PRINTED: 01/17/2025

	R MEDICARE & MEDIC					IB NO. 0938-039	
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 12/27/2024		
	PROVIDER OR SUPPLIE	R	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, 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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E ERIATE	(X5) COMPLETION DATE	
F 0000 Bldg. 00	This visit was for a the Recertification completed on 11/14 PSR to the Investig IN00442899, IN00 completed on 11/14 Complaint IN0044 Complaint IN0044 Complaint IN0044 Survey dates: Decertification of Provider number: AIM number: 1000 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type Medicare: 2 Medicaid: 66 Other: 1 Total: 69 These deficiencies accordance with 41	Post Survey Revisit (PSR) to and State Licensure Survey 4/2024. This visit included a gation of Complaints 446004 and IN00442666 4/2024. 2666 - Corrected 6004 - Not corrected 2899 - Corrected ember 26 & 27, 2024 00034 155086 274880	F 0000				
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(Notify of Changes	iv)(15) s (Injury/Decline/Room, etc.)					

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

Based on observation, review and interview, the

facility failed to notify the physician timely of a

(X6) DATE

What corrective actions will be

TITLE

accomplished for those residents

01/24/2025

Chris Chalman Interim Administrator 01/14/2025

F 0580

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1Q7P12 Facility ID: 000034 If continuation sheet Page 1 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155086	B. W	ING		12/27/2	2024
		<u> </u>		CTDEET	ADDRESS CITY STATE ZIR COR	I	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
WOOD	AND MANOR				RT, IN 46514		
VVOODL/	AIND IVIAINUR			ELNHA	IN 1, IN 40014		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	(EACH DEFICIEN	CY 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
	-	for 1 of 3 residents reviewed			found to have been affected b	У	
	for accidents. (Resi	dent L)			· DON/designee notified the		
					physician for Resident L r/t a		
	Finding includes:				change in condition r/t burn in	jury	
					on 12/26/24.		
		Resident L was completed on			How other residents have the		
		P.M. Diagnoses included, but			potential to be affected by the		
		muscle weakness, seizures,			same deficient practice will be		
	osteoarthritis and d	iabetes mellitus type 2.			identified and what corrective		
					actions will be taken?		
		um Data Set (MDS)			· Other residents who have		
		2/23/2024, indicated Resident			experienced a change in cond	I	
		ntact. She required set-up			r/t a burn have the potential to	be	
		ng and locomotion in her			affected.		
		sessment indicated she did not			· DON/designee will complete		
	have a burn, but an	open lesion of the skin.			audit to identify other burns x's	s 60	
					days to ensure physician		
		sing Note, dated 12/17/2024 at			notification was made.		
	·	ed Resident L stated she had			What measures will be put into		
	_	nd on her leg. The wound			place or what systemic change	I	
		eters by 2.5 centimeters and			will be made to ensure that the		
		resident's right anterior shin.			deficient practice does not rec		
		ellow drainage present. The			· A 3rd party licensed clinician		
		was pink. A new physician's			from IHCA is scheduled to pro	1	
		for doxycycline (antibiotic)			education to licensed nurses a		
	100 milligrams twi	ce daily for 10 days.			Qualified Medication Aides on		
		N 1 . 1 10/10/2024 2 . 22			requirement to notify the phys		
		Note, dated 12/18/2024 at 3:22			for changes in condition r/t bu	rns.	
	_	hysician's order was received.			DON/designee will complete		
		to cleanse Resident L's			routine observations of change	es in	
		ound wash or normal saline and			conditions r/t burn injuries to		
		antibiotic ointment and cover			ensure timely physician		
		t dressing daily for 10 days for			notification.		
	the wound.				How the corrective actions wil		
	AN B. N 1 . 110/00/2004 .				monitored to ensure the defici		
	A Nursing Progress Note, dated 12/20/2024 at				practice will not recur, i.e., who	1	
	10:00 A.M., indicated during an interview with				quality assurance program wil	ı be	
		icated the wound occurred last			put into place?		
	• .	24) when a CNA handed her a			· DON/designee will complete		
	bowl of Cup of Noc	odles and the bowl fell onto her	1		routine observations of change	es in	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		12/27/	2024
				CERET	ADDRESS OF A STATE OF SOR		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MOODI	AND MANIOD				IAPPANEE ST		
WOODL	AND MANOR			ELKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(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' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	leg. The note indica	ited the wound was red and			conditions r/t burn injuries to		
	open with serous dr	ainage. Resident L's right shin			ensure timely physician		
	was edematous com	npared to the left leg. Resident			notification by review of the		
		hurt off and on, but not all the			medical record. Auditing to occ	cur:	
		as to be followed by the wound			changes in conditions r/t burns		
	physician.	,			daily M-Fri x's 30 days, then 4		
	F				changes in conditions r/t burns		
	During a facility-in	itiated investigation, on			wkly x's 30 days, then 4 chang		
		indicated that she was aware			in conditions r/t burns x's 4	,	
	· ·	t soup on her lap. LPN 2			months for a total of 6 months	of	
	_	ned Resident L she would look			monitoring.		
		LPN 2 went to Resident L's			The results of these reviews w	ill be	
	_	vas outside smoking. LPN 2			immediately reported if concer		
		sident L's leg when she			exist and will be discussed at t		
	_	g outside. There was not a			monthly facility Quality Assura		
	nursing progress no				Committee meeting monthly for		
		2024 regarding the burn.			three months and then quarter		
	12/14/2024-12/10/2	2024 regarding the burn.			thereafter once full compliance	-	
	During an interview	y, on 12/27/2024 at 11:14 A.M.,			has been achieved for a total		
		esident L had informed her on			months of monitoring.	0 0	
		urn on her thigh. LPN 2			Re-education, frequency and/o	ar.	
		L came to her while she was			duration of reviews will be	וכ	
		ork. LPN 2 indicated Resident L			increased as needed, if areas	of	
		oke and both she and Resident			· · · · · · · · · · · · · · · · · · ·	OI	
		ourn. LPN 2 indicated she			noncompliance are identified		
		ccurred on 12/14/2024.			through the auditing process.		
	believed the burn of	ccurred on 12/14/2024.					
	D	12/27/2024 -+ 2.50 D.M					
	_	y, on 12/27/2024 at 3:59 P.M.,					
		he first discovered the burn					
		he 24-hour nursing report that					
		s a wound. He indicated the					
		we been notified immediately					
	about the burn.						
		1 1 12/27/2024 (2.40 P.M.					
		ded, on 12/27/2024 at 3:40 P.M.,					
		rance Administrator. The					
		ge in a Resident's Condition or					
		Our facility shall promptly					
		his or her Attending					
	Physician, and repre	esentative [sponsor] of					

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>00</u> COMPL			LETED	
		155086	B. W	ING		12/27	/2024
				CTREET	ADDRESS SITU STATE ZIR SOD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WOODL A	ND MANOR						
WOODLA	AND MANOR			ELNHA	.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
	changes in the resid	ent's medical/mental condition					
	and/or status1. Th	ne nurse will notify the					
	resident's Attending	Physician or physician on					
	call when there has	been a[an]: a. accident or					
	incident involving the	he resident"					
	3.1-5(a)(1)						
F 0677	483.24(a)(2)						
SS=D	ADL Care Provide	ed for Dependent Residents					
Bldg. 00							
		, record review and interview,	F 0	677	What corrective actions will be		01/24/2025
	•	ensure showers were provided			accomplished for those reside		
		reviewed for ADL's (Activities			found to have been affected b	y the	
	of Daily Living). (R	Residents 53, E, F & 202)			deficient practice?		
					· Resident 53, E, F, and 202 v	vas	
	Findings include:				offered a shower by certified		
					nursing staff during the survey	/	
		for Resident 53 was completed			process on 12/26/24.		
		0:10 A.M. Diagnoses included,			· DON/designee will review th	eir	
		l to, chronic kidney disease,			bathing preferences with		
	obesity, lymphedem	na, and depression.			Residents 53, E, F, and 52 an		
		D G . (14DG)			will update the plan of care for		
		m Date Set (MDS) assessment,			bathing preferences if indicate	ed.	
		ndicated Resident 53 required			How other residents have the		
		num assistance for transfers,			potential to be affected by the		
	-	ing, was occasionally			same deficient practice will be)	
		ler and frequently incontinent			identified and what corrective		
	of bowels.				actions will be taken?		
	A aumont Cana Di	initiated on 12/10/2022			· All residents have the potent	แลเ เด	
		i, initiated on 12/19/2023, lent has an ADL Self Care			be affected		
		related to impaired mobility			The DON/designee will revie	:vv	
	-	stay. BATHING: The resident			current residents bathing preferences to ensure the		
	-	on staff to provide a			schedule reflects those		
	bath/Shower weekly	-			preferences and will update th	10	
		er/bed bath on Wednesday			1 -	i C	
	and Saturday after b	-			plan of care for bathing preferences if indicated.		
	and Saturday after t	orcaniast.			1 7	^	
	The charge deares	entation for December			What measures will be put into		
	THE SHOWER GOCUME	ananon for December			place or what systemic chang	C S	

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 4 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155086	B. W	'ING		12/27/	2024
			ı	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			NAPPANEE ST		
WOODL							
VVOODLA	AND MANOR			ELNHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated Resident	53 had received a bed bath on			will be made to ensure that the	е	
	12/14 and refused o	on 12/18. No further showers			deficient practice does not rec	ur?	
	were documented.				· The DON/designee will provi	de	
					education to nursing associate	es	
		ess Notes, dated 12/14/2024			on the requirements that bathi	ng	
	~	, lacked the documentation to			type and frequency be comple	eted	
	show the resident h	ad refused showers.			according to resident preferen	ce	
					as per the bathing schedule.		
		for Resident E was completed			Refusals are to be documente		
		0:32 A.M. Diagnoses included,			· Newly admitted residents wil		
		d to, encephalopathy, diabetes,			interviewed to determine bath	ing	
	anxiety, and depres	sion.			preference as to type and		
					frequency. The bathing sched		
		um Data Set (MDS)			will be updated to reflect those	9	
	· ·	2/17/2024, indicated the			preferences		
		artial to moderate assist for			How the corrective actions wil		
	bathing.				monitored to ensure the defici		
					practice will not recur, i.e., who		
		n, initiated on 12/17/2024,			quality assurance program wil	l be	
		E required 1 staff for			put into place?		
	bathing/showering	on Tuesday and Fridays.			· The DON/designee will comp	olete	
	D '1 (EL 1	1			routine auditing of shower		
		r documentation indicated the			documentation to ensure that		
		d a shower on 12/2, 12/6 and			bathing is being completed an	d	
		on 12/10. There was no			documented per the bathing		
	documentation for $24/2024$.	12/13, 12/17, 12/20 or 12/			schedule. Auditing to occur: 4		
	Z4/ZUZ4.				random residents daily x's 4 w then 4 random residents wkly		
	The Numeine Due one	aga Natas datad 19/14 thuanah			1		
		ess Notes, dated 12/14 through documentation to show the			4 wks, then 4 random resident		
	showers had been re				monthly x's 4 months for a total	ai Oi	
	SHOWERS HAU DEEH FO	Cluscu.			6 months of monitoring. Any findings will be addressed.		
	3 A record review	for Resident F was completed			The results of these reviews	vazill	
):49 A.M. Diagnoses included			be immediately reported if	VVIII	
		d to, diabetes, osteoarthritis,			concerns exist and will be		
	and obesity.	a to, diabetes, osteodrumius,			discussed at the monthly facili	itv	
	and obesity.				Quality Assurance Committee	-	
	A Quarterly Minim	um Data Set (MDS)	meeting monthly for three months				
		0/16/2024, indicated the			and then quarterly thereafter of		
		make his own decisions and			full compliance has been achie		
	resident was able to	make ms own decisions and	1		I ian compnance has been achie	CV C U	

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

Event ID:

1Q7P12 Facil

Facility ID: 000034

If continuation sheet

Page 5 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155086	B. W	ING		12/27/	2024
NAME OF F	PROVIDER OR SUPPLIER	.			ADDRESS, CITY, STATE, ZIP COD		
WOODL	AND MANOR				IAPPANEE ST RT, IN 46514		
WOODLA	AND MANOR		_	ELKHAI	K1, IN 40014		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		n of 1 staff for showering.		TAU	for a total of 6 months of		DATE
	l required supervision	a of 1 start for sine worting.		monitoring. Re-education,			
	A current Care Plan	n, initiated on 3/15/2021,			frequency and/or duration of		
	indicated Resident	F required assistance with adl's			reviews will be increased as		
	due to pain and arth	-			needed, if areas of noncompli		
		led but were not limited to			are identified through the inter	view	
		e of 1 staff, and his preference			process.		
	scheduled day with	rs at 5:00 A.M., on his					
	scheduled day with	noip noin stair.					
	A current Physician	a's Order dated 11/25/2023					
		vere to be done at 5:00 A.M.					
	on Tuesday and Fri	day mornings per resident					
	choice.						
	The shower documentation for Resident F indicated he had not received any showers or bed baths for the past 14 days from 12/13 to 12/26/2024.						
		ess Notes, dated 12/13 through documentation to show the d his showers.					
	on 12/26/2024 at 11	for Resident 202 was completed 1:04 A.M. Diagnoses included, d to, heart failure, hypertension					
		imum Data Set (MDS) 0/5/2024, indicated the					
		artial to moderate assist for					
	resident had an AD care performance de	ed on 11/2/2024, indicated the L (activity of daily living) self efficit related to sprained ankle.					

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 6 of 24

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 12/27/2024	
	PROVIDER OR SUPPLIEF		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, 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	
TAG	Resident 202's show December indicated Monday and Thurse sheet for Resident 2 to show that Reside of personal hygiene 12/26/2024. During an interview CNA 3 indicated sh computer and on pa During an interview Director of Nursing complete shower sh showers are logged lack of documentati residents did not rec A policy for Adl ca requested, but one v survey exit.	or, on 12/27/24 at 2:03 P.M. the indicated the staff did not leets anymore, and all the in the computer, and by the son in the computer, the serive their showers. The and showering was was not provided prior to the series of	TAG	DEFICIENCY	DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care				
. 2.3g. 00	interview, the facili	on, record review and ty failed to follow dietary or 1 of 3 residents reviewed for sidents 101)	F 0684	What corrective actions will be accomplished for those reside found to have been affected be deficient practice? Resident 101 has not had a negative outcome r/t untimely recommendation implementat	nts y the

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet

Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155086	B. W	ING		12/27/	/2024
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			NAPPANEE ST		
WOODLA	AND MANOR				RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
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TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		Resident 101 was completed			Resident 101 has not had a		
		0:27 A.M. Diagnoses included,			significant wt loss since		
		I to: acute kidney failure,			admission and has gained 6 lb	าร	
		lure and bradycardia. Resident			since admission.		
	-	facility on 11/20/2024.			The DON/designee notified to	he	
					physician of Res 101 r/t the		
	A Ouarterly Minim	um Data Set (MDS)			untimely RD recommendation		
		2/12/2024, indicated Resident			implementation with no new		
		ognitive impairment and no			orders. Responsible party not	ified	
	oral issues or weigh	-			Resident 101's C/P has been		
					updated to reflect residents'	•	
	A Care Plan initiate	ed 12/3/2024, indicated			status/needs.		
		nutritional problem or a			How other residents have the		
		tional problem. Interventions			potential to be affected by the		
	_	not limited to: provide			same deficient practice will be		
		ders and monitor percentage			identified and what corrective	•	
	consumed.	acis and memor percentage			actions will be taken?		
	consumed.				· Residents who receive RD		
	A General Note, da	ted 12/4/2024 at 10:47 P.M.,			recommendations from the RI)	
		101 was discussed with the			have the potential to be affect		
		am during the weekly			· DON/designee will review RI		
		review. Resident 101 had lost			recommendations x's last 30 d		
	-	mission. The interdisciplinary			to ensure recommendations g	-	
	_	luded, but were not limited to:			by the RD have been		
		Mighty Shakes twice daily at			implemented. Any findings wil	l be	
	-	with a request to order Nepro			addressed by notifying the	. 50	
		al impairment) 1 carton daily.			physician, and implementing t	he	
	` * *	continue the Mighty Shakes			recommendation, if ordered.		
	-	oplement was available.			What measures will be put into	0	
		ned at nutritional risk related to			place or what systemic chang		
	his new admission s				will be made to ensure that the		
					deficient practice does not rec		
	A Nurse Practitione	er's Note, dated 12/4/2024 at			The DON/designee will provi		
		d the nurse practitioner had			education to licensed nursing		
		y staff they needed to follow			on the requirement to address		
	the dietary recomm				recommendations within 72 hi		
					them being given.		
	A Physician's Order	r, dated 12/9/2024, indicated			· DON/designee will complete		
	-	y for nutritional support.	routine auding of RD				
		y cappoin			recommendations to ensure ti	melv	
			1		I resommendations to ensure the		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	NG		12/27/	/2024
				CED FEET	ADDRESS OF A STATE OF COR		
NAME OF P	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
14/00001	AND MANOD				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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Physician's Order	r for the Mighty Shake could			implementation.		
	not be located in the	e medical record.			How the corrective actions will	be	
					monitored to ensure the defici-	ent	
	The Medication Ad	ministration Record for			practice will not recur, i.e., wha	at	
	December 2024, inc	dicated the Nepro supplements			quality assurance program wil	l be	
	were not started unt	til 12/11/2024. There was no			put into place?		
	documentation fron	n 12/4/2024 - 12/11/2024 of any			· The DON/designee will comp	olete	
	Might Shakes suppl	lement being provided.			routine auding of RD		
					recommendations to ensure ti	mely	
	A policy was provide	ded, on 12/27/2024 at 3:40 P.M.,			implementation. Auditing to oc	-	
	by the Quality Assu	rance Administrator. The			wkly x's 30 days then monthly		
	policy titled, "Chan	ge in a Resident's Condition or			5 months for a total of 6 month	าร of	
	Status", indicated, "	Our facility shall promptly			monitoring.		
	notify the resident,	his or her Attending			· The results of these reviews	will	
	Physician, and repro	esentative [sponsor] of			be immediately reported if		
	changes in the resid	lent's medical/mental condition			concerns exist and will be		
	and/or status1. T	he nurse will notify the			discussed at the monthly facili	ty	
	resident's Attending	Physician or physician on			Quality Assurance Committee		
	call when there has	been a[an]: f. refusal of			meeting monthly for three mor	ıths	
	treatment or medica	ation two [2] or more			and then quarterly thereafter c	nce	
	consecutive times	"			full compliance has been achie	eved	
					for a total of 6 months of		
	3.1-37(a)				monitoring. Re-education,		
					frequency and/or duration of		
					reviews will be increased as		
					needed, if areas of noncomplia	ance	
					are identified through the inter	view	
					process.		
F 0689	483.25(d)(1)(2)						
SS=D	Free of Accident						
Bldg. 00	Hazards/Supervis						
		on, record review, and	F 06	589	What corrective actions will	ре	01/24/2025
		ty failed to ensure adequate			accomplished for those		
	_	ided to prevent hot soup			residents found to have beer	1	
		esidents reviewed for			affected by the deficient		
	accidents. (Residen	t L)			practice?		
					DON/designee has upda	ited	
	Finding includes:				Resident Ls physician and		
					updated on overall status,		

STATEMEN	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		12/27/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			NAPPANEE ST		
WOODI	AND MANOR				RT, IN 46514		
VVOODL	- WANON			LLINIIA			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		r Resident L was completed on			including status of burn.		
		P.M. Diagnoses included, but			DON/designee complete		
	were not limited to, muscle weakness, seizures,				an updated hot liquid safety e		
	osteoarthritis and diabetes mellitus type 2.				assessment on Resident L an	d	
					will be served hot liquids at a		
		num Data Set (MDS)			table.		
		12/23/2024, indicated Resident			Resident L's plan of care		
		ntact, required set-up			and Kardex has been updated	I to	
		ing and supervision/touch			reflect needs r/t hot liquids		
		omotion in her wheelchair. The					
		ed Resident L had an open			How other residents have th		
	lesion of the skin.				potential to be affected by th		
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			same deficient practice will I		
		rsing Note, dated 12/17/2024 at			identified and what corrective	e	
		red Resident L had informed			actions will be taken?		
		reating a wound on her leg. A			All residents who consul		
	_	4 centimeters by 2.5 centimeters			hot liquids have the potential t	o be	
		ght anterior shin of Resident L.			affected.		
		rellow drainage present. The			DON/designee will comp	olete	
	_	was pink and larger in size			an updated hot liquid safety	1	
		eft calf. The physician was order was obtained for			assessment on current reside	nıs	
		tibiotic) 100 milligrams twice			to determine risk and will		
	daily for 10 days.	tiolotic) 100 minigrams twice			implement safety interventions indicated. The plan of care an		
	daily for 10 days.				Kardex will be updated to refle		
	Δ Nursing Progress	s Note, dated 12/18/2024 at 3:22			those needs.	701	
		new physician's order was			those needs.		
	· ·	ent L's leg wound. The order			What measures will be put in	nto	
		e the wound site with wound			place or what systemic		
		ine and pat dry, apply triple			changes will be made to		
		and cover with a non-adherent			ensure that the deficient		
	dressing daily for 1				practice does not recur?		
	<i>g</i> ,	,			DON/designee will provi	de	
	A Nursing Progress	s Note, dated 12/20/2024 at			education to nursing associate		
		ted during an interview with			on the requirement to ensure		
	Resident L, she indicated the wound had occurred				safety interventions are in place	ce	
	last Saturday (12/14/2024) when a CNA handed				per hot liquid assessment whe		
		of Noodles in the hallway and			hot liquids are served		
	_	vent to place the bowl on her			DON/designee will comp	olete	
		opel her wheelchair, the bowl			an updated hot liquid safety		

1Q7P12

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		12/27/	/2024
		l	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			IAPPANEE ST		
WOODL	AND MANOR				RT, IN 46514		
VVOODLA	JONNAIN ON			LLNHA	IXI, IIN 40014		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		I the hot liquid and noodles fell			assessment for new admits,		
		esident L indicated the wound			quarterly and with a change in		
		, but not all the time. Resident			condition to residents to deter		
		ed to be red with serious			risk, and will implement safety		
	I -	lent's right shin was pink in			interventions as indicated. The	Э	
		s when compared to her left			plan of care and Kardex will		
		s wound was to be followed by			updated to reflect those needs		
	the wound physicia	n.			How the corrective actions w	vill	
					be monitored to ensure the		
		Incident to the Indiana			deficient practice will not		
		th was completed on			recur, i.e., what quality		
		port indicated Resident L had			assurance program will be p	ut	
		g and a burn was noted to the			into place?		
	_	tigation was initiated.			The DON/designee will		
	_	otes indicated Resident L had			complete routine audits of		
		at up a bowl of noodle soup for			residents who require safety		
		ve. The resident asked for the			measures when served/consu	ımed	
		the microwave for 3 minutes.			hot liquids to ensure those		
		e task, CNA 9 handed the			measures are in place. Audit	-	
	_	ent L, but during the process			to occur: 4 random residents o	daily	
		after the bowl was handed to			x's 4 wks, then 4 random		
		ip had spilt onto the resident's			residents wkly x's 4 wks, then		
	_	Resident L indicated her pants			random residents monthly x's		
		was "not a problem." CNA 9			months for a total of 6 months		
		oned the incident to QMA 8			monitoring. Any findings will b	е	
		and heard her as he was busy			addressed.		
		s but he did respond "OK."			The results of these revi		
	1	e did not know anything about			will be immediately reported if		
		L's leg or spilt soup. QMA 10,			concerns exist and will be		
		n 12/14/2024 indicated she was			discussed at the monthly facili	-	
	_	oup and had informed LPN 2 of			Quality Assurance Committee		
		2, who worked on 12/14/2024			meeting monthly for three mor		
		icated she was made aware of			and then quarterly thereafter of		
		e spilt soup on 12/14/2024 and			full compliance has been achi	eved	
	told Resident L she would look at her leg but				for a total of 6 months of		
	when she went to assess Resident L's leg, the				monitoring. Re-education,		
	resident was outside and she forgot to look at her				frequency and/or duration of		
	_	t returned from being outside.			reviews will be increased as		
		ne was working on 12/14/2024			needed, if areas of noncompli		
	and he had delivere	d another bowl of heated soup	1		are identified through the inter	view	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155086	B. W	/ING		12/27/	/2024
	PROVIDER OR SUPPLIER		•	343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ilE	DATE
	to Resident L's roon	n after a different staff member			process.		
	had heated up the be	owl. He was not aware of the			•		
	spilt soup from the	previous bowl of soup.					
	on 12/20/2024, the Resident L. Resider asked an employee was heated and handindicated she spilled Resident L indicated looked at her legs. Suburning and she pla over the wounded a informed the nurse was experiencing an address the wound. employee indicated but she did not do a Resident L indicated leg pain and drainagpants. Resident L in picture of the woundphysician and applied A handwritten with indicated Resident I about a small burn of size of a dime on 12 indicated the nurse or burn that had occ indicated Resident I was completing oth when she finished hands	Administrator had interviewed at L indicated after dinner she to heat up her soup. The soup ded back to her. Resident L d the soup down her leg. d she removed her pants and She indicated her leg was ced a tissue with medical tape rea. Resident L indicated she on 12/15/2024 of the pain she and that she needed someone to Resident L indicated the she would look at the wound, mything about the wound. d she later told RN 12 of her ge that had seeped through her adicated RN 12 then took a d, sent the picture to the ed cream to the area. Less statement, t by LPN 2, L came to her and told her on her thigh that was about the 2/15/2024. Resident L had had not assessed the situation curred on her leg. LPN 2 L had came to her when she er documentation tasks and her task went to assess					
		PN 2 indicated Resident 2 had					
		oke and Resident 2 indicated EPN 2 after she came back					
		ated both herself and Resident					
		and had forgotten about the					
	assessment.	and had forgotten about the					
	assessment.						

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 12 of 24

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		12/27/	2024
				CTREET	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WOODLA	ND MANOD				IAPPANEE ST		
WOODLA	AND MANOR			ELNHAI	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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
	During an interview	y, on 12/27/2024 at 10:55 A.M.,					
	Resident L indicated	d she had asked the staff to					
	heat up her Ramen	noodles for a bedtime snack.					
	The Ramen noodles	were heated up in her own					
	plastic square bowl.	Resident L indicated she may					
	have placed too mu	ch water in the bowl and it					
		esident L indicated she					
	informed several nu	rses about the burn. Resident					
	L indicated she felt	the burn would not have					
	_	in infection if the staff had					
	done something abo	out the burn earlier.					
	_	y, on 12/27/2024 at 11:14 A.M.,					
		sident L had informed her on					
		urn on her thigh. LPN 2					
	indicated Resident I	came to her while she was					
		ork. LPN 2 indicated Resident L					
		oke and both she and the					
	_	at the burn. LPN 2 indicated					
	she believed the but	n occurred on 12/14/2024.					
	_	on and interview, on					
		P.M., the Director of Nursing					
	, , , <u> </u>	dressing to Resident L's left					
	-	e area was a healing burn. He					
		s 2 burns with the initial burn					
		nd where the hot liquid had					
		ent's leg. The DON indicated					
		y a second-degree burn. The					
		lressing on the wound area. He					
		d cream would be applied					
	when overnight dres	ssing change was completed.					
		10/07/0001					
	-	y, on 12/27/2024 at 3:59 P.M.,					
		he first discovered the burn					
		he 24-hour nursing report that					
		s a wound. The DON					
		ald have know better than to					
		ound resident attempt to carry					
	hot liquids. He indi	cated the physician should					

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 13 of 24

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 12/27/2024
	PROVIDER OR SUPPLIER AND MANOR		343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST NRT, 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 APPROPRIATI DEFICIENCY)	
TAG		METERITIES AND ASSESSED	TAG	DEFICIENCE!)	DATE
	physician or a Nurs Resident L's wound A Hot Liquid Safety completed on 12/24 had impaired safety muscle strength of l abnormal muscle m history of spilling li indicated the reside propelling her whee A policy was provid by the Quality Assu policy titled, "SafetResidents will be and potential for inj Appropriate precau	sment completed by a e Practioner regarding /burn as of 12/26/2024. y Evaluation for Resident L, //2024 indicated the resident with hot liquids due to altered ner hands, tremors and ovements of her hands and a quids. The assessment nt was capable of self elchair. ded, on 12/27/2024 at 3:40 P.M., urance Administrator. The y of Hot Liquids" indicated, " evaluated for safety concerns ury from hot liquids. tions will be implemented to beverage while minimizing the			
F 0755 SS=D	potential for injury from hot liquids is a among residents wi	1. The potential for burns considered an ongoing concern th weakened motor skills, aired cognition, and nerve or aditions"			
Bldg. 00	Srvcs/Procedures Based on observation interview, the facility ordered medication	/Pharmacist/Records on, record review and ty failed to ensure physician s were available for 5 of 6 dications were reviewed. 01 & 41)	F 0755	What corrective actions will be accomplished for those resider found to have been affected by deficient practice? • The DON/designee contacted pharmacy to reorder Resident I L, F, 101 & 41 and verified delivers.	the the E,

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet

Page 14 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		12/27/	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			NAPPANEE ST		
WOODLA	AND MANOR				RT, IN 46514		
	Г				,	1	are:
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	1 .	C D '1 (F 1 1 1			How other residents have the		
		for Resident E was completed			potential to be affected by the		
		0:32 A.M. Diagnoses included,			same deficient practice will be	;	
		to, encephalopathy, diabetes,			identified and what corrective		
	anxiety and depress	ion.			actions will be taken?	4:	
	The				· Residents who have medica	tions	
	following:	an orders included the			ordered and administered by		
		(milligram) 1 tablet are time a			facility associates have the		
	day for antidiabetes	(milligram) 1 tablet one time a			potential to be affected.	nloto	
	1 .				· The DON/designee will comp		
	1	e tablet 10 mg 1 tablet in the			a facility wide medication audi	ii io	
	morning for season	iai allergy.			ensure that medications are		
	The December Med	liantian Administration Bassed			available as per physician's		
		lication Administration Record			orders.		
	, ,	n 12/14/2024 the Sitagliptin oral			What measures will be put into		
	1	time a day for diabetes was			place or what systemic chang		
		Hold/See Nurse Note and the			will be made to ensure that the		
	as 16 on 12/20/2024	t 10 mg was also documented			deficient practice does not rec		
	as 10 on 12/20/202	+.			· A 3rd party provider from IH(
	Am amam (alaatmamia	a madical administration record)			will provide education to licens		
		c medical administration record) 024, indicated Sitagliptin 100			nursing staff on timely reorder	-	
		e a day for antidiabetes was			of medications. Education will		
	"on order."	c a day for antiquatetes was			be provided to nursing associa		
	on order.				who administer medications o		
	An emar note data	d 12/20/2024, indicated the			utilizing the EDK for medication when necessary for medication		
	Zyrtec medication v				not yet dispensed to resident.		
	Zyrice medication (was on order.			How the corrective actions will		
	2 A record review	for Resident F was completed			monitored to ensure the defici		
		0:49 A.M. Diagnoses included			practice will not recur, i.e., wh		
		d to, diabetes, osteoarthritis			quality assurance program wil		
	and obesity.	. to, diabetes, oscodiumius			put into place?	1 50	
	and occurry.				· The DON/designee will routing	nelv	
	The current physici	an's orders included:			audit medication carts to ensu	-	
		convulsant) 400 mg 1 capsule			medications are available for		
	at bedtime.	convenient, 100 mg i capsuic			administration. Auditing to occ	nır.	
	at oodinie.				4 residents daily M-F x's 4 wk		
	The December MA	R indicated on 12/15, 12/16 and			then 4 residents wkly x's 4 wk		
		bapentin medication was			then 4 residents monthly x's 4		
		- Hold See Nurse Note."			months for a total of 6 months		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155086	B. W	ING		12/27	/2024
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WOOD!							
VVOODLA	AND MANOR			ELNHA	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 OF	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
					monitoring.		
	The Nursing Progre	ess Notes, dated 12/15 through			· The DON/designee will revie	w the	
	12/17/2024, lacked	the documentation to indicate			Medication Admin Audit Repo	rt to	
	why the medication	had not been administered on			ensure that residents have		
	12/15, 12/16 and 12	2/17/2024.			received their medications as		
					ordered. Any findings will be		
	3. A record review	for Resident L was completed			addressed. Auditing to occur:		
	on 12/27/2024 at 1:	17 P.M. Diagnoses included,			Daily M-F x's 4 weeks, then		
	but were not limited	d to, kidney failure, diabetes,			weekly x's 4 weeks, then mon	thly	
	osteoarthritis, anxie	ty and diabetic			x's 4 months for a total of 6		
	polyneuropathy.				months of monitoring.		
					· The results of these reviews	will	
	The current Physici	an's Orders included Sertraline			be immediately reported if		
	(an antidepressant)	25 mg (milligram) 1 tablet at			concerns exist and will be		
	bed time.				discussed at the monthly facili	ity	
					Quality Assurance Committee		
	The December MA	R indicated on 12/25/2024, the			meeting monthly for three mor	nths	
	Sertraline medication	on was documented as "16 -			and then quarterly thereafter o	once	
	Hold See Nurse No	te."			full compliance has been achi	eved	
					for a total of 6 months of		
		ess Notes, dated 12/25/2024,			monitoring. Re-education,		
	lacked documentati	on to indicate why the			frequency and/or duration of		
	medication had not	been administered.			reviews will be increased as		
					needed, if areas of noncompli	ance	
		for Resident 41 was completed			are identified through the inter	view	
		42 P.M. Diagnoses included,					
		d to, hypertension, dysphagia,					
	depression and anxi	iety.					
	-	an's Orders included the					
	_	e (an antidepressant) 100 mg					
	one time a day.						
		R indicated on 12/14/2024 the					
		on was documented as "16 -					
	Hold See Nurse No	te."					
		, dated 12/14/2024, indicated					
	the medication was	"on order."					
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155086	B. W	ING		12/27	/2024
				CTREET A	DDDFGG CITY GTATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
MOODL	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	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)		DATE
	5. A record review	for Resident 101 was					
	completed on 12/26	5/2024 at 10:27 A.M. Diagnoses					
	included, but were	not limited to: acute kidney					
		heart failure and bradycardia.					
	_	ted to the facility on					
	11/20/2024.	j					
	A Physician's Order	r, dated 11/21/2024, indicated					
		diabetes) 1.5 milligrams per 0.5					
	• `	ocutaneously weekly every					
	Tuesday.						
	1 accamy.						
	A Care Plan initiat	ed 11/22/2024, indicated					
		iabetes mellitus. The					
		led, but were not limited to:					
	provide medication						
	provide medication	as ordered.					
	The Medication Ad	ministration Record, for					
		dicated Resident 101 did not					
		y injections on 12/3/2024,					
		•					
	12/10/2024, 12/17/2	2024 and 12/24/2024.					
	There were no Nurs	sing Progress Notes that					
	indicated the physic	cian or nurse practitioner were					
		ssing administration of the					
		son why the resident did not					
	receive their medica						
	A Care Plan, initiat	ed 12/3/2024, indicated					
	Resident 101 had a	nutritional problem or a					
		tional problem. Interventions					
	_	not limited to: provide					
	· ·	ders and monitor percentage					
	consumed.	F					
	During an interview	v, on 12/27/2025 at 2:37 P.M.,					
	-	sing indicated he was on the					
		day with the pharmacy. He					
		ses had contacted the					
	pharmacy, they sho	ould have documented in the					

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 17 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPLETED	
		155086	B. WING			12/27/	2024
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD	•	
			343 S NAPPANEE ST				
WOODLA	AND MANOR		L	LKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION lition, the nurses should have	T	AG	DEFICIENC!)		DATE
		nurses notes why they were					
		rdered medications. The					
	_	indicated the residents should					
	have received their	medications.					
	During an interview, on 12/27/2024 at 2:54 P.M.,						
	_	a medication was not in the cart,					
		ee if it was in back stock, look					
	to see if it was orde	red and looked in the EDK					
		(it) for the medication. She					
	indicated if she still could not locate the medication, she notified the physician and the pharmacy. LPN 2 indicated if the MAR indicated						
		lable and it could not be					
		documented in the progress					
	notes that it was "or	n order."					
	On 12/27/2024 at 3	:40 P.M., the Corporate Nurse					
		titled, "Ordering and					
		ons", dated 5/20/2020, and					
		was the one currently used					
		policy indicated "					
		lated products are received in a timely manner i. Reorder					
		four day supply remains, in					
		assure an adequate supply on					
	hand"						
	This deficiency	vaited on 11/14/2024. The					
	-	s cited on 11/14/2024. The plement a systemic plan of					
	correction to prever						
	•						
	3.1-25(a)						
F 0880	483.80(a)(1)(2)(4)	(e)(f)					
SS=D	Infection Prevention						
Bldg. 00							
		on, interview and record	F 0880		What corrective actions will be		01/24/2025
	review, the facility	failed to ensure infection			accomplished for those reside	nts	

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

Event ID:

1Q7P12

Facility ID: 000034

If continuation sheet

Page 18 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155086	B. W	ING		12/27/	2024
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
W000	AND MANOD				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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	control practices we	ere followed related to glove			found to have been affected b	v the	
	use and handwashir	ng during perineal and			deficient practice?	,	
		of 2 residents observed for			· Resident 50 and 34 did not		
	catheter care. (Resid				experience a negative outcom	e	
		,			from deficient practice.		
	Findings include:				· C.N.A 6, QMA 4, and LPN 2	was	
	8				educated by the DON/designe		
	1. During an observ	ration, on 12/27/2024 at 10:07			glove use and handwashing d		
	_	ut wearing a gown, was			peri care, catheter care. These	-	
		e incontinence/catheter care to			associates will perform and	-	
	1	she used a washcloth and			successfully pass a return		
		catheter tubing. LPN 2,			demonstration competency.		
		er gloves or washing her			How other residents have the		
		ew brief. After obtaining the			potential to be affected by the		
	1	then changed her gloves and			same deficient practice will be		
		over to his left side with the			identified and what corrective		
		4. LPN 2 then washed			actions will be taken?		
		cks and peri area. She then			Other residents who receive	nori	
		over to his back. LPN 2,			care and catheter care have the	-	
		er gloves, touched the call			potential to be affected	IC	
		s and the residents bed control			1 *	do	
	remote.	s and the residents bed control			 The DON/designee will provi education to licensed and cert 		
	Telliote.						
	During an intervious	y, on 12/27/2024 at 10:51 A.M.,			nursing associates on glove u	-	
		e should have changed her			and handwashing during peri	care	
		her hands and worn a gown			and catheter care.	_	
	l -	nei nanus anu woin a gown			What measures will be put into		
	for protection.				place or what systemic change		
	2 During an abar	ration on 12/27/2024 at 12:00			will be made to ensure that the		
	_	ration, on 12/27/2024 at 12:00			deficient practice does not rec		
		MA 4 was observed to provide			· The DON/designee will provi		
		er care to Resident 34. QMA 4			education to licensed and cert		
		tubing and the resident's			nursing associates on glove u		
	-	as. She changed her gloves			during peri care and catheter		
		d and dried the areas. She			and will complete routine audi		
	_	of gloves and applied cream to			to ensure best practices are b	eing	
		ks. Without changing her			followed.		
		ner hands, QMA 4 then			How the corrective actions wil		
		ef and linens on the resident's			monitored to ensure the defici		
	bed.				practice will not recur, i.e., who		
					quality assurance program wil	l be	

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

Event ID:

1Q7P12 Facility ID: 000034

If continuation sheet Page 19 of 24

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 12/27/2024	
	PROVIDER OR SUPPLIEF	2	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST .RT, IN 46514	
(X4) ID PREFIX TAG	During an interview QMA 4 indicated si hands. On 12/27/2024 at 1 Assurance Administitled, "Perineal Car 2/2018, and indicate currently used by the indicated: "m. Withoroughly, including the anus, and the buthoroughly 10. Redesignated contained hand thoroughly" This deficiency was facility failed to imcorrection to prevent	emove gloves and discard into er. 11. Wash and dry your s cited on 11/14/2024. The plement a systemic plan of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) put into place? The DON/designee will comproutine observations of glove used and hand washing during peristory to ensure best practices are be performed. Observations to occur a for a fine period of the performed of the performing care wkly x's 4 wks, then a fine random associates performing care monthly x's 5 months for total of 6 months of monitoring. The results of these reviews be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three more and then quarterly thereafter of full compliance has been achief 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 identified through the interprocess.	olete use care eing ccur: ng 4 uperi a uwill ty nths once eved
F 0883 SS=D Bldg. 00	Based on record reviated failed to provide coresidents reviewed 101) Finding includes: A record review for on 12/26/2024 at 10	eumococcal Immunizations view and interview, the facility nsented vaccinations for 1 of 4 for immunizations. (Resident Resident 101 was completed 0:27 A.M. Diagnoses included, d to: acute kidney failure,	F 0883	What corrective actions will be accomplished for those reside found to have been affected by deficient practice? Resident 101 was given the Influenza vaccination on 1/8/20 How other residents have the potential to be affected by the same deficient practice will be identified and what corrective	nts y the

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

Event ID:

1Q7P12

Facility ID: 000034

If continuation sheet

Page 20 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONST A. BUILDING B. WING	TRUCTION 00	(X3) DATE SURVEY COMPLETED 12/27/2024	
	PROVIDER OR SUPPLIER		RESS, CITY, STATE, ZIP COD PANEE ST 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	congestive heart failure and bradycardia. A Quarterly Minimum Data Set (MDS) assessment, dated 12/12/2024, indicated Resident 101 had moderate cognitive impairment. The assessment indicated Resident 101 had declined the influenza vaccination. Admission documents, dated 11/14/2024, indicated consent was provided for the influenza vaccination.	cc int pc W pl: wi de · [ctions will be taken? Other residents who have onsented to receiving the fluenza vaccination have the otential to be affected that measures will be put in ace or what systemic changill be made to ensure that the ficient practice does not reconvided to a consume that the ficient practice does not reconvide the flucation to licensed nurses the requirement to administe	nto ges he ecur?	
	Documentation could not be located in the electronic medical record of the influenza vaccination being administered.	In cc	fluenza immunization wher onsented to. The DON/designee will con n audit of all current resider	nplete	
	A policy for the influenza vaccination was requested, on 12/27/2024 at 3:23 P.M. However, the policy was not provided by the facility.	cc	nsure the influenza vaccine onsent or declination has be ompleted. If residents have onsented to the vaccine and	een	
	During an interview, on 12/27/2024 at 4:00 P.M., the Director of Nursing (DON) indicated residents or resident representatives that give consent for vaccinations should have the vaccine ordered immediately and should have received the vaccination upon arrival from the pharmacy. The DON indicated he was unsure why Resident 101 not received the influenza vaccination. 3.1-13(a)	tin va or Hu m pr qu pu · 1 ro re va cc Tr ec ar	me for them to receive it, Concination will be administed dered ow the corrective actions wo onitored to ensure the deficit actice will not recur, i.e., who will allity assurance program wout into place? The DON/designee will computine auditing of newly admissions to ensure the Influence actions has been administer onsented to; and document in swill be repeated annually ducation is provided to reside advice the results of these reviews the immediately reported if oncerns exist and will be secussed at the monthly faciliary the received and the results of these reviews the immediately reported if oncerns exist and will be secussed at the monthly faciliary and the results of the secussed at the monthly faciliary and the received and and the receiv	OVID red as fill be cient hat fill be inplete initted enza red if ed. ly after dents s will	

If continuation sheet

PRINTED: 01/17/2025

	T OF HEALTH AND HU						RM APPROVED IB NO. 0938-039
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		ILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/27/2024	
WOODL	PROVIDER OR SUPPLIE			343 S I ELKHA	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST NRT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ίΤΕ	(X5) COMPLETION DATE
F 0887	483.80(d)(3)(i)-(v	•			Quality Assurance Committee meeting monthly for three monand then quarterly thereafter of 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.	nths once eved	
SS=D Bldg. 00	failed to provide or residents reviewed 101) Finding includes: A record review for on 12/26/2024 at 1 but were not limited congestive heart fath A Quarterly Mining assessment, dated 101 had moderate	oview and interview, the facility consented vaccinations for 1 of 4 of for immunizations. (Resident or Resident 101 was completed 0:27 A.M. Diagnoses included, and to: acute kidney failure, cilure and bradycardia. The mum Data Set (MDS) 12/12/2024, indicated Resident cognitive impairment. The ed Resident 101's COVID-19	F 08	87	What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Resident 101's COVID vaccine was administered Jan 14, 2025. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Other residents who have consented to receiving the CO vaccination have the potential	nuary e ne be ve	01/24/2025

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

booster.

vaccinations were not up to date.

having been administered.

Admission documents, dated 11/14/2024,

Documentation could not be located in the

electronic medical record of the vaccination

indicated consent was given for the COVID-19

Event ID:

1Q7P12

Facility ID: 000034

be affected

What measures will be put into

DON/designee will provide

education to licensed nurses on

the requirement to administer

place or what systemic

changes will be made to

ensure that the deficient practice does not recur?

If continuation sheet

Page 22 of 24

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

PRINTED: 01/17/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/27/2024
	PROVIDER OR SUPPLIER		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
WOODLA (X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) COVID immunization when consented to. The DON/designee will complete an audit of all curre residents to ensure a COVID vaccine consent or declination been completed. If residents consented to the vaccine and time for them to receive it, CO vaccination will be administer ordered How the corrective actions to be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be properties.	nt n has have it is OVID ed as
				into place? The DON/designee will complete routine auditing of radmitted residents to ensure COVID vaccine has been administered if consented to; documented. This will be repeannually after education is provided to residents and/or responsible parties. The results of these revisible be immediately reported in concerns exist and will be discussed at the monthly facion Quality Assurance Committed meeting monthly for three monand then quarterly thereafter full compliance has been ach for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncomples.	and eated iews f ity e nths once ieved

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

Event ID:

1Q7P12

Facility ID: 000034

If continuation sheet

Page 23 of 24

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

PRINTED: 01/17/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 12/27/	ETED
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 APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				are identified through the inter	view	
				process.		
F 9999						
Bldg. 00			F 9999	No citation noted		01/24/2025

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1Q7P12 Facility ID: 000034 If continuation sheet Page 24 of 24