STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/23/2024	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
E 0000	REGERTION ON ESC IDENTIFY THE INFORMATION	1710		BATE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/23/24	E 0000			
	Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880				
	At this Emergency Preparedness survey, Woodland Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.				
	The facility has 80 certified beds. At the time of the survey, the census was 69.				
	Quality Review completed on 12/27/24				
E 0004 SS=F Bldg	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually				
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation could be found to show the EPP was reviewed and updated within	E 0004	The corrective action taken for those residents found to be affected by the deficient practi include: Emergency Preparedness Pol and Procedures were reviewed January 3, 2025. Other residents that have the potential to be affected have be identified by: All residents have the potential be affected. The measures of systemic	icies d	

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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/23/2024			LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
E 0007	review, the Mainten previous Administra the last year; howev available showing a completed. This finding was rev Administrator and M exit conference.	on interview during record nance Director stated the ator reviewed the EPP within ter, no documentation was review or update had been viewed with the Interim Maintenance Director at the			changes that have been put in place to ensure that the defici practice does not recur includ. The administrator calendar has schedule in place to review Emergency Preparedness Poevery January. The corrective action taken to monitor the performance to as compliance through quality assurance is: The Emergency Preparedness Binder will be reviewed month QAPI x6 months to assure all systems are in place.	ent e: as a licies ssure	
SS=F Bldg	failed to ensure the addressed resident plimited to, persons a LTC facility has the emergency; and corincluding delegation plans in accordance deficient practice coand visitors. Findings include: Based on record revision Maintenance Direct on 12/23/24, the En (EPP) failed to addresservices the LTC provide in an emergeduring record review.	riew and interview, the facility emergency preparedness plan population, including, but not at-risk; the type of services the enability to provide in an attinuity of operations, as of authority and succession with 42 CFR 483.73(a)(3). This puld affect all residents, staff riew and interview with the cor from 9:16 a.m. to 12:32 p.m. hergency Preparedness Plan ress persons at-risk or the type facility has the ability to gency. Based on interview w, the Maintenance Director andividual had started to	E 00	07	The corrective action taken for those residents found to be affected by the deficient practinclude: A Resident Evacuation Assessment was completed in January, 2025 Other residents that have the potential to be affected have to identified by: All residents have the potential be affected. The measures of systemic changes that have been put in place to ensure that the deficing practice does not recur include the Resident Evacuation Assessment will be reviewed annually. The corrective action taken to monitor the performance to as	n peen al to nto ent e:	01/22/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE			ETED	
		155086	B. W	NG		12/23/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				IAPPANEE ST		
WOODLA	AND MANOR		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 APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DEFICIENCY)	
	review and update the Emergency Preparedness				compliance through quality		
		er, the review and update was			assurance is:		
	-	he EPP was missing policies			The Emergency Preparedness		
	and procedures. The Maintenance Director also				Binder will be reviewed month	y in	
		process of reviewing and			QAPI x6 months to assure all		
updating the EPP.				systems are in place.			
	This finding was reviewed with the Interim						
	Administrator and N	Maintenance Director at the					
	exit conference.						
E 0013 SS=F Bldg	Development of E	4(b), 418.113(b), 441.1 P Policies and Procedures					
		riew and interview, the facility	E 00	013	The corrective action taken for		01/22/2025
	failed to review and update the Emergency				those residents found to be		
	-	EPP) Policies and Procedures			affected by the deficient practi	ce	
	-	accordance with 42 CFR			include:		
		C facility must develop and			The Emergency Preparedness		
		cy preparedness policies and			binder has a Disaster Policy a		
	-	n the emergency plan set			Procedure updated January 20)25.	
		a) of this section, risk			Other residents that have the		
		raph (a)(1) of this section, and plan at paragraph (c) of this			potential to be affected have b	een	
		s and procedures must be			identified by:	l to	
		ed at least annually. This			All residents have the potentia be affected.	110	
		ould affect all residents, staff			The measures of systemic		
	and visitors.	vara arreet arr residents, starr			changes that have been put in	to	
	una vibitors.				place to ensure that the deficie		
	Findings include:				practice does not recur include		
					The Disaster Policy and		
	Based on record rev	riew and interview with the			Procedure will be reviewed		
	Maintenance Direct	or from 9:16 a.m. to 12:32 p.m.			annually.		
		umentation could be found to			The corrective action taken to		
	show the EPP Police	ies and Procedures were			monitor the performance to as	sure	
	reviewed and updated within the last year. Based				compliance through quality		
	on interview during	record review, the			assurance is:		
	Maintenance Direct	or stated the previous			The Emergency Preparedness	;	
	Administrator review	wed the EPP within the last			Binder will be reviewed month		
	year; however, no d	ocumentation was available			QAPI x6 months to assure all		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/23/2024		
	PROVIDER OR SUPPLIEF AND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
E 0018 SS=F Bldg	This finding was re Administrator and Mexit conference. 403.748(b)(2), 410 Procedures for Transaction and Procedures for Transaction and Procedures and procedures incl	r update had been completed. viewed with the Interim Maintenance Director at the 5.54(b)(1), 418.113(b)(acking of Staff and Patients view and interview, the facility ergency preparedness policies uded a system to track the staff and sheltered residents	E 0018	The corrective action taken for those residents found to be affected by the deficient practic include:	01/22/2023	
	location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all residents and staff.			The facility has a form entitled Resident Evacuation Checklist that will be used in the event of evacuation. Other residents that have the potential to be affected have be identified by: All residents have the potential be affected. The measures of systemic	f an een	
Findings include: Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview during record review, the Maintenance Director stated a contracted individual had started to review and update the Emergency Preparedness Plan (EPP); however, the review and update was not completed and the EPP was missing policies and procedures. The Maintenance Director also stated he was in the process of reviewing and updating the EPP.			changes that have been put interplace to ensure that the deficie practice does not recur include. The Resident Evacuation Checklist is readily available in Emergency Preparedness Bindand will be used in the event of evacuation. The corrective action taken to monitor the performance to assocompliance through quality assurance is: The Emergency Preparedness Binder will be reviewed monthly QAPI x6 months to assure all systems are in place.	the der f an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPL	COMPLETED		
		155086	B. W	B. WING		12/23/	12/23/2024	
				CTD FFT A	ADDRESS SITE STATE SID COD			
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD			
WOOD! A	ND MANOD		343 S NAPPANEE ST					
WOODLA	AND MANOR			ELNHA	RT, IN 46514			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	DEFICIENCY 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	
	This finding was reviewed with the Interim							
	Administrator and Maintenance Director at the							
	exit conference.							
						ļ		
E 0029 403.748(c), 416.54(c), 418.113(c), 441.1								
SS=F Development of Communication Plan								
Bldg								
	Based on record rev	view and interview, the facility	E 00)29	The corrective action taken for	•	01/22/2025	
	failed to review and update the Emergency				those residents found to be			
	Preparedness Comn	nunication Plan at least			affected by the deficient practi	ce		
	annually in accorda	nce with 42 CFR 483.73(c). The			include:			
	facility must develop and maintain an emergency				The facility has in place an			
preparedness communication plan th		unication plan that complies			Emergency Communication Po	olicy		
	with Federal, State and local laws and must be				and Procedure reviewed Janu	ary,		
	reviewed and updated at least annually for LTC				2025.			
		eient practice could affect all			Other residents that have the			
	residents, staff and	visitors.			potential to be affected have b	een		
					identified by:			
	Findings include:				All residents have the potentia	I to		
					be affected.			
		view and interview with the			The measures of systemic			
		or from 9:16 a.m. to 12:32 p.m.			changes that have been put in			
		cumentation could be found to			place to ensure that the deficie			
	show the Emergenc				practice does not recur include			
		in was reviewed and updated			The Emergency Communication	on		
	•	Based on interview during			Policy and Procedure will be			
		Maintenance Director stated			reviewed annually.			
	•	istrator reviewed the EPP			The corrective action taken to			
	•	however, no documentation			monitor the performance to as	sure		
		ing a review or update had			compliance through quality			
	been completed.				assurance is:			
					The Emergency Preparedness			
	_	viewed with the Interim			Binder will be reviewed month	y in		
		Maintenance Director at the			QAPI x6 months to assure all			
	exit conference.				systems are in place.			
E 0033	400 740(-)(0) 440	2.54(-)(2).440.442(-)(ļ		
E 0032 SS=F		3.54(c)(3), 418.113(c)(
	Primary/Alternate	Means for Communication						
Bldg	Dagad on masand	riany and intervious the	L C	22	The commenting action tales of		01/22/2025	
	Daseu on record rev	view and interview, the	E 00	152	The corrective action taken for		01/22/2025	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/23/2024	
	OVIDER OR SUPPLIER		343 S	T ADDRESS, CITY, STATE, ZIP COD S NAPPANEE ST IART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and alternate means accordance with 42 Emergency Preparer must include: (3) Pr communicating with (i) [Facility] staff. (ii) Federal, State, the emergency manager This deficient practice staff and visitors. Findings include: Based on record rev Maintenance Direct on 12/23/24, the Em Communications Platternate means of communications platternate platternate means of communications platternate means of communications platternate means of communications platternate means of communications platternate platternate platternate platternate platternate platternate platternate platternate platternate platt	an failed to address primary of communication in CFR 483.73(c)(3). The facility's dness Communications Plan imary and alternate means for in the following: Tibal, regional, and local ment agencies. Tibe could affect all residents, Tiew and interview with the or from 9:16 a.m. to 12:32 p.m. hergency Preparedness and id not address primary and communication. Based on cord review, the Maintenance intracted individual had started the Emergency EPP); however, the review and pleted and the EPP was a procedures. The or also stated he was in the g and updating the EPP nunication Plan. Typical procedure with the Interim Maintenance Director at the		those residents found to be affected by the deficient practinclude: The facility has in place an Emergency Communication Fand Procedure which includes primary and alternate means communication. The policy wreviewed January, 2025. Other residents that have the potential to be affected have lidentified by: All residents have the potential be affected. The measures of systemic changes that have been put in place to ensure that the deficit practice does not recur include The Emergency Communicating Policy and Procedure will be reviewed annually. The corrective action taken to monitor the performance to as compliance through quality assurance is: The Emergency Preparednes Binder will be reviewed month QAPI x6 months to assure all systems are in place.	Policy s of ras been al to nto fent fe: sion ssure s ally in
SS=F Bldg	LTC and ICF/IID S Based on record rev failed to ensure the	charing Plan with Patients riew and interview, the facility emergency preparedness in includes a method for sharing	E 0035	The corrective action taken fo those residents found to be affected by the deficient pract	01/22/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		A. BUIL B. WING	DING		COMPL 12/23/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	facility has determined residents and their fraccordance with 42. This deficient practice staff and visitors. Findings include: Based on record reverage Maintenance Director on 12/23/24, the Engine Communications Plant for sharing informate that the facility has residents and their fraccordance with 42 interview during recordance with 42 interview during recordance with 42 interview and update Preparedness Plan (update was not commissing policies and Maintenance Director process of reviewing including the Communications of the finding was reveraged.	iew and interview with the or from 9:16 a.m. to 12:32 p.m. hergency Preparedness an failed to include a method ion from the emergency plan determined is appropriate with families or representatives in CFR 483.73(c)(8). Based on cord review, the Maintenance intracted individual had started the Emergency EPP); however, the review and pleted and the EPP was a procedures. The or also stated he was in the g and updating the EPP intrincation Plan.			include: A letter from the facility about to Emergency Preparedness Planthas been sent to residents and family members. Other residents that have the potential to be affected have be identified by: All residents have the potential be affected. The measures of systemic changes that have been put in place to ensure that the deficite practice does not recur included. The Administrator has set up a system to review the Emergen Preparedness Binder regularly. The corrective action taken to monitor the performance to as compliance through quality assurance is: The Emergency Preparedness Binder will be reviewed monthle QAPI x6 months to assure all systems are in place.	een I to to ent cy sure	
E 0036 SS=F Bldg	Based on record rev failed to review and Preparedness Traini least annually in acc 483.73(d). The LTC	esting iew and interview, the facility update the Emergency ng and Testing Program at cordance with 42 CFR facility must develop and ncy preparedness training and	E 003	6	The corrective action taken for those residents found to be affected by the deficient practicinclude: The facility has a policy in place for Exercise, Drills and	ce	01/22/2025

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	343 S I			
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION testing program that is based on the emergency		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
in paragraph (a) of this section, risk paragraph (a)(1) of this section, procedures at paragraph (b) of this he communication plan at paragraph tion. The training and testing the reviewed and updated at least so deficient practice could affect all ff and visitors. In the deficient practice could affect all feath and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the deficient practice could affect all ff and visitors. In the d		identified by: All residents have the potential to be affected. The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include: The Policy and Procedure for Exercise, Drills and Simulations will be reviewed annually. The corrective action taken to monitor the performance to assure compliance through quality assurance is: The Emergency Preparedness		
ord review and interview, the facility fluct annual training for the reparedness Program (EPP). The LTC do all of the following: ning in emergency preparedness procedures to all new and existing hals providing services under	E 0037	The corrective action taken for those residents found to be affected by the deficient practice include: All current staff members have received training on the Emergency Preparedness Plan. Other residents that have the	01/22/2025	
Cantifit est id to the second of the second	ericiency Must be Preceded by Full ORY OR LSC IDENTIFYING INFORMATION am that is based on the emergency in paragraph (a) of this section, risk it paragraph (a)(1) of this section, procedures at paragraph (b) of this the communication plan at paragraph ction. The training and testing at be reviewed and updated at least is deficient practice could affect all aff and visitors. Inde: For review and interview with the end of Director from 9:16 a.m. to 12:32 p.m. no documentation could be found to dergency Preparedness Testing and gram was reviewed and updated at year. Based on interview during wear, the Maintenance Director stated Administrator reviewed the EPP st year; however, no documentation the showing a review or update had ted. Was reviewed with the Interim or and Maintenance Director at the force. 1), 416.54(d)(1), 418.113(d)(Program For dreview and interview, the facility duct annual training for the Preparedness Program (EPP). The LTC do all of the following: ning in emergency preparedness procedures to all new and existing uals providing services under and volunteers, consistent with their	arm that is based on the emergency in paragraph (a) (1) of this section, risk transparent paragraph (a) (1) of this section, procedures at paragraph (b) of this the communication plan at paragraph ction. The training and testing straining to the reviewed and updated at least is deficient practice could affect all eff and visitors. Induce: Ford review and interview with the end of the proparedness of the more and maintenance of the program was reviewed and updated at gram was reviewed and updated straining the more and Maintenance Director stated Administrator reviewed the EPP straining are reviewed with the Interim or and Maintenance Director at the face. 1), 416.54(d)(1), 418.113(d)(Program From the program (EPP). The LTC do all of the following: ming in emergency preparedness procedures to all new and existing uals providing services under, and volunteers, consistent with their	Agriciancy Must be preceded by Full or ord review and interview with the december of the program was reviewed and updated st year. Based on interview during and sty year, however, no documentation es showing a review or update had ted. Was reviewed with the Interim or and Maintenance Director at the facility duct annual training for the program (EPP). The LTC do all of the following: ning in emergency preparedness procedures to all new and existing under the procedures to all new and existing under the proper of the proper of the proper of the proper of the procedure of the following: ning in emergency preparedness procedures to all new and existing under the procedures to all new and existing under the proper of the procedures to all new and existing under the proper of the proper of the procedures to all new and existing under the proper of the proper of the procedures to all new and existing under the proper of the proper of the procedures to all new and existing under the proper of the proper of the procedures to all new and existing under the proper of the p	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/23/2024	
	PROVIDER OR SUPPLIEF		343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX		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 APPROPRI	(X5) COMPLETION
TAG	(ii) Provide emerge	R LSC IDENTIFYING INFORMATION ncy preparedness training at	TAG	identified by:	DATE
		nentation of all emergency		All residents have the potenti be affected.	al to
		aff knowledge of emergency		The measures of systemic changes that have been put it	
	procedures in accordance with 42 CFR 483.73(d) (1).			place to ensure that the defice practice does not recur include	de:
	This deficient practice could affect all residents, staff and visitors. Findings include:			Emergency Preparedness to has been added to general	
				orientation for all new employ The corrective action taken to	·
	Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, no documentation of annual EPP training and no documentation to show staff			monitor the performance to a compliance through quality	ssure
				assurance is: The Administrator/designee v	
	could demonstrate l	knowledge of the EPP was 7. Based on an interview at the		audit employee files to ensur staff have received training o Emergency Preparedness	
	time of records revi	ew, the Maintenance Director had not been conducted since		system. Audits will be condu 1x per month x6 months. The	
	he started his emplo	byment approximately seven aintenance Director also		results of these audits will be reviewed in the monthly QAP	
	stated he was not av			meeting.	
	conducted in the las	-			
	ľ	viewed with the Interim Maintenance Director at the			
E 0039 SS=F Bldg	403.748(d)(2), 410 EP Testing Requi	6.54(d)(2), 418.113(d)(rements			
	failed to conduct ex plan at least twice p unannounced staff of procedures. The LT	view and interview, the facility electrices to test the emergency er year, including drills using the emergency C facility must do the eipate in an annual full-scale	E 0039	The corrective action taken for those residents found to be affected by the deficient practinclude: A tornado drill was completed the facility on December 27, 2	tice
exercise that is community-based; or			Other residents that have the	•	

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

PRINTED: 01/14/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		A. BUILDIN B. WING	VECONSTRUCTION NG	COMPLETED 12/23/2024	
	PROVIDER OR SUPPLIEF	t.	343	REET ADDRESS, CITY, STATE, ZIP COD 3 S NAPPANEE ST KHART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROP	(X5) E COMPLETION DATE
	accessible, conduct facility-based funct b. If the LTC facility or man-made emerg of the emergency p from engaging its n community-based of full-scale functional the onset of the actr (ii) Conduct an add include, but is not learned as a second full-scale functional exercise. b. A mock disaster c. A tabletop exercifacilitator that include a narrated, clinically and a set of problem messages, or preparchallenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 This deficient pract staff and visitors. Findings include: Based on record revisited and the facility of the facilit	y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based lexercise for 1 year following hal event. It itional exercise that may imited to the following: It exercise that is ran individual, facility-based drill; or see or workshop that is led by a des a group discussion, using exercise and exercise that is ran individual, facility-based drill; or see or workshop that is led by a des a group discussion, using exercise and exercise the designed to be ency plan. The facility's response to and facility is response to an actual response to an act		potential to be affected have identified by: All residents have the potent be affected. The measures of systemic changes that have been put place to ensure that the definition practice does not recur included the Maintenance Director wischedule a full-scale exercise least one time annually going forward. The corrective action taken monitor the performance to compliance through quality assurance is: The Emergency Prepared mental Binder will be reviewed mon QAPI x6 months to assure a systems are in place.	tial to cinto cient ude: vill se at g to assure ess thly in

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING COMPLETED B. WING 12/23/2024			ETED		
	PROVIDER OR SUPPLIE	R	•	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION rcises were conducted.		TAG	DEFICIENCY		DATE
	This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.						
K 0000							
Bldg. 01	Licensure Survey of Department of Hea 483.90(a). Survey Date: 12/23 Facility Number: 0 Provider Number: 100 At this LSC survey not in compliance of Participation in Mes Subpart 483.90(a), 2012 edition of the Association (NFPA)	00034 155086	K 00	000			
	Type II (000) cons sprinklered. The fa with smoke detecti open to the corrido detectors in the res	lity was determined to be of truction and was fully acility has a fire alarm system on in the corridor and areas r and battery-operated smoke ident rooms. The building is by a Type II EES 33 kW ergency generator.					
	The facility has a c of 69 at the time of	apacity of 80 and had a census this survey.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		155086	B. Wl	B. WING			12/23/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
K 0321 SS=E	Quality Review con NFPA 101 Hazardous Areas							
Bldg. 01	failed to ensure the that was determined separated from othe partitions and doors or automatic closing 7.2.1.8. This deficie residents, staff and compartments. Findings include: Based on observation Maintenance Direct on 12/23/24, the con Supply Storage room self-closing device I close and latch into more than three sepinterview at the time Maintenance Direct corridor door would stated the facility has to look at it."	on and interview, the facility Central Supply Storage room It to be a hazardous area was r spaces by smoke resistant . Doors shall be self-closing g in accordance with LSC ent practice could affect visitors in 1 of 6 smoke on and interview with the or from 12:32 p.m. to 1:55 p.m. rridor door to the Central m was equipped with a but the door failed to fully the door frame when tested arate times. Based on e of observation, the or stated he was aware the I not fully close or latch and as "got someone coming out viewed with the Interim Maintenance Director at the	K 0	321	What corrective actions will accomplished to address the deficient practice? The door to central supp was fixed January 3, 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? All residents have the potential to be affected by this deficiency. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director wire routinely check closure of dood the facility as preventative maintenance. How the corrective actions we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be point place? Maintenance Director/designee will complete audit of 10 doors per week for proper closure x4 weeks, 10 doer month x4 months, then 10	ely ely ele ele ely into II rs in viII ut ele an loors	01/22/2025	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING			LETED (2004	
		155086						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
					doors x1 month. Those result will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly six months.			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities							
	1.) Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect kitchen staff. Findings include: Based on record review and interview with the Maintenance Director from 9:16 a.m. to 12:32 p.m. on 12/23/24, a document titled "Kitchen Suppression System Inspection" dated 04/16/24 indicated the kitchen fire suppression system was inspected; however, no documentation of a semiannual kitchen fire suppression system inspection six months after was available for review. Based on interview at the time of record review, the Maintenance Director stated he was		K 0.	324	What corrective actions will accomplished to address the deficient practice? Commercial Fire inspect the fire suppression system are the kitchen exhaust system or August 1, 1024. 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 by this process. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director had developed a tracking system the assure inspections are completed annually. How the corrective actions we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be possible.	ed and a second of the second	01/22/2025	

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		IDENTIFICATION NUMBER 155086	A. BUILDING B. WING	G <u>01</u>	COMPLETED 12/23/2024	VY			
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			343	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COM	(X5) PLETION DATE			
	facility failed to easystems was inspect 2011 Edition, Stand Fire Protection of C Operations, Section system shall be inspection, Section system shall be inspection, if the execondaminated with execution and certificates, far appurtenances shall combustible contain becoming heavily coily sludge. After the it shall not be coated substances. When executing company, performing the work cleaning shall be must be executed in the execution of the	A 96, 11.6.1 states, upon haust system is found to be deposits from grease laden nated portions of the exhaust uned by a properly trained, fied person(s) acceptable to the risdiction. Hoods, grease		into place? Inspections have been completed for 2024. Two inspections are due in 2025. Maintenance Director/design will audit records in 2025.	l I				
	on 12/23/24, an un-	titled document dated 02/14/24 n exhaust system was							

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 12/23/2024		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0355	semiannual kitchen inspection six mont review. Based on it review, the Mainten not aware of a semi inspection being con. These findings were Administrator and Mexit conference. 3.1-19(b)	no documentation of a fire suppression system hs after was available for a nterview at the time of record nance Director stated he was annual exhaust system ampleted. The reviewed with the Interim Maintenance Director at the					
K 0355 SS=E Bldg. 01	interview, the facility portable fire extingual was given maintenation one year apart. NFI Portable Fire Exting requires that fire exto maintenance at in year, at the time of specifically indicate electronic notification extinguisher maintened to give material extinguisher will open and to determine if will prevent its open replacement is necessiting or internal materials. Section 7.3.3 states have a tag or label sindicates the month	riew, observation and ty failed to ensure 1 of 1 nisher in the maintenance office once at periods not more than PA 10, the Standard for guishers, at Section 7.3.1.1.1 tinguishers shall be subjected attervals of not more than 1 hydrostatic test, or when and by an inspection or on. Section 3.3.15 defines nance as a thorough fire extinguisher that is aximum assurance that a fire perate effectively and safely physical damage or condition ration, if any repair or ssary, and if hydrostatic naintenance is required. The each fire extinguisher shall necurely attached that and year the maintenance was as the person performing the	K 0355	The corrective action taken for those residents found to be affected by the deficient practinclude: The fire extinguisher in the maintenance office was insperiently and any 3, 2025. Other residents that have the potential to be affected have be identified by: All residents have the potential be affected. The measures of systemic changes that have been put in place to ensure that the deficing practice does not recur included. All fire extinguishers are insperiently. The corrective action taken to monitor the performance to as compliance through quality assurance is: Maintenance Director/designer.	ice cted been al to nto ent e: ected		

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	work, and identifies performing the work. This deficient pract maintenance office. Findings include: Based on record rev. Maintenance Direct on 12/23/24, docume extinguisher inspect 03/26/24; however, located in the maint inspection tag that v. Based on interview. Maintenance Direct extinguisher in the maintenance Direct extin	ice could affect staff in the	TAG	responsible for ensuring fire extinguishers are completed monthly. A random audit of 5 extinguishers will be complete weekly x4 weeks, then monthl month. Those results will be submitted to the Administrator included in Quality Assurance Process Improvement meeting monthly for six months.	d y x4 and	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors					
j	failed to ensure 1 of doors in the 100 hal suitable for keeping impediment to closi the passage of smol	on and interview, the facility f 20 resident room corridor l were provided with a means the door closed, had no ing, latching and would resist ite. This deficient practice its, staff and visitors in 1 of 6 its.	K 0363	The corrective action taken for deficient practice include: The door to room 102 has bee fixed. Other residents that have the potential to be affected have be identified by: All residents on this hall have potential to be affected. The measures of systemic	en Been	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155086	B. WING 12/23/202			2024	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, resident room 102 corridor door was not able to be closed and latched. At the time of observation, the Maintenance Director attempted to close and latch the door more than three times but was unable to latch the door. Based on interview at the time of observation, the Maintenance director stated he was not able to latch the door shut and that the door would need to be adjusted. This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference.				changes that have been put in place to ensure that the deficie practice does not recur include Door audits will be included in regular preventative maintenar. The corrective action taken to monitor the performance to as compliance through quality assurance is: Maintenance Director/designe responsible for ensuring all do close properly. A random aud 5 doors will be completed daily weeks, then monthly x4 month. Those results will be submitted the Administrator and included Quality Assurance Process Improvement meeting monthly six months.	ent e: nce. sure e is ors it of / x4 n. d to I in	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice affects residents, staff and visitors in 2 of 6 smoke compartments. Findings include: Based on observation and interview with the Maintenance Director from 12:32 p.m. to 1:55 p.m. on 12/23/24, the set of smoke barrier doors between the Director of Nursing office and the		K 0			en and een I to to	01/22/2025

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AND PLAN OF CORRECTION ID:		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155086	B. W	B. WING			12/23/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				NAPPANEE ST			
WOODLA	AND MANOR				RT, IN 46514			
T			1		,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		the main hall corridor did not		TAG	The corrective action taken to		DATE	
		he door coordinator failed to			monitor the performance to as	cure		
		eaving one door open when			compliance through quality	Suit		
		on interview at time of			assurance is:			
	_	ntenance Director stated the			Maintenance Director/designe	e is		
		as loose preventing the doors			responsible for ensuring all do			
	from closing proper				close properly. A random aud			
		•			5 doors will be completed daily			
	This finding was rev	viewed with the Interim			weeks, then monthly x4 month			
	Administrator and M	Maintenance Director at the			Those results will be submitted			
	exit conference. 3.1-19(b)				the Administrator and included	l in		
					Quality Assurance Process			
					Improvement meeting monthly	for		
					six months.			
14.0740								
K 0712	NFPA 101							
SS=F	Fire Drills							
Bldg. 01	Dogad on record ray	riew and interview, the facility	17.0	710	The corrective action taken for	tha	01/22/2025	
		arterly fire drills on each shift.	K 0	/12	deficient practice include:	lile	01/22/2025	
	_	ates: Drills shall be conducted			A fire drill was completed on the	nird		
		aift to familiarize facility			shift on December 28, 2024.	iii u		
	personnel (nurses, in	-			Other residents that have the			
		nistrative staff) with the			potential to be affected have b	een		
	_	ncy action required under			identified by:			
		This deficient practice could			All residents have the potentia	l to		
	affect all residents,	staff and visitors.		be affected.				
					The measures of systemic			
	Findings include:				changes that have been put in	to		
					place to ensure that the deficie	ent		
		riew and interview with the			practice does not recur include	e :		
		or from 9:16 a.m. to 12:32 p.m.			Fire drills are routinely schedu	led		
		ility failed to provide			one time per shift per quarter.			
		fire drill conducted during the			The corrective action taken to			
		ond quarter of 2024. Based on			monitor the performance to as	sure		
		Maintenance Director, he			compliance through quality			
		o follow a schedule that was			assurance is:			
	•	the facility's corporation. The			Maintenance Director/designe			
		chedule that was dated 2023, it			responsible for completing all t			
	did not appear that t	he times and dates would			drills. The Administrator/design	nee		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155086	B. W	NG		12/23/	2024
	rovider or supplier AND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
K 0920 SS=E Bldg. 01	on each shift. The se it included other ever The dates and times conducted in 2024 of times listed on the se interview at the time Maintenance Direct was not conducted of second quarter of 20. This finding was read Administrator and Mexit conference. 3.1-19(b) 3.1-51(c) NFPA 101	ements of quarterly fire drills chedule was not current, and ents such as tornado drills. of the fire drills that were lid not match the dates and chedule provided. Based on e of record review the or acknowledged a fire drill during the third shift in the 124. wiewed with the Interim Maintenance Director at the			will conduct an audit of all fire drills completed each month x months. Those results will be submitted to the Administrator included in Quality Assurance Process Improvement meeting monthly for six months.	and	
	Based on observation failed to ensure flex not used in 2 of 6 sr substitute for fixed relectrical wiring and accordance with NF Code. NFPA 70, 20 requires that, unless cords and cables shar for fixed wiring of a 3.3.139 Patient care within a location into treatment of patients normal location of to or other device that examination and treextends vertically to floor. This deficient	on and interview, the facility ible cords and adapters were moke compartments as a wiring. LSC 9.1.2 requires dequipment shall be in PA 70, National Electrical 11 Edition, Article 400.8 specifically permitted, flexible all not be used as a substitute a structure. NFPA 99, section vicinity is defined as a space, tended for the examination and se, extending 6 feet beyond the he bed, chair, table, treadmill, supports the patient during atment. A patient care vicinity of feet 6 inches above the practice could affect visitors in 2 of 6 smoke	K 0	920	The corrective action taken for deficient practice include: The power cord and extension cord were removed from the premises. Other residents that have the potential to be affected have be identified by: All residents have the potential be affected. The measures of systemic changes that have been put in place to ensure that the deficie practice does not recur include Education provided to resident family members and staff regarding the policy for use of extension cords and power str.	neen Il to nto ent e: ts,	01/22/2025

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Findings include: Based on observation Maintenance Director on 12/23/24, 1) A prating was found pounknown rating that	on and interview with the tor from 12:32 p.m. to 1:55 p.m. sower strip of an unknown owering another power strip of t supplied power to fish tank ent room 100. The power strips			monitor the performance to as compliance through quality assurance is: Maintenance Director/designe will conduct an audit for extens cords or power strips of 5 room or offices per day x4 weeks, th 5 rooms or offices per month x months Those results will be submitted to the Administrator	e sion ns nen :5	
	were located within the patient care vicinity. 2) An extension cord was found powering 2 electronic chargers in the Community Liaison Director's office. These findings were reviewed with the Interim Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)				included in Quality Assurance Process Improvement meeting monthly for six months.	}	

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