STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	12/27/2024

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/14/2024. This visit included a PSR to the Investigation of Complaints IN00442899, IN00446004 and IN00442666 completed on 11/14/2024. Complaint IN00442666 - Corrected Complaint IN00446004 - Not corrected Complaint IN00442899 - Corrected Survey dates: December 26 & 27, 2024 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 2 Medicaid: 66 Other: 1 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 1/6/2025	F 0000		
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, review and interview, the facility failed to notify the physician timely of a	F 0580	What corrective actions will be accomplished for those residents	01/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Chalman	Interim Administrator	01/14/2025

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.

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	change in condition for 1 of 3 residents reviewed for accidents. (Resident L) Finding includes: A record review for Resident L was completed on 12/26/2024 at 1:36 P.M. Diagnoses included, but were not limited to: muscle weakness, seizures, osteoarthritis and diabetes mellitus type 2. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident L was cognitively intact. She required set-up assistance with eating and locomotion in her wheelchair. The assessment indicated she did not have a burn, but an open lesion of the skin. A Skin/Wound Nursing Note, dated 12/17/2024 at 11:05 P.M., indicated Resident L stated she had been treating a wound on her leg. The wound measured 4 centimeters by 2.5 centimeters and was located on the resident's right anterior shin. There was a little yellow drainage present. The resident's right calf was pink. A new physician's order was obtained for doxycycline (antibiotic) 100 milligrams twice daily for 10 days. A Nursing Progress Note, dated 12/18/2024 at 3:22 A.M., indicated a physician's order was received. The order indicated to cleanse Resident L's wound site with wound wash or normal saline and pat dry, apply triple antibiotic ointment and cover with a non-adherent dressing daily for 10 days for the wound. A Nursing Progress Note, dated 12/20/2024 at 10:00 A.M., indicated during an interview with Resident L, she indicated the wound occurred last Saturday (12/14/2024) when a CNA handed her a bowl of Cup of Noodles and the bowl fell onto her		found to have been affected by · DON/designee notified the physician for Resident L r/t a change in condition r/t burn injury on 12/26/24. 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 experienced a change in condition r/t a burn have the potential to be affected. · DON/designee will complete an audit to identify other burns x's 60 days to ensure physician notification was made. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · A 3rd party licensed clinician from IHCA is scheduled to provide education to licensed nurses and Qualified Medication Aides on the requirement to notify the physician for changes in condition r/t burns. DON/designee will complete routine observations of changes in conditions r/t burn injuries to ensure timely physician notification. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · DON/designee will complete routine observations of changes in	

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	leg. The note indicated the wound was red and open with serous drainage. Resident L's right shin was edematous compared to the left leg. Resident L indicated the area hurt off and on, but not all the time. Resident L was to be followed by the wound physician. During a facility-initiated investigation, on 12/20/2024, LPN 2 indicated that she was aware Resident L had spilt soup on her lap. LPN 2 indicated she informed Resident L she would look at her leg, but when LPN 2 went to Resident L's room, Resident L was outside smoking. LPN 2 forgot to look at Resident L's leg when she returned from being outside. There was not a nursing progress note made from 12/14/2024-12/18/2024 regarding the burn. During an interview, on 12/27/2024 at 11:14 A.M., LPN 2 indicated Resident L had informed her on 12/15/2024 of the burn on her thigh. LPN 2 indicated Resident L came to her while she was completing paperwork. LPN 2 indicated Resident L went outside to smoke and both she and Resident L forgot about the burn. LPN 2 indicated she believed the burn occurred on 12/14/2024. During an interview, on 12/27/2024 at 3:59 P.M., the DON indicated he first discovered the burn when he reviewed the 24-hour nursing report that described the area as a wound. He indicated the physician should have been notified immediately about the burn. A policy was provided, on 12/27/2024 at 3:40 P.M., by the Quality Assurance Administrator. The policy titled, "Change in a Resident's Condition or Status", indicated, " ...Our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of		conditions r/t burn injuries to ensure timely physician notification by review of the medical record. Auditing to occur: changes in conditions r/t burns daily M-Fri x's 30 days, then 4 changes in conditions r/t burns wkly x's 30 days, then 4 changes in conditions r/t burns x's 4 months for a total of 6 months of monitoring. 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 auditing process.	

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	changes in the resident's medical/mental condition and/or status ...1. The nurse will notify the resident's Attending Physician or physician on call when there has been a[an]: a. accident or incident involving the resident ...." 3.1-5(a)(1)			
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 4 of 7 residents reviewed for ADL's (Activities of Daily Living). (Residents 53, E, F & 202) Findings include: 1. A record review for Resident 53 was completed on 12/26/2024 at 10:10 A.M. Diagnoses included, but were not limited to, chronic kidney disease, obesity, lymphedema, and depression. An Annual Minimum Date Set (MDS) assessment, dated 10/23/2024, indicated Resident 53 required substantial to maximum assistance for transfers, bathing and showering, was occasionally incontinent of bladder and frequently incontinent of bowels. A current Care Plan, initiated on 12/19/2023, indicated: The resident has an ADL Self Care performance deficit related to impaired mobility and recent hospital stay. BATHING: The resident is totally dependent on staff to provide a bath/Shower weekly and as necessary. ADL-Bathing shower/bed bath on Wednesday and Saturday after breakfast. The shower documentation for December	F 0677	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident 53, E, F, and 202 was offered a shower by certified nursing staff during the survey process on 12/26/24. · DON/designee will review their bathing preferences with Residents 53, E, F, and 52 and will update the plan of care for bathing preferences if indicated. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? · All residents have the potential to be affected · The DON/designee will review current residents bathing preferences to ensure the schedule reflects those preferences and will update the plan of care for bathing preferences if indicated. What measures will be put into place or what systemic changes	01/24/2025

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	indicated Resident 53 had received a bed bath on 12/14 and refused on 12/18. No further showers were documented. The Nursing Progress Notes, dated 12/14/2024 through 12/27/2024, lacked the documentation to show the resident had refused showers. 2. A record review for Resident E was completed on 12/26/2024 at 10:32 A.M. Diagnoses included, but were not limited to, encephalopathy, diabetes, anxiety, and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 12/17/2024, indicated the resident required partial to moderate assist for bathing. A current Care Plan, initiated on 12/17/2024, indicated Resident E required 1 staff for bathing/showering on Tuesday and Fridays. Resident E's shower documentation indicated the resident had refused a shower on 12/2, 12/6 and received a bed bath on 12/10. There was no documentation for 12/13, 12/17, 12/20 or 12/24/2024. The Nursing Progress Notes, dated 12/14 through 12/26/2024, lacked documentation to show the showers had been refused. 3. A record review for Resident F was completed on 12/26/2024 at 10:49 A.M. Diagnoses included but were not limited to, diabetes, osteoarthritis, and obesity. A Quarterly Minimum Data Set (MDS) assessment, dated 10/16/2024, indicated the resident was able to make his own decisions and		will be made to ensure that the deficient practice does not recur? · The DON/designee will provide education to nursing associates on the requirements that bathing type and frequency be completed according to resident preference as per the bathing schedule. Refusals are to be documented. · Newly admitted residents will be interviewed to determine bathing preference as to type and frequency. The bathing schedule will be updated to reflect those preferences How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will complete routine auditing of shower documentation to ensure that bathing is being completed and documented per the bathing schedule. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 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	

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	required supervision of 1 staff for showering. A current Care Plan, initiated on 3/15/2021, indicated Resident F required assistance with adl's due to pain and arthritis of the left hip. Interventions included but were not limited to extensive assistance of 1 staff, and his preference was to have showers at 5:00 A.M., on his scheduled day with help from staff. A current Physician's Order dated 11/25/2023 indicated showers were to be done at 5:00 A.M. on Tuesday and Friday 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. The Nursing Progress Notes, dated 12/13 through 12/26/2024 lacked documentation to show the resident had refused his showers. 4. A record review for Resident 202 was completed on 12/26/2024 at 11:04 A.M. Diagnoses included, but were not limited to, heart failure, hypertension and Schizophrenia. An Admission Minimum Data Set (MDS) assessment, dated 10/5/2024, indicated the resident required partial to moderate assist for showering. A Care Plan, initiated on 11/2/2024, indicated the resident had an ADL (activity of daily living) self care performance deficit related to sprained ankle. Resident 202 required staff participation with showering.		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 process.	

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	Resident 202's shower documentation for December indicated he was to receive showers on Monday and Thursday evenings. The shower sheet for Resident 202 lacked the documentation to show that Resident 202 had received any type of personal hygiene from 12/14 through 12/26/2024. During an interview, on 12/27/2024 at 2:00 P.M., CNA 3 indicated showers were documented in the computer and on paper. During an interview, on 12/27/24 at 2:03 P.M. the Director of Nursing indicated the staff did not complete shower sheets anymore, and all the showers are logged in the computer, and by the lack of documentation in the computer, the residents did not receive their showers. A policy for Adl care and showering was requested, but one was not provided prior to the survey exit. This deficiency was cited on 11/14/2024. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review and interview, the facility failed to follow dietary recommendations for 1 of 3 residents reviewed for quality of care. (Residents 101) Finding includes:	F 0684	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident 101 has not had a negative outcome r/t untimely RD recommendation implementation.	01/24/2025

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	A record review for Resident 101 was completed on 12/26/2024 at 10:27 A.M. Diagnoses included, but were not limited to: acute kidney failure, congestive heart failure and bradycardia. Resident 101 admitted to the facility on 11/20/2024. A Quarterly Minimum Data Set (MDS) assessment, dated 12/12/2024, indicated Resident 101 had moderate cognitive impairment and no oral issues or weight loss. A Care Plan, initiated 12/3/2024, indicated Resident 101 had a nutritional problem or a potential for a nutritional problem. Interventions included, but were not limited to: provide supplements per orders and monitor percentage consumed. A General Note, dated 12/4/2024 at 10:47 P.M., indicated Resident 101 was discussed with the interdisciplinary team during the weekly nutritionally at-risk review. Resident 101 had lost 2.5 pounds since admission. The interdisciplinary team comments included, but were not limited to: recommend starting Mighty Shakes twice daily at breakfast and lunch with a request to order Nepro (supplement for renal impairment) 1 carton daily. The plan was to discontinue the Mighty Shakes when the Nepro supplement was available. Resident 101 remained at nutritional risk related to his new admission status. A Nurse Practitioner's Note, dated 12/4/2024 at 2:06 P.M., indicated the nurse practitioner had informed the facility staff they needed to follow the dietary recommendations. A Physician's Order, dated 12/9/2024, indicated Nepro 1 carton daily for nutritional support.		Resident 101 has not had a significant wt loss since admission and has gained 6 lbs since admission. · The DON/designee notified the physician of Res 101 r/t the untimely RD recommendation implementation with no new orders. Responsible party notified. · Resident 101's C/P has been updated to reflect residents' status/needs. 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 receive RD recommendations from the RD have the potential to be affected. · DON/designee will review RD recommendations x's last 30 days to ensure recommendations given by the RD have been implemented. Any findings will be addressed by notifying the physician, and implementing the recommendation, if ordered. What measures will be put into 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 to address RD recommendations within 72 hrs of them being given. · DON/designee will complete routine auding of RD recommendations to ensure timely	

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	A Physician's Order for the Mighty Shake could not be located in the medical record. The Medication Administration Record for December 2024, indicated the Nepro supplements were not started until 12/11/2024. There was no documentation from 12/4/2024 - 12/11/2024 of any Might Shakes supplement being provided. A policy was provided, on 12/27/2024 at 3:40 P.M., by the Quality Assurance Administrator. The policy titled, "Change in a Resident's Condition or Status", indicated, " ...Our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status ...1. The nurse will notify the resident's Attending Physician or physician on call when there has been a[an]: f. refusal of treatment or medication two [2] or more consecutive times ...." 3.1-37(a)		implementation. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will complete routine auding of RD recommendations to ensure timely implementation. Auditing to occur: wkly x's 30 days then monthly x's 5 months for a total of 6 months of monitoring. · 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 process.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure adequate assistance was provided to prevent hot soup spillage for 1 of 3 residents reviewed for accidents. (Resident L) Finding includes:	F 0689	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** DON/designee has updated Resident Ls physician and updated on overall status,	01/24/2025

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	A record review for Resident L was completed on 12/26/2024 at 1:36 P.M. Diagnoses included, but were not limited to, muscle weakness, seizures, osteoarthritis and diabetes mellitus type 2. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident L was cognitively intact, required set-up assistance with eating and supervision/touch assistance with locomotion in her wheelchair. The assessment indicated Resident L had an open lesion of the skin. A Skin/Wound Nursing Note, dated 12/17/2024 at 11:05 P.M., indicated Resident L had informed staff she had been treating a wound on her leg. A wound measuring 4 centimeters by 2.5 centimeters was noted on the right anterior shin of Resident L. There was a little yellow drainage present. The resident's right calf was pink and larger in size than the resident's left calf. The physician was notified and a new order was obtained for doxycycline (an antibiotic) 100 milligrams twice daily for 10 days. A Nursing Progress Note, dated 12/18/2024 at 3:22 A.M., indicated a new physician's order was received for Resident L's leg wound. The order indicated to cleanse the wound site with wound wash or normal saline and pat dry, apply triple antibiotic ointment and cover with a non-adherent dressing daily for 10 days. A Nursing Progress Note, dated 12/20/2024 at 10:00 A.M., indicated during an interview with Resident L, she indicated the wound had occurred last Saturday (12/14/2024) when a CNA handed her a bowl of Cup of Noodles in the hallway and when the resident went to place the bowl on her lap so she could propel her wheelchair, the bowl		including status of burn. DON/designee completed an updated hot liquid safety eval assessment on Resident L and will be served hot liquids at a table. Resident L's plan of care and Kardex has been updated to reflect needs r/t hot liquids **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who consume hot liquids have the potential to be affected. DON/designee will complete an updated hot liquid safety assessment on current residents to determine risk and will implement safety interventions as indicated. The plan of care and Kardex will be updated to reflect those needs. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to nursing associates on the requirement to ensure safety interventions are in place per hot liquid assessment when hot liquids are served DON/designee will complete an updated hot liquid safety	

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	fell onto her leg and the hot liquid and noodles fell onto her pant leg. Resident L indicated the wound area hurt off and on, but not all the time. Resident L's wound was noted to be red with serious drainage. The resident's right shin was pink in color and edematous when compared to her left shin. The resident's wound was to be followed by the wound physician. A Facility Reported Incident to the Indiana Department of Health was completed on 12/20/2024. The report indicated Resident L had spilt soup on her leg and a burn was noted to the right shin. An investigation was initiated. The investigation notes indicated Resident L had asked CNA 9 to heat up a bowl of noodle soup for her in the microwave. The resident asked for the soup to be placed in the microwave for 3 minutes. After completing the task, CNA 9 handed the soup back to Resident L, but during the process and immediate time after the bowl was handed to the resident, the soup had spilt onto the resident's lap. She indicated Resident L indicated her pants were "thick" and it was "not a problem." CNA 9 indicated she mentioned the incident to QMA 8 but was unsure he had heard her as he was busy passing medications but he did respond "OK." QMA 8 indicated he did not know anything about a burn on Resident L's leg or spilt soup. QMA 10, who also worked on 12/14/2024 indicated she was aware of the spilt soup and had informed LPN 2 of the incident. LPN 2, who worked on 12/14/2024 and 12/15/2024 indicated she was made aware of the incident with the spilt soup on 12/14/2024 and told Resident L she would look at her leg but when she went to assess Resident L's leg, the resident was outside and she forgot to look at her leg after the resident returned from being outside. CNA 11 indicated he was working on 12/14/2024 and he had delivered another bowl of heated soup		assessment for new admits, quarterly and with a change in condition to residents to determine risk, and will implement safety interventions as indicated. The plan of care and Kardex will updated to reflect those needs. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine audits of residents who require safety measures when served/consumed hot liquids to ensure those measures are in place. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 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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	155086	A. BUILDING 00 B. WING	12/27/2024

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	to Resident L's room after a different staff member had heated up the bowl. He was not aware of the spilt soup from the previous bowl of soup. On 12/20/2024, the Administrator had interviewed Resident L. Resident L indicated after dinner she asked an employee to heat up her soup. The soup was heated and handed back to her. Resident L indicated she spilled the soup down her leg. Resident L indicated she removed her pants and looked at her legs. She indicated her leg was burning and she placed a tissue with medical tape over the wounded area. Resident L indicated she informed the nurse on 12/15/2024 of the pain she was experiencing and that she needed someone to address the wound. Resident L indicated the employee indicated she would look at the wound, but she did not do anything about the wound. Resident L indicated she later told RN 12 of her leg pain and drainage that had seeped through her pants. Resident L indicated RN 12 then took a picture of the wound, sent the picture to the physician and applied cream to the area. A handwritten witness statement,t by LPN 2, indicated Resident L came to her and told her about a small burn on her thigh that was about the size of a dime on 12/15/2024. Resident L had indicated the nurse had not assessed the situation or burn that had occurred on her leg. LPN 2 indicated Resident L had came to her when she was completing other documentation tasks and when she finished her task went to assess Resident L's leg. LPN 2 indicated Resident 2 had gone outside to smoke and Resident 2 indicated she would come see LPN 2 after she came back inside. LPN 2 indicated both herself and Resident L lost track of time and had forgotten about the assessment.		process.	

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	During an interview, on 12/27/2024 at 10:55 A.M., Resident L indicated 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 much water in the bowl and it spilt onto her lap. Resident L indicated she informed several nurses about the burn. Resident L indicated she felt the burn would not have gotten so bad with an infection if the staff had done something about the burn earlier. During an interview, on 12/27/2024 at 11:14 A.M., LPN 2 indicated Resident L had informed her on 12/15/2024 of the burn on her thigh. LPN 2 indicated Resident L came to her while she was completing paperwork. LPN 2 indicated Resident L went outside to smoke and both she and the resident forgot about the burn. LPN 2 indicated she believed the burn occurred on 12/14/2024. During an observation and interview, on 12/27/2024 at 3:43 P.M., the Director of Nursing (DON) changed the dressing to Resident L's left leg. He indicated the area was a healing burn. He described the area as 2 burns with the initial burn on top and the second where the hot liquid had slid down the resident's leg. The DON indicated the burn was initially a second-degree burn. The DON placed a dry dressing on the wound area. He indicated the ordered cream would be applied when overnight dressing change was completed. During an interview, on 12/27/2024 at 3:59 P.M., the DON indicated he first discovered the burn when he reviewed the 24-hour nursing report that described the area as a wound. The DON indicated staff should have know better than to have a wheelchair bound resident attempt to carry hot liquids. He indicated the physician should			

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	have been notified immediately about the burn. There was no assessment completed by a physician or a Nurse Practioner regarding Resident L's wound/burn as of 12/26/2024. A Hot Liquid Safety Evaluation for Resident L, completed on 12/24/2024 indicated the resident had impaired safety with hot liquids due to altered muscle strength of her hands, tremors and abnormal muscle movements of her hands and a history of spilling liquids. The assessment indicated the resident was capable of self propelling her wheelchair. A policy was provided, on 12/27/2024 at 3:40 P.M., by the Quality Assurance Administrator. The policy titled, "Safety of Hot Liquids" indicated, " ...Residents will be evaluated for safety concerns and potential for injury from hot liquids. Appropriate precautions will be implemented to maximize choice of beverage while minimizing the potential for injury ...1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions ...." 3.1-45(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure physician ordered medications were available for 5 of 6 residents whose medications were reviewed. (Residents E, F, L 101 & 41) Findings include:	F 0755	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · The DON/designee contacted the pharmacy to reorder Resident E, L, F, 101 & 41 and verified delivery	01/24/2025

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	1. A record review for Resident E was completed on 12/26/2024 at 10:32 A.M. Diagnoses included, but were not limited to, encephalopathy, diabetes, anxiety and depression. The current physician orders included the following: -Sitagliptin 100 mg (milligram) 1 tablet one time a day for antidiabetes. -Zyrtec Allergy One tablet 10 mg 1 tablet in the morning for seasonal allergy. The December Medication Administration Record (MAR) indicated on 12/14/2024 the Sitagliptin oral tablet 100 mg one time a day for diabetes was documented as 16 - Hold/See Nurse Note and the Zyrtec allergy tablet 10 mg was also documented as 16 on 12/20/2024. An emar (electronic medical administration record) note, dated 12/14/2024, indicated Sitagliptin 100 mg 1 tablet one time a day for antidiabetes was "on order." An emar note, dated 12/20/2024, indicated the Zyrtec medication was "on order." 2. A record review for Resident F was completed on 12/26/2024 at 10:49 A.M. Diagnoses included but were not limited to, diabetes, osteoarthritis and obesity. The current physician's orders included: Gabapentin (an anticonvulsant) 400 mg 1 capsule at bedtime. The December MAR indicated on 12/15, 12/16 and 12/17/2024, the Gabapentin medication was documented as "16 - Hold See Nurse Note."		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 medications ordered and administered by facility associates have the potential to be affected. · The DON/designee will complete a facility wide medication audit to ensure that medications are available as per physician's orders. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · A 3rd party provider from IHCA will provide education to licensed nursing staff on timely reordering of medications. Education will also be provided to nursing associated who administer medications on utilizing the EDK for medications when necessary for medications not yet dispensed to resident. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will routinely audit medication carts to ensure medications are available for administration. Auditing to occur: 4 residents daily M-F x's 4 wks, then 4 residents wkly x's 4 wks, then 4 residents monthly x's 4 months for a total of 6 months of	

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	The Nursing Progress Notes, dated 12/15 through 12/17/2024, lacked the documentation to indicate why the medication had not been administered on 12/15, 12/16 and 12/17/2024. 3. A record review for Resident L was completed on 12/27/2024 at 1:17 P.M. Diagnoses included, but were not limited to, kidney failure, diabetes, osteoarthritis, anxiety and diabetic polyneuropathy. The current Physician's Orders included Sertraline (an antidepressant) 25 mg (milligram) 1 tablet at bed time. The December MAR indicated on 12/25/2024, the Sertraline medication was documented as "16 - Hold See Nurse Note." The Nursing Progress Notes, dated 12/25/2024, lacked documentation to indicate why the medication had not been administered. 4. A record review for Resident 41 was completed on 12/26/2027 at 2:42 P.M. Diagnoses included, but were not limited to, hypertension, dysphagia, depression and anxiety. The current Physician's Orders included the following: Sertaline (an antidepressant) 100 mg one time a day. The December MAR indicated on 12/14/2024 the Sertraline medication was documented as "16 - Hold See Nurse Note." A Medication Note, dated 12/14/2024, indicated the medication was "on order."		monitoring. · The DON/designee will review the Medication Admin Audit Report to ensure that residents have received their medications as ordered. Any findings will be addressed. Auditing to occur: Daily M-F x's 4 weeks, then weekly x's 4 weeks, then monthly x's 4 months for a total of 6 months of monitoring. · 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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	5. A record review for Resident 101 was completed on 12/26/2024 at 10:27 A.M. Diagnoses included, but were not limited to: acute kidney failure, congestive heart failure and bradycardia. Resident 101 admitted to the facility on 11/20/2024. A Physician's Order, dated 11/21/2024, indicated Trulicity (controls diabetes) 1.5 milligrams per 0.5 milliliters inject subcutaneously weekly every Tuesday. A Care Plan, initiated 11/22/2024, indicated Resident 101 had diabetes mellitus. The interventions included, but were not limited to: provide medication as ordered. The Medication Administration Record, for December 2024, indicated Resident 101 did not receive the Trulicity injections on 12/3/2024, 12/10/2024, 12/17/2024 and 12/24/2024. There were no Nursing Progress Notes that indicated the physician or nurse practitioner were informed of the missing administration of the Trulicity or any reason why the resident did not receive their medication. A Care Plan, initiated 12/3/2024, indicated Resident 101 had a nutritional problem or a potential for a nutritional problem. Interventions included, but were not limited to: provide supplements per orders and monitor percentage consumed. During an interview, on 12/27/2025 at 2:37 P.M., the Director of Nursing indicated he was on the phone almost every day with the pharmacy. He indicated if the nurses had contacted the pharmacy, they should have documented in the			

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	nurses notes. In addition, the nurses should have documented in the nurses notes why they were not administering ordered medications. The Director of Nursing indicated the residents should have received their medications. During an interview, on 12/27/2024 at 2:54 P.M., LPN 2 indicated if a medication was not in the cart, she would look to see if it was in back stock, look to see if it was ordered and looked in the EDK (Emergency Drug Kit) 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 the med was unavailable and it could not be found, it should be documented in the progress notes that it was "on order." On 12/27/2024 at 3:40 P.M., the Corporate Nurse provided the policy titled, "Ordering and Receiving Medications", dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated "... Medications and related products are received from the pharmacy in a timely manner... i. Reorder medication when a four day supply remains, in advance of need, to assure an adequate supply on hand..." This deficiency was cited on 11/14/2024. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure infection	F 0880	What corrective actions will be accomplished for those residents	01/24/2025

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	control practices were followed related to glove use and handwashing during perineal and catheter care for 2 of 2 residents observed for catheter care. (Residents 50 & 34) Findings include: 1. During an observation, on 12/27/2024 at 10:07 A.M., LPN 2 without wearing a gown, was observed to provide incontinence/catheter care to Resident 50. First, she used a washcloth and cleaned the urinary catheter tubing. LPN 2, without changing her gloves or washing her hands, obtained a new brief. After obtaining the clean brief, LPN 2 then changed her gloves and turned the resident over to his left side with the assistance of QMA 4. LPN 2 then washed Resident 50's buttocks and peri area. She then turned the resident over to his back. LPN 2, without changing her gloves, touched the call light, linens, pillows and the residents bed control remote. During an interview, on 12/27/2024 at 10:51 A.M., LPN 2 indicated she should have changed her gloves and washed her hands and worn a gown for protection. 2. During an observation, on 12/27/2024 at 12:00 P.M., CNA 6 and QMA 4 was observed to provide incontinence/catheter care to Resident 34. QMA 4 washed the catheter tubing and the resident's groin and penis areas. She changed her gloves after she had washed and dried the areas. She donned a new pair of gloves and applied cream to the residents buttocks. Without changing her gloves or washing her hands, QMA 4 then touched the new brief and linens on the resident's bed.		found to have been affected by the deficient practice? · Resident 50 and 34 did not experience a negative outcome from deficient practice. · C.N.A 6, QMA 4, and LPN 2 was educated by the DON/designee on glove use and handwashing during peri care, catheter care. These associates will perform and successfully pass a return demonstration competency. 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 receive peri care and catheter care have the potential to be affected · The DON/designee will provide education to licensed and certified nursing associates on glove usage and handwashing during peri care and catheter care. What measures will be put into 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 and certified nursing associates on glove usage during peri care and catheter care and will complete routine auditing to ensure best practices are being followed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	During an interview, on 12/27/2024 at 12:20 P.M., QMA 4 indicated she should have washed her hands. On 12/27/2024 at 12:56 P.M., the Quality Assurance Administrator provided the policy titled, "Perineal Care," with a revision date of 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated: "...m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly... 10. Remove gloves and discard into designated container. 11. Wash and dry your hand thoroughly...." This deficiency was cited on 11/14/2024. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(a)		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 associates performing peri care wkly x's 4 wks, then 4 random associates performing peri care monthly x's 5 months for a total of 6 months of monitoring. · 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 process.	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on record review and interview, the facility failed to provide consented vaccinations for 1 of 4 residents reviewed for immunizations. (Resident 101) Finding includes: A record review for Resident 101 was completed on 12/26/2024 at 10:27 A.M. Diagnoses included, but were not limited to: acute kidney failure,	F 0883	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident 101 was given the Influenza vaccination on 1/8/2024 How other residents have the potential to be affected by the same deficient practice will be identified and what corrective	01/24/2025

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	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. Documentation could not be located in the electronic medical record of the influenza vaccination being administered. 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. 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)		actions will be taken? · Other residents who have consented to receiving the influenza vaccination have the potential to be affected What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · DON/designee will provide education to licensed nurses on the requirement to administer Influenza immunization when consented to. · The DON/designee will complete an audit of all current residents to ensure the influenza vaccine consent or declination has been completed. If residents have consented to the vaccine and it is time for them to receive it, COVID vaccination will be administered as ordered How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DON/designee will complete routine auditing of newly admitted residents to ensure the Influenza vaccine has been administered if consented to; and documented. This will be repeated annually after education is provided to residents and/or responsible parties. · The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility	

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			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 process.	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on record review and interview, the facility failed to provide consented vaccinations for 1 of 4 residents reviewed for immunizations. (Resident 101) Finding includes: A record review for Resident 101 was completed on 12/26/2024 at 10:27 A.M. Diagnoses included, but were not limited to: acute kidney failure, 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's COVID-19 vaccinations were not up to date. Admission documents, dated 11/14/2024, indicated consent was given for the COVID-19 booster. Documentation could not be located in the electronic medical record of the vaccination having been administered.	F 0887	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 101's COVID vaccine was administered January 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 COVID vaccination have the potential to be affected **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to licensed nurses on the requirement to administer	01/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	12/27/2024

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

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	A policy for the COVID-19 vaccination was requested on 12/27/2024 at 3:23 P.M. Policies were not provided by the facility. During an interview, on 12/27/2024 at 4:00 P.M., the Director of Nursing (DON) indicated residents or resident representatives that gave 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 had not receive the consented vaccination.		COVID immunization when consented to. The DON/designee will complete an audit of all current residents to ensure a COVID vaccine consent or declination has been completed. If residents have consented to the vaccine and it is time for them to receive it, COVID vaccination will be administered as ordered **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of newly admitted residents to ensure the COVID vaccine has been administered if consented to; and documented. This will be repeated annually after education is provided to residents and/or responsible parties. 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	

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			are identified through the interview process.	
F 9999 Bldg. 00		F 9999	No citation noted	01/24/2025