STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE OF DANVILLE	200 S ARBOR LANE, DANVILLE, , 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 470003, 470454, and 470544. Intake Number 470003 - No deficiencies related to the allegations are cited. Intake Number 470454 - State deficiencies related to the allegations are cited at R90. Intake Number 470544 - State deficiencies related to the allegations are cited at R41. Survey dates: June 30 and July 1, 2026 Facility number: 014518 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed on July 11, 2026			
R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on observations, interviews, and record reviews, the facility failed to ensure timely and effective follow up was provided for a resident's grievances related to a potentially hazardous environment for 1 of 3 residents reviewed for grievances (Resident D). Findings include: During an interview on 7/1/26 at 1:00 p.m., Resident D stated she was very upset and frustrated that she could not enjoy her balcony patio because the resident above her fed birds	R 0041		07/22/2026

	from his balcony. As a result, bird droppings, seed shells, feathers, and other discarded bird food fell onto her balcony. She reported that she attempted to move her chairs closer to the door, but bird food still fell onto her while she sat outside. Resident D stated she had complained multiple times to multiple staff members, and her children had also contacted the facility to seek a resolution. She reported that a maintenance staff member had "cleaned" her balcony earlier that morning. At 1:10 p.m. on 7/1/26, an observation of Resident D's balcony revealed copious amounts of discarded bird feed built up between the slats of the balcony floor. Bird-dropping stains were visible on her personal deck chairs, and additional droppings were present on the balcony railing. During the observation, birds repeatedly accessed a feeder located above her balcony, and seed shells were seen falling onto her balcony. Upon re-entering the apartment, the balcony door swept additional bird feed into her living space, which she stated made her afraid she might slip. During an interview on 7/1/26 at 1:20 p.m., Resident D's daughter stated she was upset on her mother's behalf because			

	the balcony was an important feature of the apartment, and Resident D had been looking forward to enjoying the weather and having morning coffee outside. She reported that her mother had not been able to use the balcony without being subjected to falling bird food and droppings. Both Resident D and her daughter had complained to facility staff, but the issue persisted. During an interview on 7/1/26 at 2:00 p.m., the Executive Director (ED) stated the facility was aware of the issue involving Resident D's balcony. The ED reported that the family had called about a month earlier and left a voicemail, after which the ED directed maintenance to sweep the balcony. The ED acknowledged that no further action had been taken to prevent the issue from recurring. When asked about the grievance procedure, the ED stated she typically attempted to address concerns as they were brought to her attention, but she did not document follow up unless the communication occurred through an email thread. On 7/1/26 at 2:00 p.m., the ED provided an untitled document containing a short list of summarized issues. The ED identified it as the Grievance			

	Log. The log contained six summarized grievances; however, Resident D's concerns were not included. As a result, no documented follow up or ongoing resolution strategies were recorded. On 7/1/26 at 2:00 p.m., the ED provided the current facility policy titled, "Resident Grievances," dated 10/31/25. The policy stated, "The community will maintain a system to appropriately receive, investigate, and resolve grievances without any form of retaliation ... The ED or designee will maintain a record of grievances submitted pertaining to Community-provided services, the resulting investigation, and the resolution of the grievance ... Grievances about services may be submitted using the Grievance Report form or using another format, including e mail ... The ED or designee will timely investigate the grievance and provide a response to the complainant as appropriate within ten (10) business days of receipt of the grievance ...." This citation relates to Intake 470544.			
R 0090	Administration and Management - Deficiency	R 0090		07/22/2026

410 IAC 16.2-5-1.3(g)(1-6)

(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:

(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

(A) epidemic outbreaks;

(B)poisonings;

(C) fires; or

(D) major accidents.

If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.

(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interviews and record review, the facility failed to ensure an injury of unknown origin was appropriately investigated to determine the cause of the injury and reported to the long-term care division of the Indiana Department of Health within 24 hours of the injury being found for 1 of 1 residents (Resident B) reviewed for investigating and reporting of an injury of unknown origin.

Findings include:

On 6/30/26 a photo taken on 6/24/26 of Resident B's left foot was provided by Resident B's daughter-in-law. The picture showed Resident B's left leg from mid-calf down to the toes, with an area of bruising noted to the mid-calf area, deep purple lines of bruising across the top to the ankle and deep purple bruising on the ankle and along the entire left side and top of the foot.

On 6/30/26 at 1:15 p.m. Resident B's medical record was reviewed. The resident resided on the memory care unit in the facility.

A progress note, dated 6/24/26 at 10:57 a.m., indicated Resident B had dark purple bruising to the left foot, ankle, and lower leg noted. The note indicated the resident had not had a fall since 6/2/26. The note also indicated Resident B's daughter-in-law was in the facility at the time of the note and the writer of the note called hospice to notify them.

A progress note, dated 6/24/26 at 2:12 p.m., indicated a second call was made to hospice regarding Resident B's bruised and swollen foot and pain. The note indicated an as needed Hydrocodone (a narcotic medication used to treat moderate to severe pain) was administered at that time to treat

the pain.

The record lacked documentation of the bruising before 6/24/26 at 10:57 a.m.

A hospice note, dated 6/24/26 at 5:03 p.m., indicated Hospice Nurse 2 was making an unscheduled visit to assess Resident B for new bruising to the left lower extremity with an unknown cause. He indicated the bruising was dark purple and covered the foot and ankle. Hospice Nurse 2 also noted a small amount of edema (swelling) in the left lower extremity as well.

During an interview on 7/1/26 at 3:17 p.m., the Health and Wellness Director (HWD) indicated on 6/23/26 on 2nd shift, bruising to Resident B's ankle and foot was found. Upon finding the bruising staff contacted the HWD and she told them to call the hospice nurse and notify Resident B's family. The HWD indicated she assessed Resident B herself the next day. She indicated upon that assessment the bruising was noted to be further down the foot than it had been on the previous day's assessment reaching to the toes. The HWD, Executive Director (ED), and Hospice Nurse 2 discussed the bruising and she indicated they all agreed the bruising was pooling of blood from a previous

fall on 6/2/26 that caused bruising to the Residents' left hip. She indicated she believed that the bruising sustained to Resident B's left hip in the fall on 6/2/26 had gradually moved down her leg and pooled in her lower leg and foot due to poor circulation and the resident's limited range of motion in the lower extremities. The HWD indicated after the discussion she and the ED met with Resident B's daughter in law and spoke to her about the bruising. The HWD indicated after speaking with Resident B's daughter-in-law, she agreed it could have been from pooling, but she was still upset that she wasn't notified sooner. The HWD indicated they told her that they notified her of the bruising as soon as they found it. The HWD indicated they did not consider this bruising to be new or of unknown origin, so they did not report it or investigate it further because they believed they knew the origin of the bruising.

The medical record lacked documentation of Resident B's family member being notified of the bruising found on 6/23/26.

During an interview on 7/1/26 at 3:38 p.m. Resident B's daughter-in-law indicated she had gone into the facility to visit her mother-in-law on the night of

	6/23/26 and found extensive bruising along Resident B's left lower leg, ankle and foot. She indicated no staff member had tried to reach out to her about this bruising, and when she told the staff on shift at that time about it, they seemed to not know anything about the bruising. Resident B's daughter-in-law indicated she couldn't understand how they missed the bruising as she had camera footage of staff assisting Resident B earlier that same day where you can clearly see the bruising. She indicated the facility was blaming the bruising on blood pooling from a fall the resident had almost a month ago, but she wasn't sure that that was the actual cause. On 7/1/26 at 4:00 p.m. a still image from a video taken on 6/23/26 at 6:42 p.m. was provided by Resident B's daughter-in-law. The image showed an unknown facility staff member facing Resident B who was lying in bed half covered by a flat sheet, with the residents' left leg sticking out from under the sheet making it visible in the image. The image showed the resident's' left leg had an area of bruising to the mid-calf area and deep purple bruising from just above the ankle to down across the top of the foot to the toes. During an interview on 7/2/26 at			

	11:08 a.m. Hospice Nurse 2 indicated Resident B had a fall on 6/2/26 and afterward complained of hip pain. He indicated they ordered an x-ray and it showed no broken bones. Hospice nurse 2 indicated it seemed the pain had started to go away, but in his opinion the facility was pushing the resident kind of hard to walk with a walker even with the recommendation that she rest and use a wheelchair while her pain subsided. Resident B's daughter-in-law contacted Hospice Nurse 2 about the bruising on 6/23/26, not the facility, he went in to see the resident and assess the bruising the next day. When Hospice Nurse 2 arrived at the facility he indicated he had the resident take a few steps and put weight on the affected foot, and it appeared to him that Resident B did not have any pain in her foot. Hospice Nurse 2 indicated from his assessment he felt there could have been a number of reasons for the bruising, one of which could have been pooling of blood from poor circulation and limited mobility, but he made a point to specifically say in his note that it was new bruising of unknown origin because based on his assessment alone he could not determine the cause. Hospice Nurse 2 reiterated that Resident B's daughter-in-law was the one			

that reached out to him about the bruising, although the staff did seem to know about it when he assessed the Resident on 6/24/26.

On 7/2/26 at 12:03 p.m. a copy of a facility grievance log was provided. That log indicated on 6/24/26 Resident B's daughter in law noted bruising on the resident's left foot and ankle.

The record lacked documentation of a thorough investigation into the origin of new bruising and lacked documentation of a report being made to the Indiana Department of Health of a new injury of unknown origin.

On 7/1/26 at 4:37 p.m. a copy of a current facility policy titled, "Accidents, Incidents, and Unusual Occurrences," dated 6/11/26, was provided. That policy indicated, " ... Definitions. Incident: any unforeseen or unplanned event or any other irregular happening in the routine operations of the company ... Policy. Incidents will be responded to and investigated timely as warranted by the nature of the incident ... The community will comply with statutory and regulatory requirements for reporting incidents ... to the appropriate governmental agencies ...."

This citation relates to Intake

	470454.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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