STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED		
IIID I DAIN	- Columbia	155086	B. WI			11/14/	
NAME OF P	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
WOODLA	AND MANOR			ELKHA	RT, IN 46514		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 0000	00						
Bldg. 00	Licensure Survey. Investigation of Co IN00442686, IN000 and IN00446377.  Complaint IN004442 related to the allegations are of Complaint IN004442 related to the allegations are of Complaint IN004442 related to the allegations are of Complaint IN004444 related to the allegations are of Complaint IN004444 the allegations are	2899 - Federal deficiencies ations are cited at F925. 6004 - Federal deficiencies ations are cited at F580. 6365 - No deficiencies related to cited. 6377 - No deficiencies related to cited. ember 7, 8, 12, 13 and 14, 2024 20034 55086 674880	F 00	000	By submitting the enclosed materials, we are not admittir truth or accuracy of any spec findings or allegations. We re the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance effect December 14, 2024, for the complaint survey completed November14, 2024.	ific serve gs or e	

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

(X6) DATE

TITLE

Chris Chalman Interim Administrator 12/13/2024

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155086	B. W	ING		11/14/	2024
	PROVIDER OR SUPPLIER		•	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	accordance with 410	0 IAC 16.2-3.1.					
	Quality Review completed on 11/26/2024						
F 0580	483.10(g)(14)(i)-(i	v)(15)					
SS=E Bldg. 00	Notify of Changes (Injury/Decline/Room, etc.)						
	Based on record review and interview, the facility			580	F 580 Notify of Changes		12/14/2024
		physician timely of changes for			What corrective action will b	е	
		ngs outside of the ordered			accomplished for those		
	parameters for 2 of 3 residents reviewed for insulin				residents found to be affecte		
	usage (Resident 30 & M), for 1 of 2 residents reviewed for death (Resident H) and for 1 of 3				by the deficit practice:The bloom		
					sugars for resident 30 and res		
	residents reviewed i	for accidents (Resident 12).			M were printed off to be review		
	F' 1' ' 1 1				by the medical provider and or		
	Findings include:				changes made if indicated. The nurse practitioner was notified		
	1. A record review t	for Resident 30 was completed			the burn for resident 12 on 9/2	20/24	
	on 11/12/2024 at 9:3	33 A.M. Diagnosis included,			and the right arm pain on 11/8	3/24.	
	but were not limited	l to Diabetes Type 2, Hepatitis			Resident H no longer resides	in	
	B, depression, anxie	ety, and dementia.			the facility. How other resider	nts	
					having the potential to be		
	-	cian Orders included, but were			affected by the same deficit		
	not limited to:				practice will be identified and		
	Humalog (a rapid ac	÷-			what corrective action will be	-	
		e meals per sliding scale of			taken:All residents who are or	า	
	_	if 250 to 500 give 6 units and			insulin with blood sugar		
	if over 400 call the				parameters ordered or with a		
	•	for blood sugar levels and call			change of condition have the		
		is less than 60 or over 400.			potential to be affected by the		
		) insulin pen - inject 20 units			alleged deficient practice. The		
	subcutaneously two	umes a day.			progress notes of all residents		
	A current Care Plan, dated 12/3/2024 and revised 5/16/2024, indicated Resident 30 had a diagnosis of Type 2 diabetes with interventions including but not limited to administer my medications as				the eMar of residents who have orders for blood sugar checks		
					were reviewed to identify cond		
					changes and blood sugar read		
					outside the established	an igo	
		n and blood sugar checks as			parameters and notification man	ade	
	ordered by physicia	_			to the medical provider if indic		
	ordered by physician.				What measures will be put in		

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CENTERS FOR MEDICARE & MEDICAID SERVICES	ARTMENT OF HEALTH AND HUMAN SERVICES
	TERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155086	B. WI				2024
				CED FEET	A PRINCIPLE OF A THE COR		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
1440001					IAPPANEE ST		
WOODLA	WOODLAND MANOR			ELKHAI	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The Medication Ad	ministration Record (MAR)			place and what systematic		
	dated October 2024	indicated Resident 30's blood			changes will be made to		
	glucose reading's or	n the following dates were:			ensure the deficit practice do	es	
	-10/07/2024 at 11:3	0 A.M. as 530			not recur.The policy and		
	-10/07/2024 at 11:3	0 A.M. as 500			procedure for Acute Condition		
					Changes – Clinical protocol wa		
	The MAR dated Oc	tober 2024, lacked the			reviewed by the IDT. An in-ser		
		now Resident 30 had received			was provided to licensed nurse		
	insulin on the follow	wing dates/times: 11:30 A.M.			on immediate notification to the		
	on 10/9/24, and 5:3	0 P.M. on 10/1, 10/6, 10/18, and			medical provider for blood sug		
	10/28/2024				readings outside the establishe		
					parameters or significant cond		
	The MAR dated November 2024 indicated				changes. Progress notes and		
	Resident 30 blood glucose reading on 11/12/2024				charts of residents receiving b	lood	
	at 8:00 P.M. was 450.				sugar checks will be reviewed		
					the morning clinical meeting. A		
	The MAR dated Oc	tober 2024, lacks the			quality assurance audit tool ha		
	documentation to sl	now Resident 30 had received			been developed to ensure med		
	insulin in the follow	ving dates/times: 11:30 A.M. on			provider notification has been		
	11/1, 11/3, 11/4, and	d 11/10/2024 and at 5:30 P.M. on			completed for those residents		
	11/1, 11/4, and 11/5	5/2024.			whose blood sugars are outsid	le of	
					established parameters or		
	During an interview	y, on 11/13/24 at 12:21 P.M.,			experience a significant condit	ion	
	LPN 19 indicated w	hen residents had a blood			change. How the corrective		
	glucose out of range	e, they would notify the			action will be monitored to		
	physician and make	a progress note. If additional			ensure the deficit practice wi	II	
		they would put it in the note,			not recur, i.e., what quality		
	but he would not w	rite it as an order.			assurance program will be p	ut	
					into place.The Quality Assura	nce	
	The chart lacked do	cumentation to show the			Audit Tool will be completed by	y	
	physician was notif	ied of the blood glucose			the Director of Nursing /Desigr	nee	
	readings over 400 a	nd no documentation to show			on all residents to identify		
	physician notification	on of missed insulin doses.2.			condition changes and those v	vith	
	A record review for	Resident 12 was completed,			blood sugar checks for three		
		20 A.M. Diagnoses included,			weeks, then monthly for three		
	but were not limited	l to: hemiplegia affecting right			months, then quarterly x three	. In	
	dominant side, apha	asia, contracture of right			the event any further concerns	are	
	elbow, wrist and ha	nd, dementia, right foot drop			identified, the issue will be		
	and polyneuropathy	7.			immediately corrected, and		
					additional training will be initiat	ted.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED		
		155086	B. W	'ING		11/14/	/2024		
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
		•			IAPPANEE ST				
WOODLA	AND MANOR			ELKHART, IN 46514					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE		
		um Data Set (MDS) 0/17/2024, indicated Resident			Results of the audit will be				
		intact. She had impairment to		reviewed at the Quality Assurance Meeting at least quarterly.Date					
		extremity on one side and			this deficiency will be correcte				
		lean up assistance for dining			January 6, 2025	u.			
	services.	1 8			oaaa., 0, 2020				
	A Nursing Progress Note, dated 9/19/2024 at 4:08								
	1	nurse entered Resident 12's							
		r was completed where the							
	l ~	sistant (CNA) observed burns							
	on both of Resident 12's inner thighs. Resident 12								
	indicated to the nurse that she had wheeled herself in her wheelchair to the nurse's station to								
	herself in her wheelchair to the nurse's station to get a cup of coffee and the CNA may have filled								
		nen Resident 12 placed the cup							
	_	to hold it while self-propelling							
	_	coffee spilled from the opening							
		and burned her. Resident 12							
	indicated she did no	ot tell anyone about the burn.							
	A Nursing Progress	Note, dated 9/19/2024 at 6:56							
		ident 12 had bilateral redness							
	l '	thighs with no blistering.							
		ed that the 1st degree burns							
		ours ago and reported							
	symptoms of itching	g and burning without pain.							
	A Nursing Progress	Note, dated 9/20/2024 at 8:06							
		sident 12's left thigh burn had a							
		nter of the burn from Resident							
	12 itching the area	and her brief rubbing the area.							
	The redness of the bilateral upper thighs								
		left side being about a fist size							
	and the right side be	eing the size of a quarter.							
	A Nursing Progress Note, dated 9/20/2024 at 11:27								
		asurements of the burns were							
	obtained. The left th	nigh burn measured 3							
	centimeters by 5 cen	ntimeters with a scabbed							

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/14/2024		
	PROVIDER OR SUPPLIER  AND MANOR	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	center of 2 centimeters by 0.25 centimeters. The right thigh burn measured 2 centimeters by 3 centimeters. Resident 12 denied any discomfort.					
	A Nurse Practitioner Note, dated 9/20/2024 at 11:30 A.M., indicated the Nurse Practitioner was notified of the burns to the bilateral, medial upper thighs. The Nurse Practitioner provided orders including, but not limited to: to gently wash the areas with cool water, pat dry, apply Silvadene cream twice daily and leave open to air for seven days.					
	During an interview, on 11/14/2024 at 9:16 A.M., the Director of Nursing (DON) indicated the physician and/or nurse practitioner should be notified immediately for any change of condition. The DON indicated he assessed the burns and contacted the nurse practitioner when he was informed on 9/19/2024 of the burns, but did not feel it was an emergency. He indicated there was no documentation in the medical record that this assessment or nurse practitioner contact had occurred timely.					
	During an interview, on 11/07/2024 at 10:07 A.M., Resident 12 indicated she had fallen and was pointing to her right arm.					
	During an observation on 11/13/2024 at 9:37 A.M., Resident 12 was observed with a sling to her right arm.					
	A Nursing Progress Note, dated 11/5/2024 at 3:38 P.M., indicated Resident 12 was observed to have gotten her wheelchair stuck and it started to tip. Resident 12 had her right side wedged between the over the bed table and bed with her weight against her. Resident 12's immobility to the right side, caused her not to be able to free herself and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155086	B. WING 11/14/2024			2024	
				CTREET	ADDRESS CITY OTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
WOODLA	AND MANOD				IAPPANEE ST		
WOODLAND MANOR				ELKHAI	RT, IN 46514		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	because she struggle	ed to free herself caused the					
	wheelchair to tip an	d Resident 12 shifted out of					
	the wheelchair. Res	ident 12 knocked over several					
	personal items and	a cup of coffee as she					
	struggled to free her	rself. Resident 12 indicated					
	she was not in pain,	, except for the usual pain in					
	_	ent 12's right leg was observed					
		narks from being wedged.					
	Resident 12 indicate	ed she was fine and was more					
	embarrassed than ar	nything.					
	A Nursing Progress	Note, dated 11/8/2024 at 2:23					
	P.M., indicated Res	ident 12 was complaining of					
	right arm pain. The	nurse practitioner was notified,					
	and an order was ob	otained for a stat (immediately)					
	x-ray.						
	A Nursing Progress	Note, dated 11/8/2024 at 7:20					
	P.M., indicated the	x-ray company was in the					
	building to obtain th	ne ordered images.					
	A General Nurse Pr	ractitioner Note, dated					
	11/10/2024 at 8:39	P.M., indicated she had been					
	informed by the DC	ON of Resident 12's x-ray					
	results obtained on	11/8/2024. The x-ray of the					
	right humerus indic	ated an acute nondisplaced					
	fracture of the proxi	imal humeral					
	metaphysis/nonsurg	gical humeral neck and severe					
	diffuse osteopenia.	A referral to orthopedics was					
	provided.						
	A General Nurse Pr	ractitioner Note, dated					
	11/10/2024 at 8:54	P.M., indicated she had					
	received a call from	the facility nurse reporting the					
	results of the x-ray						
	·						
	A Nursing Progress Note, dated 11/11/2024 at 8:33 A.M., indicated Resident 12 was informed of the						
	abnormal x-ray resu						
	•						
			- 1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/14/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
TAG	During an interview the Director of Nurse the Director of Nurse physician and/or nurse on the physician and/or nurse on the physician and/or nurse on the physician and/or nurse on 11/12/2024 at 3: but were not limited alcohol cirrhosis with with septic shock.  An Admission Minassessment, dated 1 was cognitively into the physician and progress P.M., indicated Reson the floor next to movement on the floor with his has the physician and progress P.M., indicated Reson the floor with his has resident H was conlocation. Resident H was conlocation. Resident H for progress per minute, and breaths per minute. The percent on the progress P.M., indicated Reson was 77 percent on the minute via nasal can all progress progress percent on the physician physician and progress percent on the physician and progress physician and progress physician and progress percent progress physician and prog	Note, dated 10/26/2024 at 3:58 ident H was observed sitting the bed with a bowel oor.  Note, dated 10/26/2024 at 7:15 ident H was found sitting on ead resting on the bed. If the second of the second	TAG	DEFICIENCY	DATE			
		cent on three liters of oxygen						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	ì í	JILDING	nstruction 00	(X3) DATE : COMPL 11/14/	ETED
	PROVIDER OR SUPPLIER	<u>.</u>	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	per minute via nasa 97/52 mmHg, a pull and a respiration rat respiratory treatmer mouthpiece close to would move the mouthpiece of P.M., indicated Responsible of 66 beats per of 24 breaths per mouthpiece A Nursing Progress P.M., indicated of 100.2 F (Fahrenh 63 percent on three nasal cannula. The cliters per minute and increased to 70 percentinued not to be the confusion continued not to be the confusion continued Responsible P.M., indicated Responsible P.M.,	I cannula, a blood pressure of se rate of 62 beats per minute, to of 24 breaths per minute. A at was completed keeping the othe mouth, but Resident H buthpiece away from his mouth.  Note, dated 10/26/2024 at 8:30 ident H had vital signs of the saturation of 95 percent on en per minute via nasal essure of 100/62 mmHg, a er minute, and a respiration rate inute.  Note, dated 10/26/2024 at 9:00 ident H continued resting in ms noted or voiced.  Note, dated 10/26/2024 at Resident H had a temperature seit) and oxygen saturations of liters of oxygen per minute via oxygen was increased to four d his oxygen saturations sent. Resident H was restless, able to know his location with		TAG	DEFICIENCY		DATE
	P.M., indicated Res saturation of 75 per per minute via nasa	Note, dated 10/26/2024 at 9:47 ident H had an oxygen cent on five liters of oxygen I cannula and his breath ag anteriorly and posteriorly.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	r í	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155086	B. WING	G <u>00</u>	-	11/14/2024	
		100000		SET ADDRESS OF VICTATE ZID CO	•	1,2021	
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CO S NAPPANEE ST	D		
WOODL	WOODLAND MANOR			HART, IN 46514			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE AP	PROPRIATE	COMPLETION DATE	
TAG	REGULATORTO	K ESC IDENTIFY TING INFORMATION	IAG			DATE	
		s Note, dated 10/26/2024 at 9:51 enurse practitioner was called.					
	During an interview, on 11/14/2024 at 9:55 A.M., the Director of Nursing indicated the nurse						
	_	have been contacted sooner					
	for the change of c	ondition.					
	<ul> <li>4. A record review for Resident M was completed on 11/12/24 at 11:23 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and vascular dementia.</li> <li>An Annual Minimum Data Set (MDS) assessment, dated 9/11/2024, indicated Resident M had a</li> </ul>						
	severe cognitive de	eficit and received insulin.					
	Δ Physician's Orde	er, dated 1/26/2024, indicated					
	-	00 units per milliliter, inject 18					
		sly at bedtime and notify the					
		actitioner of a blood sugar					
	_	g/dL (milligram per deciliter) or					
	less than 60 mg/dL						
	A Physician's Orde	er, dated 9/30/2024, indicated to					
	_	ar daily to notify the medical					
	_	d sugar greater than 400 mg/dL					
	or less than 70 mg/	/dL.					
	The following bloc	od sugars were documented in					
	the medical record	:					
	-11/8/2024 5:24 P.M. 490.0 mg/dL						
	-11/6/2024 8:13 P.	_					
	-11/2/2024 7:52 P. -10/30/2024 7:46 F	_					
		•					
-10/24/2024 10:19 P.M. 435.0 mg/dL -10/20/2024 9:10 P.M. 500.0 mg/dL							
	-10/20/2024 8:11 F	P.M. 500.0 mg/dL					
	-10/17/2024 4:44 F	P.M. 438.0 mg/dL					

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		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		ΓE	(X5) COMPLETION DATE
		-10/16/2024 7:18 P10/16/2024 5:14 P10/15/2024 8:41 P10/13/2024 8:39 P10/13/2024 8:10 P10/13/2024 4:38 P10/12/2024 11:41 P10/11/2024 11:32 P10/10/2024 5:09 P10/10/2024 5:09 P10/9/2024 4:40 P.N10/7/2024 12:13 40 P.N10/3/2024 12:13 P.N.	M. 478.0 mg/dL M. 457.0 mg/dL M. 430.0 mg/dL M. 430.0 mg/dL M. 495.0 mg/dL M. 495.0 mg/dL M. 442.0 mg/dL M. 448.0 mg/dL A.M. 419.0 mg/dL A.M. 404.0 mg/dL M. 404.0 mg/dL M. 401.0 mg/dL M.					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				COMPLETED	
		155086	B. W	B. WING 11/14/2			2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
		equest a prompt response ely one-half hour or less]"						
	This citation relates to complaint IN00446004.							
	3.1-5(a)(1)							
	3.1-5(a)(2)							
	3.1-5(a)(3)							
F 0622 SS=D Bldg. 00	SS=D Transfer and Discharge Requirements							
	Based on record review and interview, the facility failed to ensure pertinent transfer and resident clinical information was completed for neccessary hospital transfers for 1 of 4 residents reviewed for hospitalization. (Resident B)  Finding includes:  A record review for Resident B was completed on 11/08/2024 at 2:32 P.M. Diagnosis included but		F 06	522	F 622 Transfer and Discharge Requirements What corrective actions will accomplished for those residents found to have beer affected by the deficient practice?  Corrective action is unable to be completed for resident B previous noncompliance.	be 1	12/14/2024	
	were not limited to Cerebral Palsy, hydronephrosis, urogenital implants, and obstructive and reflux uropathy.  A Nursing Progress Note, dated 6/19/24 at 11:45 A.M., indicated Resident B had returned from the hospital.				Resident Bs physician w notified that physicians orders were not put into the electronic medical record for the previou	C		
					transfers  How other residents have the potential to be affected by the same deficient practice will the same deficient practice.	е		
	was obtained prior t hospital. In addition				identified and what corrective actions will be taken?  Other residents who are transferred to the hospital have potential to be affected.  The SSD/designee will complete an audit of residents.	<b>e</b> e the		
	A.M., indicated Res	Note, dated 8/16/2024 at 12:00 sident B was transferred to a ck and abdominal pain.			who were transferred to the hospital in the last 30 days to ensure that the resident and/o			

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155086	B. WI	NG		11/14/	2024
				CED FEET	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
1440001					NAPPANEE ST		
WOODLA	AND MANOR			ELKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					responsible parties have been		
	The chart lacked a physician's order to send				provided with a notice of		
	Resident B to the hospital and there was no				transfer/discharge and a bed h	nold	
		a transfer/discharge form or			policy. Notices will be sent to		
		s provided by the facility to the			those who did not receive thes	se.	
		r representative for this			notices.	,,,	
	transfer.	Topico di mino			The DON/designee will		
	u u u u u u u u u u u u u u u u u u u				complete an audit of residents		
	A Nursing Progress	s Note, dated 11/4/2024 at 09:59			transferred to the hospital x's I		
		ident B was on a LOA (Leave			30 days to ensure a physician		
	of Absence) for sur				order was obtained. The physi		
	of Mosence, for sur	gery.			will be notified if an order was		
	The chart lacked documentation to show a				obtained.	ΠΟι	
	transfer/discharge form and bed hold policy was				What measures will be put in	4.0	
	provided by the facility to the resident and/or				-	10	
	their representative	-			place or what systemic		
	men representative	for this transfer.			changes will be made to		
	During an intervious	v, on 11/13/2024 at 09:31 A.M.,			ensure that the deficient		
	_	hey have a checklist of all the			practice does not recur?		
		-			The DON/designee will		
		do when they sent someone			provide education to licensed		
	-	uding but not limited to:			nursing staff on the requireme		
	-	c/discharge form, a bed hold,			obtain a physicians order and	put	
	_	ne transfer in a nursing			the order into the electronic		
		V 20 indicated they do not write			medical record to send to the	EK.	
		to send someone to the			The DON/designee will		
	hospital.				provide education to licensed		
	D	11/12/2024 4 10 00 4 3 5			nursing staff and the SSD on t		
	_	v, on 11/13/2024 at 10:00 A.M.,			requirement to provide a notice		
		he nurses had a checklist of			transfer/discharge and a bed h	nold	
		ansfer that two nurses were			policy to the resident and/or		
		nce completed. This checklist			responsible party for transfers	to	
		ing: transfer/discharge form,			the hospital.		
		d documenting a nursing			How the corrective actions w	rill	
		N 19 indicated the Nurse's Note			be monitored to ensure the		
		ical information, physician			deficient practice will not		
	notification and a physician's order to send the				recur, i.e., what quality		
	resident to the hospital had been obtained.				assurance program will be p	ut	
					into place?		
	During an interview, on 11/14/2024 at 8:55 A.M.,				The DON/designee will		
	the Quality Assurar	nce Administrator indicated			complete routine auditing of a	cute	
					l .		

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

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155086	B. WIN	G		11/14/	/2024	
WOODL	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG:		TE	(X5) COMPLETION	
TAG	she could not prov	-		TAG	transfers to ensure that a		DATE	
	transfer/discharge	forms for Resident B.			physician's order was obtained			
	3.1-12(a)(6)(A)				and out into the electronic me- record, as well ensuring a noti of transfer/discharge and bed	ce		
					policy was provided to the res			
					and/or responsible party for a	cute		
					transfers to the hospital. Audit	ing		
					to occur: with each hospital			
					transfer x's 4 wks, then 4			
					residents monthly x's 5 month			
					a total of 6 months of monitori	-		
					The results of these revi			
					will be immediately reported if			
					concerns exist and will be discussed at the monthly facili	t.,		
					Quality Assurance Committee	-		
					meeting monthly for three mor			
					and then quarterly thereafter of			
					full compliance has been achie			
					for a total of 6 months of			
					monitoring. Re-education,			
					frequency and/or duration of			
					reviews will be increased as			
					needed, if areas of noncompli	ance		
					are identified through the inter	view		
					process.			
L 0000	400 45( )(0) (0) (1)	2)						
F 0623 SS=E	483.15(c)(3)-(6)(8	•						
SS=E   Bldg. 00	Notice Requireme							
Bidg. 00	Transfer/Dischard	ge view and interview, the facility	F 062	12	F623 Notice Requirements		12/14/2024	
		ransfer/discharge form was	F 062	.3	before Transfer/Discharge		12/14/2024	
		residents reviewed for			Scrole Hansier/Discharge			
	_	esidents B, 52, 55, 69)			What Corrective action(s) wi accomplished for those	II be		
	Findings include:	Findings include:  1. A record review for Resident B was completed			residents found to have been	า		
	1 A record ression				affected by the deficient			
		2:32 P.M. Diagnosis included but			practice?			

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THE STANDARD REPORTED AND DESCRIPTION OF THE STANDARD STA						CLIDATEN.	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155086	B. W	ING		11/14/	/2024
		_	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	ROVIDER OR SUPPLIEI	₹			NAPPANEE ST		
WOODLA	AND MANOR				RT, IN 46514		
(X4) ID	SHMMARV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
TAG	were not limited to			IAG	Resident's B, 52, 55, 69		DATE
		ogenital implants, and			had no adverse effects from		
	obstructive and refl				alleged deficient practice.		
	obstructive and remain arepainty.				Resident 69 no longer resides	· in	
	Δ Nursing Progress	s Note, dated 6/19/24 at 11:45			the facility.	) II I	
	A.M., indicated Resident B had returned from the				the facility.		
	hospital.				How other residents having	tho	
	позріші.				potential to be affected by the		
	The chart lacked documentation a				same deficient practice will		
	transfer/discharge form was provided by the				identified and what corrective		
	facility to the resident and/or the resident's				action(s) will be taken?	/ <del>C</del>	
	representative for this transfer. In addition, the				action(3) will be taken:		
	Ombudsman was not notified of the resident's				All residents residing in	tha	
	transfer.				health care area have the pot		
	transier.				to be affected by this alleged	Cittai	
	A Nursing Progress	s note, dated 8/16/2024 at 12:00			deficiency. DON or designee	will	
		t Resident B was transferred to			review all resident with a disc		
	· ·	back and abdominal pain.			from the facility to ensure	largo	
		F			notification of the Ombudsma	n	
	The chart lacked do	ocumentation a			was completed on a monthly	•	
	transfer/discharge f	form was provided by the			basis.		
	_	ent and/or the resident's			230.0.		
	-	his transfer. In addition, the			What measures will be put in	nto	
	-	ot notified of the resident's			place or what systemic char		
	transfer.				will be made to ensure that	-	
					deficient practice does not		
	A Nursing Progres	s Note, dated 11/4/2024 at			recur?		
		ted resident B was out for a					
	LOA (Leave of Ab	sence) for surgery.			DON or designee will		
					re-educate the Social Service	s	
	The chart lacked do	ocumentation a			Director on the following camp	ous	
	transfer/discharge f	form was provided by the			guideline: SOP Notice of trans	sfer	
	facility to the reside	ent and/or the resident's			or discharge communication t		
	representative for this transfer. In addition, the				ombudsman		
	Ombudsman was not notified of the resident's						
	transfer.				How the corrective actions(s	s)	
					will be monitored to ensure	-	
	During an interview, on 11/13/2024 at 09:31 A.M.,				deficient practice will not re	cur,	
	LPN 20 indicated to	hey have a checklist of all the			i.e, what quality assurance		
	things they are to do when they send someone to				program will be put into place	ce?	

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CENTERS FOR	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	a. building <u>00</u>		COMPL	LETED
		155086	B. WING	·		11/14	/2024
	PROVIDER OR SUPPLIER	<b>1</b>		343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514	ı	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ing but not limited to: sending					
	_	ge form and documenting a			The Administrator or		
	nursing note.	ge rerm and accumenting a			designee will complete weekly	ı,	
	harbing note.				auditing of ombudsman notific		
	During an interview	v, on 11/13/2024 at 10:00 A.M.,			of transfer/discharge x's 1 mo		
	_	he nurses have a checklist of			then monthly x's 5 months for		
		ansfer that two nurses were			total of 6 months of monitoring		
	_	ansier that two hurses were nee completed, this included			The results of these revi	•	
	but was not limited	•			will be discussed at the month		
		_			facility Quality Assurance	ııy	
	transfer/discharge form and documenting a nursing note.				•	0	
					Committee meeting monthly for	or 3	
	D	11/14/2024 -4 9.55 A M			months and then quarterly	-4	
	During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated				thereafter once compliance is		
					100%. Frequency and duration	on of	
		any further Transfer/discharge			reviews will be increased as		
	forms in the buildir	ng for Resident B.			needed, if compliance is below	W	
					100%.		
	_	v, on 11/14/2024 at 1:10 P.M.					
		rker, regarding documentation					
	_	dsman notification of resident					
		onths of June and August 2024,					
		ent B was not on the list					
	provided to the Om						
		for Resident 52 was completed					
		56 P.M. Diagnoses included,					
		d to: chronic obstructive					
		(COPD), pneumonia and acute					
	respiratory failure.						
		um Data Set (MDS)					
		0/17/2024, indicated Resident					
	52 was cognitively	intact.					
	A Nursing Dragge	s Note, on 5/27/2024 at 4:05					
		2:45 A.M. Resident 52					
	· ·						
		sounds to be evaluated.					
	_	sounds had scattered wheezing					
	posteriorly and exp	iratory wheezing anteriorly.					1

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Resident 52 refused a nebulizer treatment or an as needed inhalation medication. Resident 52

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155086	B. WI			_ 11/14/2024	
	PROVIDER OR SUPPLIER	2		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne had bronchitis and needed					
		offered for hospice to be called					
	for further instruction. Resident 52 decided to call the Emergency Medical Services for transfer.						
	the Emergency Med	dical Services for transfer.					
	A Nursing Progress Note, on 7/25/2024 at 8:10						
		sident 52 called emergency					
		ansfered to the hospital. The					
		ice services of Resident 52's					
	transfer to the hospi	ital.					
	A Muraina Droaraga	Note on 0/26/2024 at 11:01					
	A Nursing Progress Note, on 9/26/2024 at 11:01 A.M., indicated Resident 52 requested to be sent						
	to the hospital.						
	•						
	The medical record	lacked any of Resident 52's					
	transfer forms from	the facility.					
		11/12/2024 . 10 20 4 35					
	1	v, on 11/13/2024 at 10:29 A.M.,					
		nce Administrator produced a  I medical records to review for					
		ge forms. After the stack was					
		ty Assurance Administrator					
		ot think they had any of the					
	transfer and/or disc						
	_	v, on 11/14/2024 at 8:55 A.M.,					
		nce Administrator indicated					
		ny further transfer and					
		er looking for the forms the					
		ated Resident 52 should have lischarge form completed.					
	nau a transfer and d	nscharge form completed.					
	3. A record review	for Resident 55 was completed					
		0:18 A.M. Diagnoses included,					
		d to: congestive heart failure					
	and pneumonia.						
		Note, on 8/17/2024 at 7:12					
	A.M., indicated Res	sident 55 was sitting on the	1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		11/14/	2024
				CEREE	DDDEGG CUTY CTATE JID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
14/00DL	AND MANOD				IAPPANEE ST		
WOODLA	AND MANOR			ELKHAI	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		16	DATE	
	edge of the bed with	n shortness of breath,					
	diminished lung sounds, a blood pressure of						
	175/119 mmHg (millimeters of mercury) and a pulse						
	of 133 beats per minute.						
	1						
	There was no documentation that Resident 55 was						
	transferred to the ho	ospital. However, a Nursing					
		/20/2024 at 2:40 A.M.,					
	_	55 was readmitted to the					
		hospital stay for heart failure,					
	-	and elevated troponin.					
	The medical record	lacked documentation a					
		orm was provided by the					
		ent and/or the resident's					
	representative.	and of the resident s					
	тергезении с.						
	During an interview	y, on 11/13/2024 at 10:29 A.M.,					
	-	ice Administrator produced a					
		medical records to review for					
		ge forms. After the stack was					
		ty Assurance Administrator					
		of think they had the transfer					
	and discharge forms	-					
	and discharge forms	s for Resident 33.					
	During an intervious	y, on 11/14/2024 at 8:55 A.M.,					
	-	ice Administrator indicated					
		ny further transfer and					
	_	er looking for the forms the					
		ated Resident 55 should have					
	nad a transfer and d	ischarge form completed.					
	4 4 1	f D: 1 1					
		for Resident 69 was completed					
		P.M. Diagnoses included, but					
		chronic pancreatitis, atrial					
	fibrillation and acut	e cholecystitis.					
		27.					
		Note, on 9/16/2024 at 6:05					
		ident 69 was observed to be					
	drowsy and disorier	nted. Resident 69's blood					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted 2024
	PROVIDER OR SUPPLIER	<b>.</b>		343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	per minute, oxygen respirations were 1	mmHg, pulse was 130 beats saturation was 88 percent and 8 breaths per minute. Resident to the hospital via an					
		ss Note, dated 9/16/2024 at 8:57 sident 69 returned to the					
	A.M., indicated the 69's skin coloring v Resident 69 was pa abnormal, and her opercent on room air	s Note, on 9/21/2024 at 11:41 nurse was notified of Resident vas not within normal limits. le; her demeanor was oxygen saturations were 82 The nurse practitioner was nt 69 decided to be transferred					
		s Note, on 9/24/2024 at 8:22 sident 69 would not be ility.					
	transfer/discharge f	lacked documentation a form was provided by the ent and/or the resident					
	the Quality Assurar stack of un-scanned transfer and dischar reviewed, the Quali	w, on 11/13/2024 at 10:29 A.M., nee Administrator produced a dimedical records to review for rege forms. After the stack was ity Assurance Administrator of think they had the transfer is for Resident 69.					
	the Quality Assurar	v, on 11/14/2024 at 8:55 A.M., nee Administrator indicated any further transfer and er looking for the forms the					

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	ARTMENT OF HEALTH AND HUMAN SERVICES TERS FOR MEDICARE & MEDICAID SERVICES								
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE C A. BUILDING B. WING	onstruction ()	(X3) DATE SURVEY COMPLETED 11/14/2024				
	PROVIDER OR SUPPLIER	3	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514					
(X4) ID PREFIX	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
TAG	prior day. She indic	R LSC IDENTIFYING INFORMATION cated Resident 69 should have lischarge form completed.	TAG	DIA CLEACT!	DATE				
	Assurance Administry. The policy, tit Facility-Initiated", the facility, residen the facility. Facility discharges, when notification and ories as specified in this Discharge [Emerge Under the following given as soon as it is transfer or discharge	as provided by the Quality strator, on 11/14/2024 at 1:54 cled, "Transfer or Discharge, indicated,"Once admitted to the shave the right to remain in reinitiated transfers and eccessary, must meet specific resident/representative entation, and documentation policyNotice of Transfer or not of Therapeutic Leave] 3. In g circumstances, the notice is its practicable but before the eter. An immediate transfer or and by the resident's urgent							
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hol	d Policy Before/Upon Trnsfr							
-	failed to provide a l residents reviewed 52, 55, 69 & B)	views and interview, the facility oed hold form for 4 of 4 for hospitalizations. (Resident	F 0625	F 625 Notice of Bed Hold Policy Before/Upon Transfer What corrective actions will b accomplished for those residents found to have been					
	on 11/12/2024 at 1: but were not limited	for Resident 52 was completed 56 P.M. Diagnoses included, d to: chronic obstructive (COPD), pneumonia and acute		affected by the deficient practice? The SSD/designee will provide bed hold forms to the resident/resident responsible part for Residents 52, 55, 69, and B the date of transfers listed on the	for				

FORM CMS-2567(02-99) Previous Versions Obsolete

A Quarterly Minimum Data Set (MDS)

assessment, dated 9/17/2024, indicated Resident

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Facility ID: 000034

If continuation sheet

statement of deficiencies.

How other residents have the

potential to be affected by the

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 11/14/2024	
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
WOODL	AND MANOR			NAPPANEE ST ART, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	A Nursing Progress A.M., indicated at 2 requested her lung s Resident 52's lung s posteriorly and exp Resident 52 refused needed inhalation n indicated she felt sh an antibiotic and wa called for further in to emergency service gathered Resident 5 A Nursing Progress P.M., indicated Res station in her wheel several other reside services for transpo nurse completed an hospice services of facility.  A Nursing Progress A.M., indicated Res to the hospital for n nourishment for for revocation of hospi  The chart lacked do was provided by the  During an interview the Quality Assurar stack of un-scanned	intact.  S Note, on 5/27/2024 at 4:05 2:45 A.M. Resident 52 sounds to be evaluated. sounds had scattered wheezing iratory wheezing anteriorly. It a nebulizer treatment or an as nedication. Resident 52 ne had bronchitis and needed as offered for hospice to be struction. Resident 52 decided ces for transfer and the nurse 62's transfer paperwork. S Note, on 7/25/2024 at 8:10 dident 52 passed the nursing chair, went to her room with note and called emergency retation to the hospital. The assessment and notified Resident 52's transfer from the store in the second of the seco	TAG	same deficient practice will identified and what correctivactions will be taken?  Other residents who have been transferred to the hospit have the potential to be affect. The DON/designee will complete an audit of the hospit transfers in the last 30 days to ensure bed hold forms were provided to the resident and/or responsible parties. Any finding will be addressed by providing those forms.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?  The DON/designee will provide education to licensed nursing staff on the requirement provide bed hold forms upon hospital transfers to the reside and/or responsible party and maintain a copy of the bed hold form.  How the corrective actions we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place?  The DON/designee will	be ve ve all ed. ital or or ngs g anto ent to ent lid	
	During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a			assurance program will be p into place?	out	
	bed hold forms. Aft	ter the stack was reviewed, the Administrator indicated she		complete routine auditing of residents who are transferred	to	

did not think the facility had the bed hold forms.

During an interview, on 11/14/2024 at 8:55 A.M.,

1Q7P11

the hospital to ensure a bed hold form was provided to the resident

and/or responsible party with a

PRINTED: 12/18/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC					AB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIE	R	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  copy of the form maintained residents medical record. Au to occur after each hospital transfer x's 4 wks, then 4 res hospital transfers wkly x's 4 v then 4 resident transfers moi x's 4 months for a total of 6 months of monitoring.  The results of these rev will be immediately reported concerns exist and will be discussed at the monthly fac Quality Assurance Committe meeting monthly for three me and then quarterly thereafter full compliance has been act for a total of 6 months of monitoring. Re-education, frequency and/or duration of	in the diding sident wks, nthly views if sillity se onths conce nieved	(X5) COMPLETION DATE	
	175/119 mmHg (millimeters of mercury) and a pulse of 133 beats per minute.  A Nursing Progress Note, on 8/20/2024 at 2:40 A.M., indicated Resident 55 was readmitted to the facility after a brief hospital stay for heart failure, shortness of breath and elevated troponin.  The chart lacked documentation a bed hold policy was provided by the facility.  During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for bed hold forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think the facility had the bed hold forms.			reviews will be increased as needed, if areas of noncomp are identified through the interprocess.		

During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further bed hold forms

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· /				SURVEY ETED
		155086	B. WI	NG		11/14/2024	
	PROVIDER OR SUPPLIEF	2	<u>,                                     </u>	343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	-	e forms the prior day. She 55 should have had a bed hold					
	on 11/12/2024 3:55	for Resident 69 was completed P.M. Diagnoses included, but chronic pancreatitis, atrial te cholecystitis.					
		imum Data Set (MDS) 1/9/2024, indicated Resident 69 act.					
	P.M., indicated Res drowsy and disorier pressure was 86/54 per minute, oxygen respirations were 18	s Note, on 9/16/2024 at 6:05 ident 69 was observed to be nted. Resident 69's blood mmHg, pulse was 130 beats saturation was 88 percent and 8 breaths per minute. Resident to the hospital via an					
	A.M., indicated the 69's skin coloring w Resident 69 was pa abnormal, and her opercent on room air	nurse was notified of Resident was not within normal limits. le; her demeanor was oxygen saturations were 82. The nurse practitioner was not 69 decided to be transferred					
		Note, on 9/24/2024 at 8:22 sident 69 would not be lility.					
	The chart lacked do was provided by the	ocumentation a bed hold policy e facility.					
		y, on 11/13/2024 at 10:29 A.M., nce Administrator produced a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPI 11/14	LETED			
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	bed hold forms. Af Quality Assurance	I medical records to review for ter the stack was reviewed, the Administrator indicated she cility had the bed hold forms.						
	the Quality Assurar she could not find a after looking for the indicated Resident form completed.  4. A record review on 11/08/2024 at 2: were not limited to	ogenital implants, and						
		s Note, dated 6/19/24 at 11:45 sident B had returned from the						
	provided by the fac	ocumentation a bed hold was illity to the resident and/or tive for this transfer.						
	A.M., indicated tha	s Note, dated 8/16/2024 at 12:00 t Resident B was transferred to back and abdominal pain.						
	provided by the fac	ocumentation a bed hold was ility to the resident and/or tive for this transfer.						
		s Note, dated 11/4/2024 at 09:59 ident B was out for a LOA for surgery.						
	provided by the fac	ocumentation a bed hold was illity to the resident and/or tive for this transfer.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER)  155086		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/14/2024			
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE		
	LPN 20 indicated things they are to define the hospital, including	w, on 11/13/2024 at 09:31 A.M., hey have a checklist of all the o when they send someone to ing but not limited to: sending ocumenting a nursing note.					
	LPN 19 indicated t things to do for a tr supposed to sign or	w, on 11/13/2024 at 10:00 A.M., he nurses have a checklist of ransfer that two nurses were nee completed, this included to the bed hold and making a ote.					
	the Quality Assuran	v on 11/14/2024 at 8:55 A.M., nce Administrator indicated de any further bed hold forms					
	Administrator, on I titled, "Bed-Hold P transferring a residence Resident to go on to the Resident, family	ded by the Quality Assurance 11/14/24 at 1:54 P.M. The policy rolicy", indicated, "Before ent to a hospital, or allowing a herapeutic leave of absence, y member, or Resident be notified in writing of this Policy"					
	3.1-12(a)(26)						
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Impleme	nt Comprehensive Care Plan					
-	interviews, the faci comprehensive per activities (Resident	on, record review and lity failed to develop a son-centered care plan for 54) and medication use of 27 residents reviewed for at E).	F 0656	F 656 Develop/Implement Comprehensive Care Plan What corrective actions will accomplished for those residents found to have bee affected by the deficient practice?			

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CENTERS FOR MEDICARE & MEDICAID SERVICES					ОМ	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155086	B. WING		11/14/	2024
	PROVIDER OR SUPPLIER	<b>R</b>	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	IE	DATE
Findings include:			The Activity			
				Director/designee will contact	the	
	1. During an observ	vation, on 11/8/2024 at 9:45		family of Resident 54 to deterr		
		was not observed in the		known activity references and		
	morning reading ac			plan of care will be updated to		
	morning reading ac	irrity.		reflect those preferences.		
	During an observat	ion, on 11/8/2024, at 2:20 P.M.,		The SSD/designee will		
		served walking in the activity		update Resident Es care plan	to	
	room of the Demen	•		include psychotropic drug use		
				Resident 64 is not in the		
		uestions from facility staff.				
Resident 54 was resistant to sit in the activity				findings.		
room despite staff encouragement and walked out			How other residents have the			
	of activity room.			potential to be affected by th		
				same deficient practice will be		
	_	ion, on 11/12/2024, at 10:21		identified and what correctiv	е	
		walked by the nursing station		actions will be taken?		
		re-directed to sit in a chair		Residents who want to		
	located in front of t	he nursing station		participate in activities have the		
	intermittently.			potential to be affected		
				Residents who have ord	ers	
	The record review t	for Resident 54 was completed		for psychotropic medications h	nave	
		1:19 A.M. Diagnosis included,		the potential to be affected		
	but were not limited	d to: Alzheimer's disease,		The Activity Director will		
	dementia, anxiety,	depression, unsteadiness on		complete resident interviews to	0	
	feet, hallucinations	and hypertension.		ensure that their activity		
				preferences are included in the	eir	
	A Quarterly Minim	um Data Set (MDS)		plan of care.		
	assessment, dated 1	0/1/2024, indicated the		The SSD/designee will a	ıudit	
	resident had short a	nd long-term memory issues.		current residents who have or	ders	
	The MDS indicated	Resident 54 had no indicators		for psychotropic medications h	nave	
	of hallucinations or	delusions but had had		a plan of care in place.		
	physical behaviors	towards others and other		What measures will be put in	ito	
		ns not directed towards others.		place or what systemic		
		ed supervision with eating,		changes will be made to		
		body dressing, partial		ensure that the deficient		
		hygiene, lower body		practice does not recur?		
	dressing, personal h			DON/designee will provide	de	
		and required substantial		education to the Activity Direct		
		eting. The MDS indicated the	1	on the requirement that reside		
		ospice services. A Significant	1	have activity preferences in the		
	1 condent received in	ospice services. A significant	1	I have activity preferences in the	CII	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155086	B. WING		11/14	/2024	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD			
WOODI				NAPPANEE ST			
WOODL	AND MANOR		ELNHA	ART, IN 46514			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	_	d 7/10/2024, indicated Resident		care plan.			
	54 was non-respons	sive and gave no responses to		DON/designee will provide	de		
	activity preference	questions.		education to the SSD on the			
				requirement that residents who	)		
	The record lacked a	a person-centered care plan for		have orders for psychotropic			
	Resident 54's activi	ity preferences.		medications have a care plan	in		
				place.			
	During an interview	v, on 11/14/2024, at 9:10 A.M.,		The Activity			
	the Activities Direc	ctor (AD) indicated the activity		Director/designee will be			
	care plans were completed by the AD upon			responsible for ensuring newly	1		
	admission and quar	rterly. The AD indicated all the		admitted residents have been			
	residents should ha	ve an activity care plan.		interviewed for activity prefere	nces		
				and that their plan of care refle	ect		
	During an interview	w, on 11/14/2024, at 9:12 A.M.,		those preferences. Care plans	will		
	the Social Services	Director (SSD) indicated the		be reviewed quarterly during the	ne		
	initial care plans w	ere completed by the admitting		quarterly care plan meeting ar	nd		
	resident's nurse but	otherwise most care plans		any changes in preferences w	ill be		
	sections were upda	ted and created by the		updated in the plan of care.			
	Minimum Data Set	(MDS) nurse. 2. A record		The SSD/designee will b	е		
	review for Residen	t E was completed on		responsible for ensuring newly	1		
	11/12/2024 at 10:5	9 A.M. Diagnoses included, but		admitted residents who have			
	were not limited to	: encephalopathy, diabetes,		orders for psychotropic			
	anxiety, and depres	ssion.		medications as well as new or	ders		
				for psychotropics have a care	plan		
	An Admission Min	imum Data Set (MDS)		in place to reflect residents ne	eds		
	assessment, dated 9	9/20/2024, indicated the		and concerns.			
	resident received as	ntipsychotic and		How the corrective actions w	rill		
	antidepressant med	lications.		be monitored to ensure the			
				deficient practice will not			
	· ·	Orders included: Risperdal		recur, i.e., what quality			
		ication) 2 mg (milligram) give 2		assurance program will be p	ut		
		imes a day. Sertraline		into place?			
		dication) 50 mg give 1 tablet by		The DON/designee will			
	mouth one time a d	lay related to depression.		complete routine auditing to			
				ensure activity preference care	Э		
		plans for Residenty E		plans are in place and remain			
		f the antipsychotic and		current. Auditing to occur: 4			
	antidepressant med	lications.		random residents wkly x's 4 w	ks,		

During an interview, on 11/13/2024 at 9:43 A.M.,

4 random residents monthly x's 5

months for a total of 6 months of

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12/14/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155086 B. WING 11/14/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 343 S NAPPANEE ST WOODLAND MANOR ELKHART, IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the Social Service Director indicated the resident monitoring. Any findings will be should have care plans for the use of the addressed.

On 11/14/2024 at 9:10 A.M., the Corporate Assurance Administrator provided the policy titled, "Care Plans, Comprehensive Person-Centered", with a revision date of 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...8. The comprehensive, person-centered care plan will... c. Describes services that would otherwise be provided for the above... h. Incorporate identified problem areas; i. Incorporate risk factors associated with identified problems... m. Identify the professional services that are responsible for each element of care...."

antipsychotic and antidepressant medications.

3.1-35(a)

F 0677 SS=D Bldg. 00

483.24(a)(2) ADL Care Provided for Dependent Residents

Based on interview, record review and interview, the facility failed to ensure showers were provided for 3 of 7 residents reviewed for ADL's (Activities of Daily Living). (Residents 53, E & F)

Findings include:

1. During an interview, on 11/7/2024 at 10:54 A.M., Resident 53 indicated "Sometimes I don't get any

The DON/designee will complete routine auditing to ensure that residents who have orders for psychotropics have updated care plans in place. Auditing to occur: 4 random residents wkly x's 4 wks, 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed

will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of non-compliance identified through the auditing process will be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved.

The results of these reviews

F 677 ADL Care Provided for Dependent Residents What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

Resident 53 was offered a shower by certified nursing staff

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F 0677

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155086	B. W	ING	11/14/2024		/2024
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			NAPPANEE ST		
WOODLA	AND MANOR				RT, IN 46514		
WOODL	TOODE WE WING TO			LLIXIIIX	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG			<u> </u>	TAG	DEFICIENCY)		DATE
	showers for 2 weeks."				during the survey process on		
		D 11 . 52			11/7/24 and declined. He has		
		Resident 53 was completed on			care plan in place for refusals		
		6 A.M. Diagnoses included, but			take showers and a preferenc	e for	
		chronic kidney disease,			bed baths.		
	obesity, lympheden	na, depression, and diarrhea.			The DON/designee will		
	An Annual Minimus	um Data Sat (MDS) aggassment			review resident bathing		
	An Annual Minimum Date Set (MDS) assessment,				preferences to ensure the schedule reflects those		
	dated 10/23/2024, indicated Resident 53 required				preferences and are schedule	d in	
	substantial to maximum assistance for transfers, bathing and showering, was occasionally				the electronic medical record	u III	
	incontinent of bladder and frequently incontinent				accordingly to ensure Resider	s+ ⊑	
	of bowels.				& F preferences are being me		
	of bowers.				How other residents have the		
	A current Care Plan, initiated on 12/19/2023,				potential to be affected by th	-	
		lent has an ADL Self Care			same deficient practice will be		
		related to impaired mobility	identified and what corrective				
	_	stay. BATHING: The resident	actions will be taken?				
	_	on staff to provide a	All residents have the				
	bath/Shower weekl	-			potential to be affected		
	· ·	ver/bed bath on Wednesday	The DON/designee will				
	and Saturday after l				review current residents bathi	ng	
	-				preferences to ensure the	Ü	
	A Skin/Wound note	e, dated 9/11/2024 at 5:20 P.M.,			schedule reflects those		
	indicated the physic	cian saw the resident. The			preferences and are schedule	d in	
	resident was to take	e showers via a shower bed.			the electronic medical record		
	The Wound Nurse	was to wash the resident's legs			accordingly		
	while the aide gave	him a bath, on Wednesday			What measures will be put ir	nto	
	morning after break	cfast.			place or what systemic		
					changes will be made to		
		wer Documentation Survey			ensure that the deficient		
	_	ted the resident had received			practice does not recur?		
	the following:				The DON/designee will		
	-a bed bath on 9/7.				provide education to nursing		
	-a shower on 9/18.				associates on the requirement		
	-a bed bath on 9/21.				that bathing type and frequenc	-	
					completed according to reside	ent	
		er Documentation Survey			preference as per the bathing		
	-	ted the residents had received			schedule. Refusals are to be		
the following:				documented.			

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		11/14/	/2024
		<u> </u>		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	₹			NAPPANEE ST		
WOODL	AND MANOR			ELKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.L	DATE
	- a shower on 10/1				Newly admitted residents	S	
	- a bed bath on 10/6	5			will be interviewed to determin	е	
	- a bed bath on 10/1	12			bathing preference as to type	and	
	- a bed bath on 10/2	20			frequency. The bathing schedu	ule	
	- a bed bath on 10/2	24/24.			will be updated to reflect those	;	
					preferences		
	The November sho	wer Documentation Survey			How the corrective actions w	rill	
	Report sheet, indica	ated no showers/bed baths had			be monitored to ensure the		
	been documented				deficient practice will not		
	from 11/1 through	11/14/2024.			recur, i.e., what quality		
					assurance program will be po	ut	
	During an interview	v, on 11/13/2024 at 10:06 A.M.,			into place?		
	CNA 16 indicated t	the resident should have had			The DON/designee will		
	his showers every 2	2 days after breakfast.			complete routine auditing to		
					ensure that bathing is being		
	During an interview	v, on 11/13/2024 at 1:58 P.M.,			completed and documented pe	er	
	the Director of Nur	sing indicated the staff do not			the bathing schedule. Auditing	to	
	write out shower sh	neets anymore, all the showers			occur: 4 random residents dail		
	were logged in the	computer.			x's 4 wks, then 4 random	•	
					residents wkly x's 4 wks, then	4	
					random residents monthly x's		
	2. During an intervi	iew, on 11/8/2024 at 11:05 A.M.,			months for a total of 6 months	of	
	Resident E indicate	ed she only received an			monitoring. Any findings will be	Э	
	occasional shower.				addressed.		
					The results of these review	ews	
	A record review for	r Resident E was completed on			will be immediately reported if		
	11/12/2024 at 10:59	9 A.M. Diagnoses included, but			concerns exist and will be		
		encephalopathy, diabetes,			discussed at the monthly facili	ty	
	anxiety, and depres	sion.			Quality Assurance Committee	•	
					meeting monthly for three mor		
	An Admission Min	imum Data Set (MDS)			and then quarterly thereafter o		
		0/20/2024, indicated the			full compliance has been achie		
		s incontinent of bladder and			for a total of 6 months of		
		artial to moderate assistance			monitoring. Re-education,		
		substantial assistance for			frequency and/or duration of		
	transfers.				reviews will be increased as		
					needed, if areas of noncomplia	ance	
	The November sho	wer Documentation Survey			are identified through the inter		

Report sheet indicated Resident E was to receive a

shower/bed bath on Mondays and Thursdays.

process.

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/14/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION I the following:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	-a shower on 10/4/2 During an interview	•					
	the Director of Nurs	y, on 11/13/2024 at 1:58 P.M., sing indicated the staff do not eets anymore, all the showers in the computer.					
	the Unit manager in	r, on 11/13/2024 at 2:49 P.M. dicated the resident was not r schedule and should have					
	_	ew, on 11/07/2024 at 10:19 indicated he was "supposed to ek at 5:00 A.M."					
	11/12/2024 at 9:21	as completed for Resident G on A.M. Diagnoses included, but diabetes, osteoarthritis of the					
	assessment, dated 1 resident was able to	um Data Set (MDS) 0/16/2024, indicated the make his own decisions and n of one staff for showering.					
	indicated Resident ( adl's due to pain and Interventions include extensive assistance	a, initiated on 3/15/2021, G required assistance with d arthritis of the left hip. led, but were not limited to, e of one staff. Resident G's ave showers at 5:00 A.M., on with help from staff.					
	The September show	wer Documentation Survey					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155086	B. WING			11/14/2024	
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MOODL							
WOODLA	WOODLAND MANOR			ELNHAI	RT, IN 46514		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Report sheet indica	ted Resident G had received					
	the following:						
	-a shower on 9/5/20	024.					
		er Documentation Survey					
	Report sheet indica	ted Resident G had received					
	the following:						
	-a shower on 10/1.						
	-a shower on 10/7.						
	-a shower on 10/18						
	-a bed bath on 10/2	0/2024					
	The November shower Documentation Survey						
	Report sheet indicated Resident G had received						
	the following:						
	-a shower on 11/5						
	-a shower on 11/12.	/2024					
	A DI	1 0 1 1 1 1 1 1 1 2 5 / 20 2 2					
	1	n's Order, dated 11/25/2023,					
		were to be done at 5:00 A.M.					
	resident's choice.	day mornings per the					
	resident's choice.						
	During on intervious	v, on 11/13/2024 at 10:15 A.M.,					
		the resident should get his					
		eek per the shower schedule.					
	showers twice a we	cek per the shower schedule.					
	During an interview	v, on 11/13/24 at 1:58 PM the					
	_	g indicated the staff do not					
	_	neets anymore, all the showers					
	were logged in the						
	were logged in the	computer.					
	During an interview	v, on 11/13/2024 at 2:49 P.M.					
	_	ndicated the resident was not					
		r schedule and should have					
	been.						
	On 11/14 2024 at 9	:10 A.M., the Corporate					
		strator provided the policy					
		hing Policy", with a revised					
							I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTII A. BUILDI	(X3) DATE SURVEY COMPLETED		
		155086	B. WING 11/14/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPI	E COMPLETION
F 0679	date of 8/2018, and one currently use by indicated "Reside considered, and sho provided at least we shower, a bed bath per the residents' production of the state of the st	indicated the policy was the the the facility. The policy of the facility of the facility. The policy of the facility of t			
SS=D Bldg. 00	Activities Meet Into Based on observation review, the facility provided with activitinterest and their physychosocial well-breviewed for activiting includes:  During an observation Resident 54 was not reading activity.  During an observation Resident 54 was observation of the Demention-responsive to quantity Resident 54 was responsive to the properties of the provided activity room despition walked out of activity and observation A.M., Resident 54 was able to be reintermittently.	ton, on 11/8/2024 at 9:45 A.M., tobserved in the morning  ton, on 11/8/2024, at 2:20 P.M., served walking in the activity tia Unit and was uestions from facility staff. sistant to sit down in the te staff encouragement and tity room.  ton, on 11/12/2024, at 10:21 walked by the nursing station e-directed to sit down	F 0679	F 679 Activities Meet Interests/Needs of Resident What corrective actions wi accomplished for those residents found to have be affected by the deficient practice?  A new activity assess was completed for Resident Activities will be offered base that assessment. How other residents have to potential to be affected by same deficient practice will identified and what correct actions will be taken?  All residents have the potential to be affected An updated activity assessment will be complete all residents on Unit 400 to a activities of interest are offer What measures will be put place or what systemic changes will be made to	en  nent 54. ed on the the ive
	During an observati Resident 54 was not reading activity.  During an observati Resident 54 was ob- room of the Demen- non-responsive to q Resident 54 was res activity room despit walked out of activity.  During an observati A.M., Resident 54 was able to be re- intermittently.	tobserved in the morning  son, on 11/8/2024, at 2:20 P.M., served walking in the activity tia Unit and was uestions from facility staff. sistant to sit down in the te staff encouragement and ity room.  son, on 11/12/2024, at 10:21 walked by the nursing station		was completed for Resident Activities will be offered base that assessment. How other residents have to potential to be affected by same deficient practice will identified and what correct actions will be taken? All residents have the potential to be affected An updated activity assessment will be complete all residents on Unit 400 to a activities of interest are offer What measures will be put place or what systemic	54. ed on the the l be ive

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	T OF HEALTH AND HUM R MEDICARE & MEDICA						TED: 12/18/2024 RM APPROVED B NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL		
		155086	B. Wl	ING		11/14/2024		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	on 11/12/2024 at 11	:19 A.M. Diagnosis included,			practice does not recur?			
	but were not limited	to: Alzheimer's disease,			Memory Care			
	dementia, anxiety, d	lepression, unsteadiness on			Director/Activity Director will			
	feet, hallucinations	and hypertension.			review interests of residents			
					quarterly and schedule activiti	es		
	A Quarterly Minimu	ım Data Set (MDS)assessment			according to those interests.			
	, dated 10/1/2024, in	ndicated the resident had short			How the corrective actions w	/ill		
	and long-term mem	ory issues, had no indicators			be monitored to ensure the			
	of hallucinations or	delusions but had had			deficient practice will not			
	physical behaviors t	owards others and other			recur, i.e., what quality			
	behavioral symptom	ns not directed towards others.			assurance program will be p	ut		
	The resident also re-	quired supervision with			into place?			
	eating, footwear and	l upper body dressing, partial			The Admin/designee will			
	assistance with oral	hygiene, lower body			complete routine auditing to			
	dressing, personal h	ygiene and			ensure activities of interest are	9		
	showering/bathing a	and substantial assistance			being offered to residents.			
	with toileting. A Si	gnificant Change MDS, dated			Auditing to occur: 4 random			
	7/10/2024, indicated	l Resident 54 was			residents daily x's 4 wks, then	4		
	non-responsive and	gave no responses to activity			random residents wkly x's 4 w			
	preference questions				then 4 random residents mont			
	_				x's 4 months for a total of 6	-		

There was no care plan to address Resident 54's activity preferences and needs. In addition, there was no documentation Resident 54 had attended any group or individual activities from October 30 through November 9.

During an interview, on 11/14/2024, at 9:38 A.M., the AD indicated all activity attendance and participation by each resident was documented in the electronic medical record (EMR).

During an interview, on 11/14/2024, at 10:55 A.M., CNA 7 indicated unit activities were scheduled from early morning through early evening when the activity assistant went home. She indicated staff tried to get all residents to attend activities, if the residents were willing.

On 11/14/2024 at 1:35 P.M., the DON provided a

months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility **Quality Assurance Committee** meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as

needed, if areas of noncompliance

are identified through the interview

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process.

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CENTERS FOR	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086			(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIE	R	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST		
WOODL	AND MANOR		ELKHA	ART, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 0684 SS=D Bldg. 00	policy titled, "Active 2013 and indicated currently used by the indicated "allow activities of his/her was no policy to in activity assessment current activity into care plan for activity to providing an index 3.1-33(a)  483.25 Quality of Care  Based on record refailed to ensure phywere discontinued resulted in the reside extremity edema remedication. (Reside Finding includes:  A record review for 11/12/24 at 11:23 A were not limited to congestive heart fare and Annual Minimus dated 9/11/2024, in severe cognitive dediuretic medication.	wity Evaluation," dated May the policy was the one he facility. The policyt the resident to participate in rechoice and interest" There dicate an comprehensive of each resident's past and erests and an individualized ties were completed in regards ividualized activity program.  view and interview, the facility ysician orders for extra fluids timely. This deficient practice dent developing bilateral lower requiring the use of diuretic ent M)  r Resident M was completed on A.M. Diagnoses included, but diabetes mellitus type 2, ilure and vascular dementia.	F 0684	F 684 Quality of Care What corrective actions will to accomplished for those residents found to have been affected by the deficient practice?  The DON/designee notifically resident M's physician that the order to give additional fluids who the discontinued timely and resident M experienced BLE edema. The BLE edema was treated appropriately by physically how other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?  Residents who have order for additional fluids have the	ed e vere sian. e e	

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hours.

indicated to encourage Resident M to consume an

additional 240 milliliters of fluids every shift for 72

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If continuation sheet

potential to be affected

The DON/designee has

reviewed physician orders of current residents who have orders

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CENTERS FOR	R MEDICARE & MEDIC	i e			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155086	B. WING	_	11/14/2024
			CANDELL	A DDD FOR CVTV OT ATE JUD COD	
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD	
14/0001				NAPPANEE ST	
WOODL/	AND MANOR		ELKH	ART, IN 46514	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DECLIDED IN AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
		dministration Record (MAR),		to give additional fluids to en	sure
		rough October 2024, indicated		orders are current. No finding	
		ued to receive 240 milliliters of		were identified.	93
	additional fluids th				into
	additional fluids th	nee times a day.		What measures will be put	iiito
	A DI CC L D	N. 4 1 4 1 7/1 6/2024 4		place or what systemic	
		gress Note, dated 7/16/2024 at		changes will be made to	
	· · · · · · · · · · · · · · · · · · ·	ed Resident M did not have		ensure that the deficient	
	edema.			practice does not recur?	
				The DON/designee will	
		gress Note, dated 7/19/2024 at		provide education to licensed	d
		ited to encourage an additional		nursing associates on the	
	240 milliliters of fl	uids every shift for 72 hours.		requirement to discontinue o	rders
				for additional fluids upon rece	eiving
	A Physician's Prog	ress Note, dated 7/30/2024 at		the order to discontinue.	
	4:38 P.M., indicate	ed Resident M was complaining		How the corrective actions	will
	of occasional short	ness of breath with moderate		be monitored to ensure the	
	activity, random B	NP (B-Type Natriuretic Peptide,		deficient practice will not	
	measures the level	of BNP protein in the blood to		recur, i.e., what quality	
		ure, range for a person over 75		assurance program will be	put
	_	l be less than 450pg/mL)		into place?	
	1 -	est was performed on 7/20/2024		The DON/designee will	
	I -	34 pg/mL (picogram per		review medical providers pro	
		dent M was not on any diuretic.		notes in the morning meeting	-
	· ′	sment indicated he had one		ensure orders to discontinue	
		teral lower extremities. The		additional fluids were discontinue	
	_	d to start Lasix (diuretic) daily		timely. Auditing to occur: M-F	
	-	at laboratory tests on 8/8/2024		4 wks, then wkly x's 4 weeks	
	and monitor Reside			,	' I
	and monitor Reside	ent wis weight.		then monthly x's 4 months fo	
	A Di	N4- 1-4-19/12/2024 -4		total of 6 months of monitorin	
		gress Note, dated 8/13/2024 at		Any findings will be addresse	
	· ·	ed BNP was 1,481pg/mL. The	1	The results of these rev	
		d to continue the Lasix		will be immediately reported	IT
		t laboratory tests on 8/28/2024		concerns exist and will be	
	and monitor Reside	ent M's weight.	1	discussed at the monthly fac	-
			1	Quality Assurance Committe	
		ress Note, dated 8/21/2024 at		meeting monthly for three mo	I
	8:42 P.M., indicate	ed Resident M had a chest x-ray	1	and then quarterly thereafter	once
	on 8/16/2024 that i	indicated mild congestive heart	1	full compliance has been ach	nieved
	failure or volume of	overload. The Physician		for a total of 6 months of	

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indicated to administer an additional dose of Lasix

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monitoring. Re-education,

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024		
	PROVIDER OR SUPPLIEF	·	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST IRT, IN 46514			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  20 milligrams and to start Lasix 20 milligrams daily.  "Heart Failure" (May 15, 2024) was retrieved on 11/14/2024 from the Centers of Disease Control (CDC) website. The guidance for heart failure treatment indicated, but was not limited to, to drink less liquids		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				frequency and/or duration of reviews will be increased as needed, if areas of noncomplia are identified through the inter- process.	sed as ncompliance		
	the Director of Nur should not have bee due to congestive h	or, on 11/14/2024 at 9:45 A.M., sing indicated Resident M en receiving additional fluids eart failure, and this may have eed for diuretic therapy.					
	Assurance Adminis P.M. The policy, tit Protocol", indicated identify or clarify of failureTreatment will prescribe treats failure that are cons	is provided by the Quality trator, on 11/14/2024 at 1:54 led, "Heart Failure-Clinical I, "The physician will help auses of congestive heart //Management 4. The physician ments for residents with heart sistent with relevant guidelines xample, those of the American"					
F 0685	3.1-25(a)(2) 483 25(a)(1)(2)						
SS=D Bldg. 00	Based on record rev failed to ensure a re received the approp	s to Maintain Hearing/Vision view and interview, the facility sident with impaired vision riate follow-up care for 1 of 1 for communication (Resident	F 0685	F 685F 685 Treatment/Device.  Main Hearing/VisionWhat corrective actions will be accomplished for those reside found to have been affected by deficient practice? Reside	nts y the	12/14/2024	

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A record review for Resident 35 was completed on

11/12/2024 at 3:21 P.M. Resident was admitted on

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If continuation sheet

optometrist during the next

scheduled visit. How other

residents have the potential to be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		11/14/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			IAPPANEE ST		
WOOD!	AND MANOR				RT, IN 46514		
VVOODLA	WAD MINIAOU			LLINIA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	_	ses included but were not			affected by the same deficient		
	limited to: multiple sclerosis, depression, chronic				practice will be identified and \	vhat	
	_	ary disease, dementia, anxiety,			corrective actions will be		
	_	ss, mood disorder, muscle			taken? All residents have	the	
	weakness and hype	rtension.			potential to be		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	D + C + (MDC) 1 + 1			affected Social Service w	'III	
		um Data Set (MDS), dated			offer vision services to each		
	•	d Resident 35 had moderate			resident if indicated. What		
		nt, had impaired vision and			measures will be put into place		
	required corrective	iens.			what systemic changes will be		
	A Dhygician's and	detect 11/21/2022 indicated			made to ensure that the defici	ent	
	A Physician's order, dated 11/21/2022, indicated				practice does not		
	the resident could be seen by an optometrist as				recur? Social Service will		
	needed.				complete consent forms for vis	SION	
	Decident 25's curre	nt Care Plan, reviewed on			services upon admission and document response in residen	4	
		d the resident had impaired			records. A vision assessment		
		rerventions included but were			be completed quarterly with th		
		resident will wear his glasses			MDS. Vision services will be	C	
		of voice when communicating			offered as needed if a change	in	
	with the resident.	or voice when communicating			vision is noted in the assessm		
	With the resident.				and for routine exams at least	Ont	
	During an interview	y, on 11/13/2024 at 11:19 A.M.,			annually. How the corrective		
		Director (SSD) indicated the			actions will be monitored to		
		vas last at the facility on			ensure the deficient practice w	/ill	
		ent 35 was not seen at that time.			not recur, i.e., what quality		
		that she could not locate any			assurance program will be put	into	
		ident has seen optometry			place? The Admin/design		
		on to the facility. The SSD			will complete routine auditing t		
		scheduler on the phone and			ensure vision services are offe		
		he scheduler did not have any			to residents. Auditing to occur		
		t being seen outside of the			random residents daily x's 4 w		
		ry. The SSD indicated the			then 4 random residents wkly		
		e sure residents with glasses			4 wks, then 4 random resident		
	· ·	netry every other year due to			monthly x's 4 months for a total		
	Medicare regulations.				6 months of monitoring. Any		
					findings will be		
	During an interview	v, on 11/14/2024 at 10:00 A.M.,			addressed. The results o	f	
		he still had not determined			these reviews will be immedia		
	when Resident 35 v	vas last seen by an eye doctor	1		reported if concerns exist and	-	

12/18/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155086 B. WING 11/14/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 343 S NAPPANEE ST WOODLAND MANOR ELKHART, IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE be discussed at the monthly On 11/14/2024 at 11:55 A.M., the Regional Quality facility Quality Assurance Assurance Administrator provided a policy titled, Committee meeting monthly for "Sensory Impairments - Clinical Protocol," dated three months and then quarterly March 2018 and indicated the policy was the one thereafter once full compliance currently used by the facility. The policy has been achieved for a total of 6 indicated, " ...physician will identify and order months of monitoring. appropriate consultations to help manage Re-education, frequency and/or ...sensory impairments ..." duration of reviews will be increased as needed, if areas of 3.1-39(a)(b)noncompliance are identified through the interview process. Date of compliance: December 14, 2024 F 0689 483.25(d)(1)(2) SS=E Free of Accident Bldg. 00 Hazards/Supervision/Devices F 0689 F 689 Accidents 12/14/2024 Based on observation, interview and record What corrective actions will be review, the facility failed to ensure the accomplished for those residents environment was free from potential hazards for 1 found to have been affected by the of 4 halls. In addition, the facility failed to ensure deficient practice? interventions were in place to prevent burns for 1 The PTAC unit in Room 111 of 3 residents reviewed for accidents. (Resident 12) was replaced November 14, 2024 Findings include: Resident 12 was effectively treated for the burn she sustained. 1. During an observation of room 111 on 11/14/2024 at 10:00 A.M., Resident R's bed was How other residents have the

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pushed against the packaged terminal air

conditioner (PTAC) (ductless, self-contained air

areas). The top and front of the PTAC was warped

roommate, was completed on 11/14/2024 at 10:02

conditioning unit for heating and cooling small

and melted. The PTAC unit was plugged in but was turned off. Resident R was not in his room.

An interview with Resident S, Resident R's

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potential to be affected by the

same deficient practice will be

identified and what corrective

All residents have the potential to be affected. All units in

the facility were checked and in

actions will be taken?

proper working order.

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155086	B. WING		11/14/2024	
WOODL	PROVIDER OR SUPPLIER  AND MANOR		343 S I ELKHA	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	(V5)	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	A.M. Resident S in least five months proommate's comfor PTAC unit and due PTAC unit. He indidicated the PTAC and caus PTAC and caus PTAC and caus PTAC to melt about indicated the MD he told him it would be not replaced. Resident R indicated the MD he told him it would be not replaced. Resident R indicated the melted PTAC we room.  During an interview CNA 21 indicated show long ago the P was more than one maintenance depart supposed to take carbon During an interview the Unit Manger (Uthe melted PTAC was ago and was told mit.	dicated the PTAC melted at rior. He indicated his ter had been in front of the to excessive heat, melted the icated the current Maintenance checked the unit after it melted say if the unit would be S indicated the melted PTAC It to heat the room when it was wo on 11/14/2024 at 11:28 A.M., and his comforter was in front of the at five months prior. He ad inspected the PTAC and the replaced, but the PTAC and the replaced was still being used to heat the the room when it was still being used to heat the the room that five months. She indicated the tement was aware and was	TAG	What measures will be put int place or what systemic chang will be made to ensure that th deficient practice does not reconstruction and an audit was completed each PTAC unit in the facility any malfunction was addressed. Staff are to enter equipment needing repair in the TELS sy and were educated on the use the system. TELS is to be monitored by maintenance to ensure repairs are completed timely.  Residents who have difficulty holding cups or glass will be offered a lid for hot beverages. A hot liquid assessment will be completed admission and at least quarte Measures will be put into place indicated and therapy if determined to be at safety risl. The safety measures will be pon the care plan to be sent to kardex and a communication sent to dietary for placement of information on the meal ticket. Staff will be educated on the assessment and communication of measures based on the residence.	o ess e cur? for and ed. estem e of  ses  d on rily. e as  k. but the form of . ion	
		dicated the PTAC unit had				
	_	eks, if not months, but she had		How the corrective actions wil	ll be	
		not reported it to anyone because Residents R		monitored to ensure the defici		

and S had told her the maintenance department

1Q7P11

practice will not recur, i.e., what

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155086	B. W.	ING		11/14	/2024	
NAME OF I	PROVIDER OR SUPPLIE	D		STREET	ADDRESS, CITY, STATE, ZIP COD	,		
NAME OF I	ROVIDER OR SOLITEE	IX.		343 S I	NAPPANEE ST			
WOODL	AND MANOR			ELKHA	ART, IN 46514			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	was already taking care of it.				quality assurance program wi	ll be		
	D	10/14/2024 + 10 20 4 34			put into place?			
		w on 10/14/2024 at 10:30 A.M.,						
		ctor (ED) indicated the facility			The Admin/designee will			
		e melted PTAC and the MD had			complete routine audits of roc			
	was not melted at t	vo days prior and the PTAC			with PTACS. DON/designee	WIII		
	was not metted at t	nat time.			review 24 hour report to note	do		
	During on interview	w on 11/14/2024 at 1:30 P.M.,			resident difficulty holding liqui Auditing to occur: 4 random	us.		
	-	ne was not aware the PTAC unit			rooms daily x's 4 wks, then 4			
		had been in the room two days			random rooms wkly x's 4 wks			
		note batteries, and would have			then 4 random rooms monthly			
		TAC unit. The MD indicated			4 months for a total of 6 months	•		
		ELS (a web-based platform			monitoring. Any findings will b			
		ging building operations,			addressed.	,0		
	-	ince, asset management, and			addi ocoda.			
	_	nce, specifically tailored for			The DON/designee will			
		nunities) to submit and prioritize			complete routine audits of			
		ever, the MD was unable to			residents who may have diffic	culty		
		the facility's TELS system			holding cups. Auditing to occ	-		
	regarding work ord	lers that had been submitted or			4 random residents daily x's 4	ļ		
	a list of work order	s he was currently working on			wks, then 4 random residents	;		
	in the facility.				wkly x's 4 wks, then 4 random	1		
					residents monthly x's 4 month	າຣ for		
	2. A record review	for Resident 12 was completed,			a total of 6 months of monitor	-		
		:20 A.M. Diagnoses included,			Any findings will be addresse	d.		
		d to: hemiplegia affecting right						
	_	asia, contracture of right						
	elbow, wrist and ha	and, dementia and			The results of these rev			
	polyneuropathy.				will be immediately reported in	f		
	11000	1. 1			concerns exist and will be			
		ssessment, compelted on			discussed at the monthly facil	-		
		uarterly Minimum Data Set			Quality Assurance Committee			
		, completed on 10/17/2024,			meeting monthly for three mo			
		12 was cognitively intact, had			and then quarterly thereafter			
		apper and lower extremity on			full compliance has been achi	eved		
	_	red set up or clean up			for a total of 6 months of			
	assistance for dinin	ig services.	1		monitoring. Re-education,			

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A Nursing Progress Note, dated 9/19/2024 at 4:08

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monitoring. Re-education, frequency and/or duration of

reviews will be increased as

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIER		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
IAU	P.M., indicated the room after a shower certified nursing asson both of Resident indicated to the nurse wheelchair to the of coffee and the Clauding of the top and she had indicated she did not a Hot Liquid Safety indicated Resident of her arms, hands a of motion or contral and fingers and had evaluation recomme with a cup with a liquid staff assistance Safety Evaluation of to 9/20/2024.  The Administrator of Heal of Resident 12's but Administrator indicated the recommendation of the recommendation of the same and the safety Evaluation of the safety E	nurse entered Resident 12's was completed where the sistant (CNA) observed burns 12's inner thighs. Resident 12 se she had wheeled herself in the nurse's station to get a cup NA may have filled the cup too to 12 placed the cup between thile self-propelling her the spilled from the opening at burned herself. Resident 12 to tell anyone about the burn.  We Evaluation, dated 9/20/2024, 12 had altered muscle strength and fingers with altered range teture of the joints to the hand a history of spills. The tended providing Resident 12 d or other adaptive equipment There was no Hot Liquid completed for Resident 12 prior  reported to the Indiana th, on 9/20/2024 at 11:44 A.M., the one of the prior of the pr	IAG	needed, if areas of noncompare identified through the interprocess.	liance
	12 was at risk for sprelated to muscle we effects from a previous and included, Res	9/26/2024, indicated Resident billing hot liquids and foods eakness and deficits due to ous stroke. The Care Plan ident 12 will not have any hot sported by herself and will not			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155086	B. W	ING		11/14	2024
	PROVIDER OR SUPPLIEF	₹		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDENG BY AN ASSAULT		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	suffer any burns fro	1					
		ded, but were not limited to:					
		ow staff to transport her hot					
	_	r her and utilize cups/mugs					
		ds for all liquids. There was no hot liquid needs/safety for					
	Resident 12 prior to						
	Resident 12 prior to	77/20/2024.					
	During an observati	ion, on 11/13/2024 at 9:37					
	_	was observed in her bed. She					
	had 2 unhandled tumbler cups with lids with						
	unknown substances. Resident 12 indicated she drinks hot liquids without a lid.						
	During an interview	v, on 11/13/24 at 9:18 A.M., the					
	_	itation indicated Resident 12					
		ly evaluated for therapy					
	services						
	_	v, on 11/14/2024 at 9:08 A.M.,					
	-	dicated special equipment for					
	_	listed on the meal ticket. The					
		served, and Dietary Aide 27 12's hot liquids would be					
		cup. Dietary Aide 27 was					
	_	e plan intervention to serve					
		quids in a cup/mug with a					
	handle and lid.						
	_	v, on 11/14/2024 at 9:16 A.M.,					
		sing (DON) indicated the					
	admission nursing assessment specifically asks about cognitive abilities and functional limb						
	abilities to determine						
		io fion for outile.					
	On 11/14/2024 at 1	1:00 A.M., the ED provided an					
		titled, "Physical Plant					
		cated the facility did not have					
		providing a safe environment,					
	but used that docun	nent. The document indicated,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0755 SS=D Bldg. 00	heating, and ventila applicable rules of the safety commission adequate air condition applicable rules of the safety commission  On 11/14/2024 at 1: Administrator proving Treatment. The position and employees who be treated at the fact treated with basic Rich the emergency mediactivated	05 P.M., the Quality Assurance ded a policy titled, "First Aid licy indicated, "Residents experience minor injuries shall illity. IF the injuries cannot be ed Cross first aid intervention, ical system [EMS] will be  (Pharmacist/Records iew, interview and illity failed to ensure physician swere available for 3 of 24 dications were reviewed.  M)  for Resident E was completed ito: encephalopathy, diabetes, sion.  Physician Order's included in 20 mg (milligram) give 1	F 0755	F 755 Pharmacy Srvs/Procedures/Pharmacist/ Records What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The DON/designee contacted the pharmacy to receive Resident E, L, M and verified delivery o The physician for Resident E, L, and M was notified of medications not administered for dates listed this statement of deficiencies.	order I in

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r '	A. BUILDING 00 COMPLE		
ANDILAN	OI CORRECTION	155086	B. WING	<u></u>	11/14/2024	
		103000	_		11/14/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				NAPPANEE ST		
WOODLA	AND MANOR		ELKHA	ART, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	before breakfast (to	decrease stomach acids).		How other residents have th	e	
	Ezetimibe 10 mg gi	ive 1 tablet one time a day (lower		potential to be affected by the	ne	
	cholesterol).			same deficient practice will	be	
	Metformin 500 mg	2 tablets two times a day (anti		identified and what corrective		
	diabetic).			actions will be taken?		
	Risperdal (antipsyc	hotic) 2 mg give 1 tablet two		Residents who have		
	times a day for psy	chosis.		medications ordered and		
	Sitagliptin 100 mg	(anti-diabetic) 1 tablet every		administered by facility assoc	iates	
	day for diabetes.	•		have the potential to be affect		
	1 -	ry day (to reduce moderate to		The DON/designee will		
	_	ymptoms due to menopause).		complete a facility wide		
		• •		medication audit to ensure that	at	
	The September Medication Administration Record			medications are available as	per	
	_	esident E had not received the		physician's orders.		
	following medication			What measures will be put in	nto	
	_	on 9/14, 9/15 and 9/16/2024.		place or what systemic		
	_	ng on 9/16, 9/18, 9/19, and		changes will be made to		
	9/28/2024.			ensure that the deficient		
		n 9/15, and 9/16/2024.		practice does not recur?		
	_	on 9/16, 9/24, 9/26, 9/27, 9/29,		The DON/designee will		
	and 9/30/2024.			provide education to licensed		
	Veozah 45 mg on 9	0/15, 9/16, 9/17, 9/19, 9/21, 9/22,		nursing staff on timely reorde	rina	
	9/24, 9/25, 9/27, 9/2			of medications. Education will	-	
	Metformin 1000 m	g on 9/15 and 9/16/2024.		be provided to nursing associ	ated	
		9/16, 9/24, 9/27, 9/29 and		who administer medications of		
	9/30/2024.			utilizing the EDK for medication	ons	
				when necessary for medication		
	Resident E's Octob	er MAR indicated she had not		not yet dispensed to resident.		
	received the follow	ing medications on these		How the corrective actions v		
	dates:			be monitored to ensure the		
	Ezetimibe 10 mg or	n 10/19, 10/20, 10/22, and		deficient practice will not		
	10/23/2024.			recur, i.e., what quality		
	Sitagliptin 100 mg	on 10/1 through 10/6, 10/8		assurance program will be p	ut	
	through 10/15, 10/1	17, 10/19, 10/20, 10/22, 10/23,		into place?		
	10/25, and 10/28 th			The DON/designee will		
	Veozah 45 mg on 1	0/1 through 10/6, 10/8 through		routinely audit medication car	ts to	
	10/23, and 10/25, a	nd 10/28 through 10/31/2024.		ensure medications are availa		
		-		for administration. Auditing to		
	The November Me	dication Administration Record		occur: 4 residents daily M-F x	's 4	

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(MAR) indicated Resident E had not received the

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wks, then 4 residents wkly x's 4

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  11/14/2024
	PROVIDER OR SUPPLIEI	8	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST .RT, IN 46514	
WOODL  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN REGULATORY OF following medicative Sitagliptin 100 mg through 11/8, 11/11 Metformin 1000 m Veozah 45 mg on 1 11/8, and 11/11 thr The clinical record indicate the reasons not administered.  During an interview the Director of Nur have called the phate the medications were (emergency drug keen an alternate medicate should be called affinot administered.  2. During an intervence Resident L indicate pain medication for A record review for 11/12/2024 at 3:22 were not limited to osteoarthritis, anxiet polyneuropathy.	on 11/1 through 11/3, 11/5 1, and 11/2024. g on 11/2/2024. 1/1 through 11/3, 11/5 through ough 11/13/2024. lacked documentation to s why the medications were  w, on 11/14/2024 at 10:40 A.M., sing indicated the nurse should rmacy, then looked to see if the in-house, looked in the EDK it) and called the provider for thion order and the physician ther 3 days if the medication was diew, on 11/7/2024 at 1:54 P.M., and she had not received her a month.  r Resident L was completed on P.M. Diagnoses included, but kidney failure, diabetes,			Audit tis ns as titly enths once eved
	Patch 5% (Lidocain bilateral hip/thighs and remove Lidoca and bilateral thighs The October Medic (MAR), indicated t	ne) pain reliever apply to in the morning for chronic pain ine patches from bilateral hips at bedtime every night. cation Administration Record he Lidoderm pain patch was following dates: 10/6, 10/10,			

10/11 and 10/18/204.

NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR  (XI) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  TAG  REQULATORY OR ISC IDENTIFYING INFORMATION  The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/5, 11/6, and 11/11 through 11/12/2024  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/5, 11/6, and 11/11 through 11/12/2024  A Medication Administration Note, dated 0/14/20/24 at 8/30 P.M., indicated the Lidoderm pain patch was not oremoved.  A Medication Administration Note, dated 10/10/20/24 at 9.59 A.M., indicated the Lidoderm patch was not oremove.  A Medication Administration Note, dated 10/11/20/24 at 9.59 A.M., indicated the Lidoderm patch was not order from the pharmacy.  A Medication Administration Note, dated 10/11/20/24 at 7.32 P.M., indicated the Lidoderm patch was no order from the pharmacy.  A Medication Administration Note, dated 10/11/20/24 at 7.32 P.M., indicated the Lidoderm patch was no order from the pharmacy.  A Medication Administration Note, dated 10/11/20/24 at 7.32 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/20/24 at 7.32 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/20/24 at 8.30 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/20/24 at 8.30 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/20/24 at 8.30 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/20/24 at 8.30 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR  (XA) ID  SIEMMARY STATEMENT OF DEPICIENCIE  PREFIX  (EACH DEFICIENCY MIST BE PRECEDED BY FULL  TAG  REGULATORY OR LSE IDENTIFYING INFORMATION  The October MAR indicated the Lidoderm pain patch was not removed on the following dates:  10'11, 10'18 through 11'24, 11'27, 11'29 and  11'30'20'24.  The November MAR indicated the Lidoderm pain patch was not applied on the following dates:  11'6, 11'6, and 11'8 through 11'13'20'24  A Medication Administration Note, dated  10'10'20'24 at 10'18 A.M., indicated the Lidoderm pain patch was not available to remove.  A Medication Administration Note, dated  10'10'20'24 at 10'18 A.M., indicated the Lidoderm pain patch was on order from the pharmacy.  A Medication Administration Note, dated  10'10'20'24 at 10'18 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated  10'11'20'24 at 10'.56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated  10'11'20'24 at 72'.8 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated  10'11'20'24 at 72'.8 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated  10'11'20'24 at 72'.8 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated  10'11'20'24 at 72'.8 P.M., indicated the Lidoderm patch was not available for removal.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
WOODLAND MANOR  WOODLAND MANOR  SUMMARY STATEMENT OF DEFICIENCE PRIETY TAG  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MIST BE PRICEDED BY FULL TAG  The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/5, 11/6, and 11/1 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/1 through 11/13/2024  A Medication Administration Note, dated 10/10/2024 at 18:30 P.M., indicated the Lidoderm patch was not order from the pharmacy.  A Medication Administration Note, dated 10/11/204 at 10:18 A.M., indicated the Lidoderm patch was not order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 12:8 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 12:8 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 12:8 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 12:8 P.M., indicated the Lidoderm patch was not available for removal.			155086	B. WI	NG		11/14	/2024
PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 1011, 1018 through 11/24, 11/27, 11/29 and 11/30/2024.  The November MAR indicated the Lidoderm pain patch was not applied on the following dates: 11/5, 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/11 through 11/13/2024  A Medication Administration Note, dated 9/14/2024 at 8:07 P.M. indicated no patch was available to remove.  A Medication Administration Note, dated 10/6/2024 at 10:18 A.M., indicated the Lidoderm patch was not available.  A Medication Administration Note, dated 10/10/2024 at 9:59 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/2024 at 8:30 P.M., indicated the Lidoderm patch was not available for removal.			3	•	343 S N	IAPPANEE ST		
PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 1011, 1018 through 11/24, 11/27, 11/29 and 11/30/2024.  The November MAR indicated the Lidoderm pain patch was not applied on the following dates: 11/5, 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/11 through 11/13/2024  A Medication Administration Note, dated 9/14/2024 at 8:07 P.M. indicated no patch was available to remove.  A Medication Administration Note, dated 10/6/2024 at 10:18 A.M., indicated the Lidoderm patch was not available.  A Medication Administration Note, dated 10/10/2024 at 9:59 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/2024 at 8:30 P.M., indicated the Lidoderm patch was not available for removal.	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 10/11, 10/18 through 11/24, 11/27, 11/29 and 11/30/2024.  The November MAR indicated the Lidoderm pain patch was not applied on the following dates: 11/5, 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not emoved on the following dates: 11/6, and 11/11 through 11/13/2024  A Medication Administration Note, dated 9/14/2024 at 8:07 P.M. indicated no patch was available to remove.  A Medication Administration Note, dated 10/6/2024 at 10:18 A.M., indicated the Lidoderm patch was not available.  A Medication Administration Note, dated 10/10/2024 at 9:59 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal.						(EACH CORRECTIVE ACTION SHOULD BE		
patch was not removed on the following dates: 10/11, 10/18 through 11/24, 11/27, 11/29 and 11/30/2024.  The November MAR indicated the Lidoderm pain patch was not applied on the following dates: 11/5, 11/6, and 11/8 through 11/12/2024.  The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/11 through 11/13/2024  A Medication Administration Note, dated 9/14/2024 at 8:07 P.M. indicated no patch was available to remove.  A Medication Administration Note, dated 10/6/2024 at 10:18 A.M., indicated the Lidoderm patch was not available.  A Medication Administration Note, dated 10/10/2024 at 9:59 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was on order from the pharmacy.  A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal.  A Medication Administration Note, dated 10/11/2024 at 3:30 P.M., indicated the Lidoderm patch was not available for removal.	TAG				TAG	DEFICIENCY)	IE	DATE
	IAU	The October MAR patch was not remo 10/11, 10/18 throug 11/30/2024.  The November MA patch was not appli 11/5, 11/6, and 11/8  The November MA patch was not remo 11/6, and 11/11 through 11/6/2024 at 8:07 Paravailable to remove 11/6/2024 at 10:18 patch was not available to remove 11/6/2024 at 10:18 patch was not available 11/10/2024 at 10:56 patch was on order 11/10/2024 at 10:56 patch was on order 11/10/2024 at 7:28 patch was not available 11/10/2024 at 8:30 patch was not available 11/10/18/2024 at 8:30 patch was not available 1	indicated the Lidoderm pain wed on the following dates: th 11/24, 11/27, 11/29 and  IR indicated the Lidoderm pain ed on the following dates: 8 through 11/12/2024.  IR indicated the Lidoderm pain wed on the following dates: bugh 11/13/2024  inistration Note, dated  I.M. indicated no patch was ed.  inistration Note, dated  A.M., indicated the Lidoderm from the pharmacy.  inistration Note, dated  A.M., indicated the Lidoderm from the pharmacy.  inistration Note, dated  A.M., indicated the Lidoderm from the pharmacy.  inistration Note, dated  P.M., indicated the Lidoderm able for removal.  inistration Note, dated  P.M., indicated the Lidoderm able for removal.		IAU			DATE

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1Q7P11 Facility ID: 000034

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		ľ í	JILDING	nstruction 00	(X3) DATE COMPL 11/14/	ETED	
	PROVIDER OR SUPPLIEI	₹		343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	patch was not avail  A Medication Adm 10/20/2024 at 10:3: patch was not avail  A Medication Adm 10/21/2024 at 10:3: patch was not avail  A Medication Adm 10/22/2024 at 10:3: patch was not avail  A Medication Adm 10/23/2024 at 9:57 patch was not avail  A Medication Adm 10/24/2024 at 9:51 patch was not avail  A Medication Adm 10/24/2024 at 9:51 patch was not avail  A Medication Adm 10/25/2024 at 9:54 patch was not avail  A Medication Adm 10/26/2024 at 9:17 patch was not avail	able for removal.  inistration Note, dated 8 P.M., indicated the Lidoderm able for removal.  inistration Note, dated 8 P.M., indicated the Lidoderm able for removal.  inistration Note, dated 8 P.M., indicated the Lidoderm able for removal.  inistration Note, dated P.M., indicated the Lidoderm able for removal.  inistration Note, dated P.M., indicated the Lidoderm able for removal.  inistration Note, dated P.M., indicated the Lidoderm able for removal.  inistration Note, dated P.M., indicated the Lidoderm able for removal.  inistration Note, dated P.M., indicated the Lidoderm able for removal.		TAG			DATE
	10/27/2024 at 9:33 patch was not avail	P.M., indicated the Lidoderm able for removal.					
	10/29/2024 at 9:43 patch was not avail						
		inistration Note, dated P.M., indicated the Lidoderm					

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	OMPLETED
155086 B. WING	4/4/4/0004
	1/14/2024
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  343 S NAPPANEE ST	
WOODLAND MANOR ELKHART, IN 46514	
WOODLAND WANDR ELKHART, IN 40314	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
patch was not available for removal.	
A Medication Administration Note, dated	
11/5/2024 at 9:53 A.M., indicated the Lidoderm	
patch was on order from the pharmacy.	
A Medication Administration Note, dated	
11/6/2024 at 7:48 A.M., indicated the Lidoderm	
patch was on order from the pharmacy.	
A Madiestica Administration Nets dated	
A Medication Administration Note, dated 11/8/2024 at 9:49 A.M., indicated the Lidoderm	
patch was on order from the pharmacy.	
patch was on order from the pharmacy.	
A Medication Administration Note, dated	
11/9/2024 at 11:33 A.M., indicated the Lidoderm	
patch was unavailable.	
paten was unavariable.	
A Medication Administration Note, dated	
11/11/2024 at 9:03 A.M., indicated the Lidoderm	
patch was on order from the pharmacy.	
A Medication Administration Note, dated	
11/12/2024 at 7:40 A.M., indicated the Lidoderm	
patch was on order from the pharmacy.	
During an interview, on 11/13/2024 at 2:17 P.M.,	
LPN 20 indicated if the medication was not in the	
cart, he would let the unit manager know. He	
would then look in the EDK, and if it was not	
available in the EDK, he would order the	
medication unless it was already ordered. If it was	
ordered, it would show on the MAR.	
During an interview, on 11/14/2024 at 10:40 A.M.,	
the Director of Nursing indicated the nurse should	
have called the pharmacy, looked see if the	
medication was in-house, looked in the EDK	
(emergency drug kit) and called the provider for	
an alternative medication order. The DON	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MUL A. BUIL B. WINC	DING	nstruction 00	(X3) DATE : COMPL 11/14/	ETED	
	ROVIDER OR SUPPLIER	₹	;	343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	days if the medicati	cian should be notified after 3 ion was not administered.					
	11/13/2024 at 11:10	n storage observation on O A.M., on the 100 hall with e no Lidocaine pain patches in for Resident L.					
	QMA 18 indicated medication cart, sho	y, on 11/13/2024 at 11:22 A.M., if the medication was not in the e would look in the EDK, and if not in the EDK, she would					
	reorder it and put a "reordered awaiting record review for R 11/12/24 at 11:23 A were not limited to:	note in the chart indicating: g arrival from pharmacy".3. A lesident M was completed on A.M. Diagnoses included, but diabetes mellitus type 2, illure and vascular dementia.					
	dated 9/11/2024, in	nm Data Set (MDS) assessment, dicated Resident M had a ficit received insulin and s.					
	limited to:	Orders, included, but were not grams in the morning initiated					
	November 2024, in doses of Jardiance	lministration Record, dated dicated Resident M missed 10 milligrams on 11/1/2024, 24, 11/10/2024, and 11/12/2024.					
	the Director of Nur was unavailable, th contacted the pharm	y, on 11/14/2024 at 9:45 A.M., sing indicated if a medication e nursing staff should have nacy and then the physician to the orders were necessary.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ í	ULTIPLE CO JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
		155086	B. Wl	ING		11/14	/2024
	PROVIDER OR SUPPLIEF			343 S N	ET ADDRESS, CITY, STATE, ZIP COD S NAPPANEE ST HART, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION: 10 A.M., the Quality		TAG	DEI ICIENC I I		DATE
		strator provided the policy					
	titled, "Emergency Pharmacy Service and						
	Emergency Kits", d	lated 5/20/2020, and indicated					
	the policy was the	one currently used by the					
		indicated "Emergency					
		s available on a 24-hour basis.					
	1	or medication are met by using					
		red medication supply or by a the pharmacy. An emergency					
	supply of medications, including emergency drugs, antibiotics, controlled substances If the						
	medication is not available, call/faxes the						
	pharmacy, using the pharmacy or appropriate						
	after-hours emerger	ncy number(s) if necessary5.					
	Medications are not	t borrowed from other					
	residents. The order	red medication is obtained					
		ergency box or from the					
	pharmacy"						
		as provided by the Quality					
		trator, on 11/14/2024 at 1:54					
		ed, "Adverse Consequences					
		ors", indicated 5. A 'medication					
	error' is defined as t						
	in accordance with	rugs or biological which is not					
		• •					
	•	fications, or accepted rds and principals of the					
	l ~	viding services. 6. Examples of					
		nclude: a. Omission-a drug is					
		ninisteredc. Wrong dose"					
		Č					
	3.1-48(a)(1)						
	3.1-48(c)(2)						
	3.1-25(a)						
E 0764	400 45(5)/5)/4)/0)						
F 0761 SS=E	483.45(g)(h)(1)(2)						
Bldg. 00	Label/Store Drugs	and biologicals					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155086	B. W	ING _		11/14/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			NAPPANEE ST		
WOODLA	AND MANOR		ELKHART, IN 46514				
	T		1		, · · · · · · · · · · · · · · · · · · ·	T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		N
TAG		R LSC IDENTIFYING INFORMATION	F 0'	TAG		DATE	
		on, interview and record	F 0'	/61	F 761 Label/Store Drugs and	12/14/2024	:4
	review, the facility failed to adequately label an over the counter medication stored in a				Biologicals What corrective actions will	<b>.</b>	
		1 of 1 medication cart reviewed			accomplished for those	be	
		ility also failed to monitor and			residents found to have beer	,	
	, ,	nperatures of a refrigerator			affected by the deficient	'	
		were stored for 1 of 1			practice?		
		ators reviewed (Nurses Station			No resident was identifie	d in	
	1).	ators reviewed (rearses station			this statement no deficiency a		
	1).				being affected r/t to the OTC		
	Findings include:				Tylenol and Melatonin not hav	ina	
	I mange metade.				appropriate labels. The	9	
	1. During an observation of the medication cart on				DON/designee removed the		
	_	8/2024 at 11:45 A.M., an			opened bottle of Tylenol and		
	opened bottle of Ty	lenol and an open bottle of			melatonin from the 400-unit		
	-	ave any resident identifying			medication cart and audited		
	information on the	bottles.			resident orders who resident of	n	
					that unit to ensure residents th	nat	
		v on 11/08/2024 at 11:48 A.M.,			have orders for Tylenol and		
	LPN 24 indicated si	he was not able to identify			melatonin have a supply on ha	and	
	_	melatonin were observed. She			designated for each resident.		
	indicated over the c	counter medications should be			DON/designee verified approp	oriate	
	labeled with the res	ident's name and room number.			labels are in place for those		
					medications.		
		v on 11/8/2024 at 11:51 A.M.,			Medications that were		
		sing (DON) indicated all			stored in the Nurses' station 1		
		be labeled with the resident's		refrigerator as listed in this			
	name, prescriber na	me and dosage information.			statement of deficiencies were	;	
					removed, disposed of, and		
	_	vation of the nursing station 1			reordered by the DON/designe		
	_	ator on 11/12/2024 at 9:30 A.M.			The refrigerated EDK was rem	noved	
		nedication refrigerator			and picked up by pharmacy.		
	thermometer indicated the temperature was 32						
	degrees Fahrenheit (F). The refrigerator had the				How other residents have the		
	following medications stored: -A locked Emergency Drug Kit with 1 vial of				potential to be affected by th		
	_	1 vial Humulin N (insulin), 1			same deficient practice will be		
	- '	insulin), 1 vial of Humulin 70/30			identified and what correctiv actions will be taken?	e	
		Novolog (insulin), 1 vial of			Residents who have OT	_	
		grams (mg) (antianxiety), 1 vial of			_	-	
	101azepani 20 milli	grams (mg) (amhamxicty), 1 viai 01	ı		medications not dispensed fro	III	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			PLETED	
11112 12111	or conduction	155086		B. WING 11/14/2024			
		10000			_	1,202 1	
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CO	DD		
MOODI	AND MANOD			S NAPPANEE ST			
WOODL	AND MANOR		ELK	(HART, IN 46514			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		OULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE	
	lorazepam 2 mg, 1	vial of Lantus (insulin), 1 vial of		the pharmacy have the	potential to		
	Leviemir (insulin),	1 promethazine (relieve or		be affected.			
	prevent some types	of allergy or allergic		The DON/designe	e will		
	reactions) 25 mg su	ippositories.		complete a cart audit to	ensure		
	-3 boxes of Tuberso	ol (aid in the diagnosis of		that residents who have	e OTC		
	tuberculosis)			medication orders not d	dispensed		
	-4 boxes of Aplisol	(aid in the diagnosis of		by the pharmacy have a	appropriate		
	tuberculosis)			labels in place. Any find			
	-3 Lantus Solostar	(insulin) pens for Resident 30		be addressed.			
	-4 Gargine (insulin) pens for Resident 26			The DON/designe	e will		
				complete a refrigerated	medication		
	The temperature lo	g hanging on the front of the		audit to ensure that the			
	Medication Refrige	erator had out of range		logs are current and wit	•		
	temperatures logge	d for the following dates:		What measures will be	-		
				place or what systemic	-		
	-11/1/2024 33 degr	ees F		changes will be made			
	-11/2/2024 33 degr	ees F		ensure that the deficie	ent		
	-11/3/2024 30 degr	ees F		practice does not recu	ır?		
	-11/4/2024 30 degr	ees F		The DON/designe			
	-11/5/2024 33 degr	ees F		provide education to nu	ırsing		
	-11/6/2024 33 degr	ees F		associates that adminis	ter		
	-11/7/2024 33 degr	ees F		medications on the requ	uirement to		
	-11/8/2024 33 degr	ees F		ensure the temp logs ke	ept on		
	-11/9/2024 33 degr	ees F		refrigerated medication	s must be		
	-11/10/2024 32 deg	grees F		obtained, current, and v	within		
	-11/11/2024 33 deg	grees F		range, and the process			
	-11/12/2024 33 deg	grees F		addressing any temps t			
				of range.			
	During an interview	v on 11/12/2024 at 9:33 A.M.,		The DON/designe	e will		
	LPN 20 indicated to	he nurses were responsible for		provide education to nu			
		ding the medication		associates who adminis	-		
	refrigerator's tempe	eratures. He indicated the		medications on the requ	uirement to		
	temperature of refr	igerator was 32 F and believed		ensure OTC medication	ns have		
	it was an appropria	te temperature. After looking at		appropriate labels.			
		perature parameters printed on		How the corrective act	tions will		
		, LPN 20 indicated the		be monitored to ensur			
		ature was out of range and he		deficient practice will	not		

would notify maintenance.

On 11/12/2024 at 10:00 A.M., the Executive

recur, i.e., what quality

into place?

assurance program will be put

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	<del></del>			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Director (ED) provi "Medication Storag identified it as the p facility. The policy requiring "refrigera 36 degrees F and 46 refrigerator with a t temperature monito storage "in a cool p otherwise directed of On 11/12/2024 at 2 policy dated, 4/200 Medication Contain policy currently use indicated, " 3. Lal containers shall inc such as: a. The resic prescribing physicia	114 P.M., the DON provided a 7, and titled, "Labeling of ers" and identified it as the d by the facility. The policy pels for individual drug tude all necessary information,	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY)  DON/designee to comp routine auditing of medication carts to ensure that OTC medications being administer have appropriate labels. Audit to occur: all med carts 4 x's w x's 4 wks, then monthly x's 5 months for a total of 6 months monitoring.  DON designee to to complete routine auditing of refrigerators that contain medications. Auditing to occur all refrigerated med storage at 4 x's wkly x's 4 wks, then mon x's 5 months for a total of 6 months of monitoring.  The results of these rev will be discussed at the month facility Quality Assurance Committee meeting monthly further emonths and then quarted thereafter once full compliance has been achieved for a total	ed ting rikly s of rrass anthly rews anly or rrly e	
F 0812 SS=E Bldg. 00	Based on observation interview, the facility pantries was maintage.	e/Prepare/Serve-Sanitary on, record review and ty failed to ensure 1 of 2 unit ined in a sanitary manner. al to affect 18 of 18 residents	F 0812	months of monitoring. Any fin of non-compliance identified through the auditing process be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved.  F 812 Food Procurement, Store/Prepare/Serve-Sanitar What corrective actions will be accomplished for those reside found to have been affected by	will 12/14/2024  y ents	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155086	B. W	ING		11/14/2024		
NIAME CE -	DOMDED OF CUEST			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF F	PROVIDER OR SUPPLIEI	K		343 S NAPPANEE ST				
WOODL	AND MANOR			ELKHART, IN 46514				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	E' 1' ' 1 1				deficient practice?			
	Finding includes:				T			
	An observation of the 400 unit pantry was				The pantry on Unit 400	was		
					cleaned November 13, 2024.			
	completed with the Dietary Director (DD) and the Executive Director on 11/13/2024 at 9:13 A.M. The				How other residents have the			
	following was obse				How other residents have the			
	_	h dried food splatter on the			potential to be affected by the same deficient practice will be			
	inside.	in arreat 100a spranter on the			identified and what corrective			
		ket with black and brown stains			actions will be taken?			
	on the bottom of the cabinet underneath the sink.				aodona wiii be taren:			
					All residents have the			
	During an interview on 11/13/2024 at 9:15 A.M.,				potential to be affected.			
		ne microwave was dirty and			, and the state of			
		ed. She indicated the blanket						
	was used to catch the	he dripping water from the						
		but was not able to recall the			What measures will be put int	io		
	last time the blanke	et had been changed. The ED			place or what systemic chang			
	indicated the blank	et should not be used to			will be made to ensure that th			
		water and she had already			deficient practice does not red	cur?		
		ce about the leaking sink prior						
		ng. A policy for maintaining			A cleaning schedule has	S		
		cleaning checklists related to			been created for the pantry.			
		uested but not provided prior			Nursing will be responsible fo			
	to the survey exit.				maintaining the cleanliness of			
	0 11/10/2021 -	are the second of the second o			pantry and have been educat	ed on		
		2:16 A.M., the ED indicated the			the cleaning schedule.			
		e a policy for maintaining the			],, ,, ,, ,, ,, ,,			
	-	n undated document titled,			How the corrective actions wi			
		ndards". The three page			monitored to ensure the defic			
		ndards" document did not			practice will not recur, i.e., wh			
		n pertaining to the sanitation or nt in pantries or the kitchen.			quality assurance program wi	ıı be		
	иркеср от ецигрте	in in panutes of the kitchen.			put into place?			
	This citation relates	s to complaint IN00442666.			The DON/designee will			
					complete routine auditing of e	each		
	3.1-21(i)(3)				pantry. Auditing to occur: 4			
					random days x's 4 wks, then			
					random days x's 4 wks, then			
ŀ			1		random days x's 4 months for	r a	İ	

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

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	A (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIER		343 S	T ADDRESS, CITY, STATE, ZIP COD S NAPPANEE ST IART, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
				total of 6 months of monitoring Any findings will be addressed	<u> </u>	
				The results of these re will be immediately reported concerns exist and will be discussed at the monthly fact Quality Assurance Committed meeting monthly for three meand then quarterly thereafter full compliance has been act for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompare identified through the integrocess.	if cility ee onths r once hieved	
F 0880 SS=D Bldg. 00	review, the facility control practices we use and handwashir catheter care for 1 catheter care. (Residual Finding includes:  During an observation A.M., Certified Nurobserved to provide Resident 50. She us the urinary catheter	on & Control on, interview and record failed to ensure infection ere followed related to glove ng during perineal and of 2 residents observed for	F 0880	F 880 Infection Prevention & Control  What corrective actions will accomplished for those residents found to have be affected by the deficient practice?  Resident 50 did not experience a negative outco from deficient practice.  CNA 23 and LPN 19 we ducated by the DON/design glove use and handwashing peri care, catheter care. The associates will perform a retire.	en  me  vas nee on during ese	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/14/2024 155086 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 343 S NAPPANEE ST WOODLAND MANOR ELKHART, IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE over to his right side. CNA 23 cleansed the smear demonstration with the of feces from her buttocks and LPN 19 applied a DON/designee of best practices in barrier cream to his buttocks. Without changing these areas. Any findings will be her gloves, or washing her hands, CNA 23 addressed. obtained a clean bed pad and clean brief and How other residents have the placed them under the resident and pulled the potential to be affected by the resident's shirt down in back. The resident was same deficient practice will be then rolled over and his brief was fastened in the identified and what corrective front. CNA 23 moved Resident 50's arms and actions will be taken? pillows, then repositioned the resident up in bed. Other residents who receive She placed a clean sheet over the resident, and peri care and catheter care have lastley CNA 23 put all the dirty linens in a bag and the potential to be affected then removed her contaminated gloves. The DON/designee will provide education to licensed and During an interview, on 11/14/2024 at 11:15 A.M., certified nursing associates on CNA 23 indicated she should have changed her glove usage during peri care and gloves and washed her hands. catheter care. What measures will be put into On 11/14/2024 at 12:56 P.M., the Quality place or what systemic Assurance Administrator provided the policy changes will be made to titled, "Perineal Care," with a revision date of ensure that the deficient 2/2018, and indicated the policy was the one practice does not recur? currently used by the facility. The policy indicated The DON/designee will "...m. Wash and rinse the rectal area thoroughly, provide education to licensed and including the area under the scrotum, the anus, certified nursing associates on and the buttocks. n. Dry area thoroughly... 10. glove usage during peri care and Remove gloves and discard into designated catheter care. container. 11. Wash and dry your hand thoroughly...." How the corrective actions will be monitored to ensure the 3.1-18(a) deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON/designee will complete routine observations of glove use and hand washing during peri care to ensure best practices are being performed.

Observations to occur: 4 random

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

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

		1			T		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155086	B. WING		11/14/2024		
			CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹					
WOODLA	AND MANOR		343 S NAPPANEE ST ELKHART, IN 46514				
WOODLA	AND MANOR		ELKITA	AR 1, IN 40514			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
				associates performing peri ca wkly x's 4 wks, then 4 random associates performing peri ca monthly x's 5 months for a tot 6 months of monitoring.  The results of these revi will be immediately reported if concerns exist and will be discussed at the monthly facil Quality Assurance Committee meeting monthly for three monand then quarterly thereafter full compliance has been achifor a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliare identified through the interprocess.	re al of ews ity nths once eved		
F 0883	483.80(d)(1)(2)						
SS=D	Influenza and Pne	eumococcal Immunizations					
Bldg. 00	failed to provide a revaccination timely vaccinations. (Resident 11's record 11/12/2024 at 11:0 were not limited to disorder, cerebral in hemiplegia and hemicerebral aneurysm.	d review was completed on  1 A.M. Diagnoses included but  multiple sclerosis, anxiety  nfarction, bipolar disorder,  niparesis of left side and	F 0883	F 883 Influenza and Pneumococcal Immunizations What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Resident 11 received the PNE20 vaccine on November 2024. Vaccine clinic was held November 15, 2024 and all residents who gave consent received influenza and pneum	be n e 15,		
	Kesident II had red	ceived the Prevnar 13	I	vaccines.			

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(pneumococcal vaccine) on 3/15/2023.

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How other residents have the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       11/14/2024			
	PROVIDER OR SUPPLIE	R	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST NRT, IN 46514	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	A document titled, "Influenza/pneumo Immunization Con resident wanted to vaccine(s). Resider 10/30/2023.  A document titled, "Influenza/pneumo Immunization Con resident wanted to vaccine(s). Resider Attorney/Guardian pneumococcal vaccine(s). Resider Attorney/Guardian pneumococcal vaccine During an intervier the Clinical Nurse followed the recon Disease Control ar pneumococcal vaccine based on the CDC should receive a pr one year after she is vaccine.  On 11/12/2024 at 2 Nursing (DON) pr 7/22/2022, and title DON indicated it varied.	ecoccal/Covid Vaccine/Booster sent or Refusal" indicated the be given the pneumococcal at 11 signed the document on ecoccal/Covid Vaccine/Booster sent or Refusal" indicated the be given the pneumococcal		potential to be affected by the same deficient practice will lidentified and what corrective actions will be taken?  All residents have the potential to be affected.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?  Facility will review vaccistatus of each new admission the facility, obtain consents are schedule vaccines upon consents are schedu	ne be //e  nto  ne to nd ent.  vill  ew  r: 4 s, s 4
	Pneumococcal disc pneumococcal imm immunization is m	immunizations 2. ease Each resident is offered a nunization, unless the edically contraindicated or the y been immunized"		findings will be addressed.  The results of these reviwill be immediately reported if concerns exist and will be discussed at the monthly facil Quality Assurance Committee meeting monthly for three moand then quarterly thereafter of full compliance has been achieved.	ity e nths once

C2210101	THE CHIEF CONTENTS	THE CERTIFICES			312 1.31 0700 007		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155086	B. WING		11/14/2024		
	PROVIDER OR SUPPLIER	2	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514			
	1						
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE		
				for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompli are identified through the interprocess.			
F 0921	483.90(i)						
SS=F Bldg. 00	` '	anitary/Comfortable Environ					
	review, the facility	on, interview and record failed to maintain a sanitary I to urine odors, dirty ceilings	F 0921	F 921 Safe/Comfortable Environment What corrective actions will be	12/14/2024		
		inted spackle in resident's		accomplished for those reside			
	_	o gouges and unpainted		found to have been affected b			
	spackle on the 400			deficient practice?	y the		
	1			acinoidin practico.			
	Findings include:			Room 222 and Room 22 have had repairs made.	29		
	1. During an observ	vation on 11/8/2024 at 11:06		'			
	A.M., a strong sme	ll of urine was detected in room		Bed and mattress in Ro	om		
	112.			112 has been replaced and ro	oom		
	During an Environ	nental tour with the		has been deep cleaned.			
	_	tor (MD), Executive Director		Unit 400 hallway repairs	;		
		tor of Housekeeping (DH) on		have been completed.			
	11/14/2024 at 9:05	A.M., a strong smell of urine					
	was detected in roo	m 112.		How other residents have the			
				potential to be affected by the			
		v on 11/14/2024 at 9:07 A.M.,		same deficient practice will be			
		oom 112 smelled of urine due		identified and what corrective			
		attress. The DH indicated the		actions will be taken?			
		s own mattress on admission		AII			
		hable. The DH indicated there		All residents have the			
		ions with the resident about		potential to be affected.			
		ess, but the resident refused. he did not have any		An audit of all rooms ha			
		ne did not have any		An audit of all rooms na	-		

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offered a new mattress.

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needing to be done.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING O B. WING  (X3) DATE SURVEY COMPLETED 11/14/2024			ED		
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID ID	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	•	RY OR LSC IDENTIFYING INFORMATION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	cleaning checklists resident's mattresses. On 11/14/2024 at 1 undated document to keep his mattress to receive a new maresident had signed.  2. During an observed 11/07/2024 at 2:06 the wall next to the spackle on the wall hanging from the unspot on the ceiling from the ceiling of the terms of the spackle on the wall hanging from the unspot on the ceiling of the terms of the bed by the down of the terms of the unpainted spack ceiling near the wird down of the polymer of the good here. The During an interview of the good here indicated here and had not painted ceiling did not leak. The DH indicated if was housekeeping's	c:00 P.M., the DH provided an indicating the resident wanted is and refused the opportunity attress. The DH indicated the the document on 11/14/2024.  The DH indicated the the document on 229 on P.M., there were gouges along bed by the door, unpainted by the ceiling with room decornpainted spackle, and a dark near the window.  The DH indicated the wall next for the following was 229: gouges along the wall next for, unpainted spackle on the with room decorn hanging from the call and a dark spot on the follow.  The MD and DH on A.M., the MD indicated he was uges in the wall along the bed. It spackled the wall a week prior the tryet. The MD indicated the and it was dirt on the ceiling and it is responsibility to clean the eeping should have been		What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not recommon to the deficient practice will be utilized be staff to communicate needs facility repairs. Staff have been educated on the TELS system and the new policy and guide for the facility environment.  How the corrective actions with monitored to ensure the deficient practice will not recur, i.e., which quality assurance program with put into place?  The Admin/designee with complete routine auditing of the environment. Auditing to occur andom rooms daily x's 4 wks then 4 random rooms wkly x's wks, then 4 random rooms wkly x's wks, then 4 random rooms monthly x's 4 months for a tot 6 months of monitoring. Any findings will be addressed.  The results of these revisions will be immediately reported in the deficiency of the deficienc	ges ne cur?  policy ye as al e by en n lines  II be iient nat iiI be ur: 4 s, s 4 tal of		

On 11/14/2024 at 10:45 A.M., the DH provided

concerns exist and will be

PRINTED: 12/18/2024

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  11/14/2024		
	PROVIDER OR SUPPLIE	R	34	43 S NA	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE	
	cleaning checklists not include dusting  3. During an obser 11/07/2024 at 11:0 the wall next to be During an Environ Maintenance Direct (ED) and the Direct 11/14/2024 at 9:12 in the wall above the MD indicated he wall in Room 2  During an interview Resident J indicate months prior and the since his admission 4. During an Envir Maintenance Direct (ED) and the Direct 11/14/2024 at 9:16 large areas along the spackled but had no During an interview the MD indicated the wall one week facility used TELS designed for managincluding maintenal life safety compliant.	The cleaning check lists did the ceiling or walls.  The cleaning check lists did the ceiling or walls.  The cleaning check lists did the ceiling or walls.  The cleaning of walls.  The cleaning of walls.  The cleaning of walls.  The cleaning of Room 222 on 4 A.M., there were two holes in down the door.  The cleaning of the cleaning o			discussed at the monthly Quality Assurance Comm meeting monthly for three and then quarterly thereat full compliance has been for a total of 6 months of monitoring. Re-education frequency and/or duration reviews will be increased needed, if areas of nonco are identified through the process.	ittee months fter once achieved of as mpliance		

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for building repairs. He indicated staff submitted work orders and he prioritized work orders based on safety concerns. The MD indicated he

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING					
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	completed a daily halls and common maintenance conce several rooms a da	walk through of the facility's areas to identify any possible erns. He indicated he visited y and was in every room at eks to identify possible					
	the ED indicated the for maintaining the	w on 11/14/2024 at 9:30 A.M., ne facility did not have a policy building and environment, but titled, "Physical Plant					
	the MD indicated of tasks that had be	w on 11/14/2024 at 1:30 P.M., he was not able to provide a list een submitted through TELS or tasks he was working on in the					
	undated document Standards" and inc a policy related to environment, but u document indicate with the following	11:00 A.M., the ED provided an titled, "Physical Plant licated the facility did not have maintaining the facility's used that document. The d, "(2) Provide each resident items upon request at the time A bed: (ii) with a clean and ess"					
		s to complaint IN00442666.					
	3.1-19 (f)						
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective	ve Pest Control Program					
	review, the facility Pest Control Progr	ion, interview and record failed to maintain an effective am related to an infestation of the potential to affect 68 of the	F 0925	F 925 Maintain Effective Pes Control Program What corrective actions will be accomplished for those reside	9		

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			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024		
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	68 residents who reside in the facility.  Finding includes:			found to have been affected by deficient practice?	the		
	During an observat	During an observation of room 229 on 11/7/2024 at 2:06 P.M., fruit flies were seen in the resident's room.  During an observation of room 112 on 11/8/2024 at 11:06 A.M., fruit flies were seen in the resident's		Aardvark Pest Control was here November 13, 2024 and sprayed foam in drains			
				How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?			
	During an observation of room 110 on 11/8/2024 at 11:11 A.M., fruit flies were seen in the resident's room.  During the Resident Council Meeting on 11/08/24 at 1:17 P.M., 5 out of 8 residents indicated fruit flies had been a problem for three months or			All residents have the potential to be affected. All roor throughout the facility were	ms		
				sprayed for gnats and will be treated weekly.  What measures will be put into			
	During a record rev on 11/8/2024 at 2:0	During a record review of the Pest Control binder on 11/8/2024 at 2:00 P.M., no documentation was located to indicate the facility had received any		place or what systemic changes will be made to ensure that the deficient practice does not recu	S		
	Pest Control visits/treatments related to fruit flies in the last three months.  On 11/14/2024 at 8:45 A.M., the ED provided an invoice from a Pest Control company dated, 11/13/2024. The invoice indicated the 100 Hall was inspected for fruit flies. Fruit flies were located in room 110, 111, 112, 114, 118, 120 and in a clean utility room behind Nurse's Station 1. The invoice did not include treatment to any other halls			Pest control services specific to gnats are scheduled weekly beginning December 6, 2024.S			
				are to enter into the TELS syste the location of pests if seen in the facility with maintenance to monitor. All staff will be in-service	he		
				on the use of the TELS system. performance improvement tool been developed to audit areas	. A has of		
		nental tour with the		the facility to ensure it is free of gnats and pest control has effectively sprayed as schedule			
	(ED) and the Direct	tor (MD), Executive Director tor of Housekeeping (DH) on A.M., fruit flies were observed		How the corrective actions will monitored to ensure the deficien			

CENTERS	FOR MEDICARE & MEDI				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  11/14/2024	
	OF PROVIDER OR SUPPLIE	ER	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
WOC  (X4) II  PREFI  TAG	SUMMARY (EACH DEFICIE REGULATORY C in the following re -402 -406 -110 -112 -229  During an intervie the MD indicated treatments for frui invoices to show a treated the facility 11/13/2024.  During an intervie the ED indicated t company to treat f the facility was ha Control company treatments and pro Pest Control comp copy of the Pest C and the ED indica submitted the Pest double check. A p the exit of the surve representative from	ew on 11/14/2024 at 9:22 A.M., the facility was receiving regular t flies but did not have any a Pest Control company had to other than the invoice on ew on 11/14/2024 at 9:30 A.M., the facility used a Pest Control for fruit flies. The ED indicated aving difficulties with the Pest providing invoices after evided the phone number of the pany the facility was using. A control Policy was requested ted she believed she had already a Control Policy but would olicy was not received before			DATE  DATE  DATE  DATE  DATE  DATE  DATE  DATE
	invoices were recessurvey.  On 11/14/2024 at documents and ide invoices for Pest O	to the facility immediately. No eived before the exit of the  1:05 P.M., the ED provided three entified the documents as Control services. The ated 9/24, 11/12 and 11/14/2024		Compliance date: December 2024	14,

services were received.

and did not list a Pest Control company or what

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPLETED		
155086		B. W	B. WING 11/14/202					
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	L			NAPPANEE ST			
WOODLA	AND MANOR				RT, IN 46514			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DD OLUDEDIG TV . IV OF GODD C		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	This citation relates	to complaint IN00442889.						
	3.1-19 (f)(4)							
F 9999								
Bldg. 00								
g. 00	3.1-14 Personnel		F 99	999	F 9999		12/14/2024	
					What corrective actions will	be		
		n organized ongoing inservice			accomplished for those			
		ng program planned in			residents found to have been	า		
	advance for all pers				affected by the deficient			
	_	le, but not be limited to, the			practice?			
	following:				No residents were affect	ed		
	(1) Residents' rights	3.			by this deficient practice.			
					How other residents have the			
	This state rule was i	not met as evidenced by:			potential to be affected by the same deficient practice will be			
	Rased on interview	and record review, the facility			identified and what correctiv			
		ployees complete yearly			actions will be taken?	<b>C</b>		
		ing on residents' rights for 4 of			Residents were not affect	cted		
		e files were reviewed. (CNA 3,			by this deficient practice.	otou		
		Cook 7, and LPN 11)			a, and denote his produce.			
		,			What measures will be put ir	ito		
	Finding includes:				place or what systemic	-		
	_				changes will be made to			
	During a review of	employee records, on 11/8/2024			ensure that the deficient			
	at 10:00 A.M., CNA	A 3, Dietary Assistant 5, Cook 7			practice does not recur?		1	
	and LPN 11's files	did not contain documentation			A new HR Director was			
	to indicate they had	completed annual training on			hired and started December 2	,		
	resident rights.				2024. A system will be develo	ped		
					to track TB tests and annual			
	_	on 11/8/2024 at 1:38 P.M., the			training to assure all employed	es		
		ated the training was not			are compliant.			
	completed for resid	ent rights.			How the corrective actions w	/ill		
					be monitored to ensure the			
		25 P.M., the Administrator			deficient practice will not			
		ated June 2023 and titled,			recur, i.e., what quality			
	"Resident Rights."	The policy indicated, "4.			assurance program will be p	ut	1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICE	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086			JILDING	instruction 00	(X3) DATE ( COMPL 11/14/	ETED	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE	(X5) COMPLETION
TAG	Orientation and in-sconducted quarterly understanding our residents shall have dementia-specific transitial employment, personnel assigned dementia special ca annually thereafter preferences, or both residents and to gai standards of care for	R LSC IDENTIFYING INFORMATION service training programs are to assist our employees in	into place?  The Admin/designee will complete routine auditing of employee files. Auditing to occur: 3 files daily x's 4 wks, then 3 files weekly x's 4 wks, then 3 files monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviee will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three month and then quarterly thereafter or full compliance has been achie for a total of 6 months of monitoring. Re-education,		nen 3 a i. i. ews	DATE	
	failed to have emploannual dementia tra whose files were re Assistant 5, Cook 7 Finding includes:	employee records on 11/8/2024			reviews will be increased as needed, if areas of noncomplia are identified through the inter process.		
	and LPN 11's files of to indicate they had annual dementia tra  During an interview Administrator indic completed for deme	on 11/8/2024 at 1:38 P.M., the ated the training was not					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>00</u> COMPLE		ETED	
		155086	B. W	B. WING		11/14	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			IAPPANEE ST		
WOODLAND MANOR					RT, IN 46514		
	445 147 44614			LEIGH			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		g Program, Nurse Aide." The					
		.f. Include training in dementia					
	management"						
	2 1 14 D1						
	3.1-14 Personnel						
	(vi) Promoting resid	dents' right to be free from					
		t, and neglect, and the need to					
	report any	i, and negrees, and the need to					
		eatment to appropriate facility					
	staff.	11 1					
	This state rule was	not met as evidenced by:					
		and record review, the facility					
		ployees complete yearly					
		ing on abuse for 4 of 10					
		iles were reviewed. (CNA 3,					
	Dietary Assistant 5	, Cook 7, and LPN 11)					
	Finding includes:						
	D	1 11/9/2024					
	_	employee records on 11/8/2024					
		A 3, Dietary Assistant 5, Cook 7, did not contain documentation					
		l completed annual training on					
	•	completed annual training on					
	abuse.						
	During an interview	v on 11/8/2024 at 1:38 P.M., the					
	_	eated the training was not					
	completed for abuse	_					
	completed for dous						
	On 11/8/2024 at 2:2	25 P.M., the Administrator					
		ated January 2020 and titled,					
		e policy did not include					
		ng annual training for					
	employees.						
	3.1-14 Personnel						
			1				I

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       11/14/2024						
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE)	OBE COMPLETION			
	(1) At the time of en month prior to emp thereafter, employe and nonpaid person screened for tuberous who have not had a documented negative during the preceding baseline tuberculing two-step method. If second test should be (3) weeks after the repeat testing will downwith tuberculosis.  This state rule was a Based on record reversity of the second test should be with tuberculosis.  This state rule was a Based on record reversity of the second test should be repeat testing will downwith tuberculosis.  This state rule was a Based on record reversity of the second test should be recorded to screen employers on the second test should be recorded to screen employers with the state of the second test should be recorded to screen employers and	Inployment, or within one (1) Iloyment, and at least annually les nel of facilities shall be lalosis. For health care workers we tuberculin skin test result g twelve (12) months, the skin testing should employ the or the first step is negative, a love performed one (1) to three first step. The frequency of lepend on the risk of infection  and met as evidenced by: wiew and interview, the facility loloyees for tuberculosis within lemployment and at least for 10 of 10 employees whose leved. (QMA 2, CNA 3, CNA 4, lietary Assistant 6, Cook 7, live Assistant 9, RN 10, and LPN  employee records on 11/8/2024 A 2, CNA 3, CNA 4, Dietary Assistant 6, Cook 7, CNA 8, ant 9, RN 10, and LPN 11's la documentation to indicate lined for tuberculosis upon hire						

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

PRINTED: 12/18/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/14/2024		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	provided a policy da "Tuberculosis Skin policy indicted, "1 volunteers) are scree tuberculosis at the ti testing)" and "4	ime of hire (baseline . The frequency of TB line is determined by the					

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