax back a list of the residents and what date they will be seen. The SSD was unsure why the resident had not seen the dentist and further indicated the resident has an appointment now to see the dentist on 6/4/15. 3.1-24(a)(1) 3.1-24(b)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review and interview, the facility failed to maintain a medication refrigerator at an acceptable temperature to maintain the quality of the medications contained in the refrigerator for 1 of 2 medication refrigerators reviewed. Finding includes: On 5/18/15 at 3:13 P.M. a mediation room refrigerator observation was conducted with the Director of Nursing (DON) on the dementia unit. Upon entering the medication room a refrigerator door was noted to have been left open approximately 1 to 2 inches. The thermometer had fallen and was	F 0431	F431 483.60(b),(d),(e) Drug records, label / store drugs and biologicals Corrective action: Facility moved refrigerator to counter height to ensureproper closure of unit. Drugs affectedby improper temperature were replaced. Identifying others at risk: Maintenance inspected all medication refrigerators forproper funcition. Preventative measures in place: Licensed Nurses have been educated on the facility policyand procedure of medication storage and temperature for proper storage. Education was also provided for properdocumentation of temperature control logs. DON or	06/12/2015

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 05/19/2015
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
	blocking the door of the refrigerator from completely closing. The DON indicated the temperature of the refrigerator was 72 degrees Fahrenheit. The refrigerator included the following items: * a Tuberculin vial-unopened, * Travatan (eye drops) one open bottle and one unopened bottle, * 8 unopened bisacodyl 10 mg suppositories, * an EDK (Emergency Drug Kit) with refrigerated medications locked inside the container. During an interview, on 5/18/15 at 3:18 P.M., the DON indicated the last time someone would of been in the refrigerator would be around 8 AM to get Resident #3's eye medication-Travatan. However a bottle containing the Travatan eye drops was located on the medication cart and had not been in the refrigerator, even though the box clearly stated "Refrigerate." The DON contacted the pharmacy and they directed the facility to dispose of all of the medication in the refrigerator. The nurse on the day shift, who had administered the eye medication , was not available for interview due to her shift had been completed, therefore the it was unclear which bottle of eye medication had been utilized for Resident #3 earlier in the day The refrigerator		designee will audit medication refrigeration logs two timesweekly for one month to ensure correct temperature of medication refrigerators,if audit shows 100% compliance audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	temperature log indicated on the night shift of 05/18/15, the refrigerator temperature was 40 degrees Fahrenheit. On 5/19/15 at 10:30 A.M., the DON provided a fax from the facility's pharmacy, dated 5/18/15. The pharmacy indicated the Travatan was no longer good and a replacement was sent. The TB solution and EDK kit were no longer good. On 5/19/15 at 4:15 P.M., the DON provided an undated policy titled, "Medication Storage in the Facility," and indicated the policy was the one currently used by the facility. The policy indicated "...K. Medications requiring "refrigeration" or "temperatures between between 2*C. (36*F) and 8*C (46*F)" were kept in a refrigerator with a thermometer to allow temperature monitoring . 3.1-25(m)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease			

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 05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interviews, the facility failed to ensure the proper glove use was followed during tracheostomy care for 1 of 1 staff observed providing tracheotomy care to 1 of 1 residents with a tracheotomy (Resident #26) and failed to ensure proper hand washing was utilized during	F 0441	F441 483.65 Infection control, prevent spread, linens Corrective action: Facility has provided education on tracheostomy care tolicensed nursing staff providing care for resident #26. Identifying others at risk: Facility only has resident #26	06/12/2015

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 05/19/2015
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
	medication pass. (Resident #19, #57 and #36) Findings include: 1. During the observation of routine tracheotomy care, including changing of the inner cannula, conducted on 05/19/2015 at 2:58 P.M., the following was noted: LPN #17 washed her hands, donned a pair of disposable gloves, moved the oxygen tubing and straps from around Resident #26's trach, removed the trach ties and a gauze dressing from around Resident #26's neck and trach and threw them away LPN #17 then washed her hands again, and removed the cover from a package containing an inner cannula and the tracheostomy cleaning kit. LPN #17 then donned a pair of sterile gloves, picked up the sterile drape and positioned it underneath the resident's trach opening, touching the resident's gown on each side with both her gloved hands. She then moved the trach cleaning equipment from the trach cleaning kit basin, handled the outside of a bottle of sterile water, touching the sides of the bottle with one of her hands and the lid of the bottle with her other hand. She then poured some of the water into the trach cleaning kit basin. She then, with her contaminated gloved hands, twisted the collar of the inner		receiving tracheostomy care Preventative measures in place: All Licensed nurses that provide tracheostomy care will beeducated on the policy and procedure for tracheostomy care and complete acompetency checklist. All nurses will beeducated on the hand washing policy and procedure and the use of handsanitizer. Any new or existing nurse notcompetent on trach care will be educated and checked off prior to being able tocare for residents with tracheostomies. Audit of trach care will be completed once a week for thirty days thenonce a month for three months, if audit shows 100% compliance audit will bediscontinued. DON or designee willconduct random medication pass audits on all shifts to ensure proper infection processedare followed during medication passes. Audit will be completed of medicationpass two times weekly for three months, if audit shows 100% compliance auditwill be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	tracheostomy cannula, removed the inner cannula, threw it away, touched the collar of the new inner cannula with her contaminated gloved hands, and placed the inner cannula into place. She then used both hands to secure and twist the collar into place. Finally, she soaked some gauze pads in the sterile water and cleaned around the stoma, then placed new trach ties, humidified oxygen tie and tubing and wash clothes around the elastic strap for the oxygen before she removed her contaminated gloves. 2. During an observation of a medication pass, on 5/12/15 at 8:56 A.M., Registered Nurse (RN) #27 did not wash her hands with soap, water, or use alcohol sanitizer before preparing a medication pass for Resident #19. The nurse was observed administrating the medication to Resident #19 and then returned to her medication cart. The RN took a pen in her hand and documented her medication administration to Resident #19. RN #27 then proceeded down the hallway, with the medication cart, and stopped in front of Resident #57's room. RN #27 prepared medication for Resident #57, touching medication cards and the cart drawers. RN #27 administered the resident's medications and touched the resident's arm. RN #27 returned to the cart and initialed the Medication Record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	Administration record with her pen. RN #27 then prepared Resident #36's medication and entered Resident # 36's room and administered his medications to him. RN#27 returned to her cart. RN #27 was asked to stop the medication pass. During an interview, on 5/12/15 at 9:20 A.M., RN #27 indicated she should have washed her hands or used alcohol sanitizer before each medication administration and after each administration. She further indicated she had the alcohol sanitizer in her medication cart. On 5/13/15 at 11:05 A.M., the Director of Nursing provided a policy titled "Hand washing," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Hand washing should be performed...as promptly as possible after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them, whether or not gloves are worn...As promptly and thoroughly as possible between resident contacts...." 3.1-18(l)			
F 0465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
Bldg. 00	TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and clean resident environment related to, urine odors in residents rooms and hallways, slow draining sink and broken tile in bathroom. This affected 2 of 4 units. The facility also failed to ensure a resident has equipment in good repair related to bed bolsters. This affected 1 of 30 resident's sampled 1 of 30 resident's reviewed for environment. (Resident #6) Findings include: On 5/18/15 from 10:20 A.M. thru 10:47 A.M., an environmental tour was conducted with the Maintenance Supervisor and the Interim Housekeeping Supervisor, during which the following was observed: 1. Unit 1: At 10:22 A.M., the shared restroom for Room 113 bed A and B was observed to have a strong smell of urine. During an interview, on 5/18/15 at 10:24 A.M., the Maintenance Supervisor indicated there was a urine smell but that the room had been cleaned and sanitized	F 0465	F465 483.70(h) Safe / functional / sanitary /comfortable environment Corrective action: Rooms 113 and 228 will be taken out of service until propercleaning or renovation to those resident bathrooms can be completed to correctthe odor concern. Tile will be replacedin room 100. Resident sink has been repaired in room 100. Resident #6 damaged bolsters have beenreplaced. Identifying others at risk: Maintenance will audit all resident rooms for need forrepair of tile or sinks. Preventative measures in place: Maintenance will audit roof top exhausts for proper functionand repair as needed for proper facility ventilation. Staff will be educated onfacility maintenance request procedure. Housekeeping Supervisor or designee will conduct a weekly audit ofrandom resident rooms for three months to ensure a safe, functional, sanitary,and comfortable environment, if audit shows 100% compliance audit will bediscontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	as far down as they could clean it. During an interview, on 5/18/15 at 10:26 A.M., the Interim Housekeeping Supervisor indicated the room was cleaned daily and had been cleaned as far down as they could clean it. At 10:27 A.M., the shared restroom for Room 110 A and B was observed to have broken tile at the base of the door and a slow draining, hand washing sink. During an interview, on 5/18/15 at 10:28 A.M., the Maintenance Supervisor indicated there had previously been a plastic cover over the tile. He further indicated there was a cap in the hand washing sink and proceeded to remove it. He then turned on the water but the sink remained slow to drain. 2. Unit 2: At 10:40 A.M., the shared restroom for Room 228 A and B was observed to have a strong smell of urine. During an interview, on 5/18/15 at 10:44 A.M., the Maintenance Supervisor indicated the restroom had a urine smell. During an interview, on 5/18/15 at 10:48 A.M., the Maintenance Supervisor		negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	indicated each nurses station had a clipboard where requests for repairs were to be documented. He further indicated he checked them daily and then made the needed repairs. On 5/18/15 at 11:15 A.M., review of the " Daily Duty Check List " undated and received from the Maintenance Supervisor indicated "...Deep Clean Check List...Bathroom... Trash can: empty, clean in/out and replace bag... check all paper products fill if needed... disinfect handrails... disinfect toilet paper and paper towel dispenser... soap dispenser clean in/out fill if less than 1/4 full...clean sink remove any buildup...clean mirror above bathroom sink...clean outside of light over sink...Toilet de-lime and clean...disinfect toilet seat, base and handle...disinfect walls around toilet... clean pipes under sink... dust vent over toilet...clean corners and edges...." On 5/18/15 at 11:42 A.M., an interview was conducted with the Administrator of the facility. The Administrator indicated the facility had done all it could do to eliminate the smell of urine from Room 113. He further indicated in order to completely irradicate the odor the whole bathroom would have to be renovated.			

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 05/19/2015
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
	On 5/19/15 at 3:27 P.M., a family member of a resident who requested to be anonymous indicated "...There ws a strong smell of urine and sewage in the hallways of the facility. It was especially bad on the weekends. Surely they [meaning facility staff] can smell it. They had a ventilation problem. I know there were two ventilation fans that weren't working and corporate's excuse was that it's an old building. The residents can't move out and should not have to smell this day in and day out...." On 5/19/15 at 4:35 P.M., a walk thru of the 100 hallway was conducted with the Administrator of the facility. The Administrator indicated he could not smell a strong odor of urine in the hallway. He further indicated he knew 2 ventilation fans were not working but they were not in the 100 Unit part of the building. 3. On 5/12/15 at 10:46 A.M., an observation was made of Resident #6's room. Two bolsters [a long cylinder cushion that is used for support] were observed on the bed with vinyl missing and stuffing coming out of the bottom of the bolsters. During an interview on 5/18/15 at 10:26 A.M., the Maintenance Supervisor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	indicated he was not aware the bolsters needed repair. He further indicated the procedure for repairs of equipment, such as bolsters or wheelchairs, was done on what he called a "clipboard system." If the staff saw something that needed to be repaired, they wrote it on the clipboard and he then ordered the parts or made the necessary repairs. He indicated the clipboard was checked daily. In regards to the bolsters, the Maintenance Supervisor indicated if he would have known they needed repaired he would have ordered the resident a new pair. 3.1-19(f)			
F 0520 SS=F Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interviews, the facility failed to ensure the Quality Assurance committee met quarterly, and addressed quality/environmental issues. The facility also failed to ensure the Medical Director attended at least quarterly. This had the potential to affect all 57 residents in the facility. Finding includes: During an interview, on 05/19/15 at 4:30 P.M., the Administrator indicated he had started working at the facility towards the end of October 2014. He indicated he was too busy attending serious facility issues and did not initiate a Quality Assurance meeting until January 2015. He indicated although he had noticed an odor issue when he started working in the facility, the QAA committee had not yet identified and/or addressed the odor issues in the building. Finally he indicated the medical director had not yet attended a QAA since the current Administrator had been working in the	F 0520	F520 483.75(O)(1) QAA Committee –members / meet / quarterly /plans Corrective action: Medical Director has attended QAA meeting Identifying others at risk: No residents at risk Preventative measures In place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Medical Director will attendat least quarterly QAA meeting. MedicalDirector did attend meeting QAA on May 27,2015, quarterly QAA meeting schedulehas been set for June, September, and December. Quality assurance program in place: Evidence of compliance will be Medical Director's signatureon meeting agenda. Compliance 6/12/15	06/12/2015

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 05/19/2015
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
	facility. He indicated the previous Administrator had not been having routine QAA meetings. A review of the attendance records from the January - April monthly QAA meetings confirmed the Medical Director was not in attendance. 3.1-52(a)(2) 3.1-52(b)(1)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care fro residents with dementia. This State rule was not met as evidenced by:	F 9999	F9999 Observations Personnel Corrective action: Employees identified will completed required training fordementia and abuse as required Identifying others at risk: Human resources will audit all employee files for complianceof dementia and annual abuse training Preventative measures in place: Human Resources will audit Healthcare Academy training every25 day after a new hire to ensure dementia training is complete. Human Resources will audit Healthcare Academytraining monthly for compliance of annual abuse training. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155086		05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	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
	Based on personnel record review and interview, the facility failed to ensure 5 of 11 employees, working on a dementia unit, had the required dementia training. (Employee #10, #11, #12, #13 and #14) Finding includes: On 5/19/15 at 9:30 A.M., a review of the personnel records were conducted. Employee #10, hired on 10/21/14 and Employee #14, hired on 8/11/14, had not received the required 6 hours of dementia training. Employee #11, hired on 4/1/15, had not received the required dementia training within 30 days. Employee #12 and #13 had not received their annual 3 hours of dementia training. During an interview, on 5/19/15 at 2:33 P.M., the Director of Nursing indicated Employee #11 worked part-time on the dementia unit and Employees #10, #12, #13 and #14 all would be on the unit periodically. 3.1-14(u) 3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This shall include, but not limited to, the		action plan will be put into place to address negativeoutcomes. Compliance 6/12/15	

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 05/19/2015
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
	following: (1) Residents' rights. This State rule was not met as evidenced by: Based on personnel record review and interview the facility failed to ensure 2 of 11 employees, had annual inservices for abuse and resident rights. (Employee #12 and #15) Finding includes; On 5/19/15 at 9:15 A.M., a review of the personnel records were conducted. Employee #12 and #15 had not received their annual abuse and resident rights' training. During an interview, on 5/19/15 at 3:00 P.M., the Director of Nursing indicated inservicing staff was difficult in the facility and she had a thick packet of several staff members who needed to complete their in-services. 3.1-14(k)(1)			