STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155086	B. WI	NG		05/05/	2025
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WOODLA	AND MANOR				IAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	Licensure survey.	Recertification and State	F 00	00			
	Revisit (PSR) to the	e PSR completed on 4/11/2025 of Complaint IN00453447					
	Survey dates: April and 5, 2025.	28 and 29, 2025 and May 1, 2					
	Facility number: 00 Provider number: 1 AIM number: 1002	55086					
	Census Bed Type: SNF/NF: 69 Total: 69						
	Census Payor Type: Medicare: 3 Medicaid: 47 Other: 19 Total: 69						
	These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1					
	Quality Review con	npleted on 5/14/2025					
F 0576 SS=C Bldg. 00	483.10(g)(6)-(9) Right to Forms of	Communication w/ Privacy					
	failed to provide ma deficient practice af	and record review, the facility hil delivery on Saturdays. This fected 10 of 10 residents who tt /surveyor group meeting.	F 05	76	Requesting a Desk Review or 8 citations please- F 576 Right to Forms of	n all	05/23/2025

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

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 203711 Facility ID: 000034 If continuation sheet Page 1 of 21

06/18/2025 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/05/2025 155086 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 343 S NAPPANEE ST WOODLAND MANOR ELKHART, IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Communication w/ Privacy Finding includes: What corrective actions will be accomplished for those During the resident/surveyor group meeting on residents found to have been 4/30/2025 at 1:30 P.M., 10 of 10 participating affected by the deficient residents indicated mail was not delivered to them practice? on Saturdays. 2567 states 10 residents were affected via indicating mail Resident 271 indicated she delivered the mail delivery not avail on Saturdays, during the week to the residents, but the Saturday but none were specifically mail was not available for delivery to the identified residents. She indicated she never delivers the How other residents have the mail to residents on Saturdays. potential to be affected by the same deficient practice will be identified and what corrective During an observation on Monday, 5/5/2025 at 8:25 A.M., staff was observed to remove a large actions will be taken? amount of mail from an outside mailbox. Other residents who may send or receive mail on Saturdays During an interview, on 5/5/2025 at 3:58 P.M., the have the potential to be affected. Business Office Manager indicated the facility Admin/designee will hold a and resident mail was delivered Monday through resident council meeting and will Friday to the receptionist who separated out the notify residents that mail will be resident's mail for Resident 271 to deliver to the available on Saturdays to send residents. The Business Office Manger indicated and receive. the receptionist only worked during the weekdays What measures will be put into and the BOM did not know who, if any staff, place or what systemic retrieved the mail on Saturdays. She thought on changes will be made to ensure that the deficient

an occasional Saturday, the Activity staff might have gottent he mail from the mailbox but she was unsure if anyone actually delivered the mail to residents on Saturdays.

A policy was provided, on 5/5/2025 at 4:10 P.M., titled, "Resident Rights: Policy Interpretation and Implementation" by the Quality Assurance Nurse. The policy did not describe how residents would be provided with their personal mail Monday through Saturday.

3.1-3(s)1

practice does not recur? The Admin/designee will provide education to the weekend manager to ensure mail is passed out and picked up to be sent out on Saturdays.

Weekend Manager/designee will pick up outgoing mail and pass out incoming mail on Saturdays.

How the corrective actions will be monitored to ensure the

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

PRINTED: 06/18/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	00	COMPL	ETED
		155086	B. WING			05/05/	
		100000	Di Willio			00/00/	2020
NAME OF I	PROVIDER OR SUPPLIE	D	S	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	ROVIDER OR SUITEE	K	3	343 S N	IAPPANEE ST		
WOODL	AND MANOR			ELKHAF	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	7	ΓAG	DEFICIENCY)		DATE
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					Weekend Manager/desigr	nee	
					will complete an audit form		
					indicating that mail has been		
					passed out and picked up to b	е	
					sent out on Saturdays. Auditin		
					occur: q Saturdays x's 30 days	_	
					then every other Saturday x's		
					days, then monthly on Saturd		
					x's 4 months for a total of 6	•	
					months of monitoring.		
					The results of these review	WS	
					will be immediately reported if		
					concerns exist and will be		
					discussed at the monthly facili	tv	
					Quality Assurance Committee	-	
					meeting monthly for three mor		
					and then quarterly thereafter of		
					full compliance has been achie		
					for a total of 6 months of		
					monitoring. Re-education,		
					frequency and/or duration of		
					reviews will be increased as		
			1		needed, if areas of noncomplia	ance	
					are identified through the inter		
			1		process.	VICVV	
			1		p. 00000.		
F 0623	483.15(c)(3)-(6)(8	3)					
SS=D	Notice Requireme		1				
Bldg. 00	Transfer/Discharg		1				
2.59.00		view and interview, the facility	F 0623	3	F 623 Notice Requirements Bo	efore	05/23/2025
		sidents were provided proper	1 002.	·	Transfer/Discharge	3,010	03/23/2023
		nvoluntary transfer or	1		What corrective actions will	he	
	-	4 residents reviewed for	1		accomplished for those	u <del>c</del>	
	hospitalizations (R		1		residents found to have beer		
	nospitalizations (R	esident 43).	1			ı	
1	1		1		affected by the deficient		I

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

Finding includes:

Event ID:

203711

Facility ID: 000034

practice?

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W.	ING		05/05/	2025
NAME OF I	DROVIDED OD CUDDI IE	D.		STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE	N.			NAPPANEE ST		
WOODLA	AND MANOR			ELKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Resident #49 was readm		
		as completed for Resident 49 on			to the facility prior to the surv	еу	
		A.M. Diagnoses included, but			process on3/6/2025		
	were not limited to	: anxiety and depression.			l		
		(A (DG))			How other residents have the	_	
		nimum Data Set (MDS)			potential to be affected by t		
	·	3/13/2025, indicated Resident			same deficient practice will		
	49's cognition was mildly impaired and the resident was a current tobacco user.				identified and what correcti	ve	
	resident was a curr	ent tobacco user.			actions will be taken?		
	A review of Resident 49's census indicated she				The Administrator/design has reviewed all discharged	iee	
					resident's x's last 6 months w	ri+la	
	was discharged from the facility on 3/3/2025 and re-admitted to the facility on 3/6/2025.				no findings r/t improper notice		
	re-admitted to the facility on 3/0/2023.				to involuntary transfer/discha		
	A Discharge assessment, dated 3/3/2025 indicated				to involuntary transfer/discria	ige.	
	the resident was being discharged to (a local hotel				What measures will be put i	nto	
	name).	ang discharged to (a rocal note)			place or what systemic	1110	
	1				changes will be made to		
	A Physician's Orde	er, dated 3/3/25 indicated to			ensure that the deficient		
	-	ent home with medications and			practice does not recur?		
	discharge instruction				The Quality Assurance		
					Administrator/designee will p	rovide	
	A review of a Nurs	sing Progress note, dated			education to the new facility		
	3/3/2025 at 11:25 A	A.M., indicated Resident 49 was			Administrator on the requiren	nent	
	informed due to he	er being a danger to others by			to give proper notice prior to		
	_	ility. The note indicated she			involuntary transfer/discharge	∍.	
	_	ately discharged. The resident					
	_	the (local hotel name). The note			How the corrective actions	will	
		acility had paid for the resident			be monitored to ensure the		
	to stay at (local hot	tel name) for three nights.			deficient practice will not		
					recur, i.e., what quality		
		s note, dated 3/3/2025 at 11:47			assurance program will be	put	
		sident 49 had been notified of			into place?		
		rge and was to be transported			The Administrator/design		
	out of the facility of	on 3/3/2025 at 1:30 P.M.			will complete routine auditing		
	D 11 (40)	11 1 11			future residents who may rec		
		d lacked documentation that			an involuntary transfer/discha	-	
		lays notice prior to her			to ensure proper notice was	_	
	involuntary dischar	rge.			Auditing to occur: prior to ea		
i					involuntary transfer/discharge	e x's 6	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155086	B. W	ING		05/05/	2025
	PROVIDER OR SUPPLIER		<u> </u>	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS DI ANI 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	DEFICIENCY)		DATE
	A Nursing Progress	note, dated 3/6/2025 at 4:49			months for a total of 6 months	of	
		Social Services Director went			monitoring.		
	`	e) to make contact with			The results of these revie	ews	
		vas informed the resident had			will be immediately reported if		
	-	with the hotel's smoking			concerns exist and will be		
	policy and was being kicked out. The note indicated Resident 49 was returning to the facility				discussed at the monthly facili	•	
					Quality Assurance Committee		
		due to being removed from			meeting monthly for three mor		
	the hotel.				and then quarterly thereafter of		
	A Niversia o Des ousses	mate dated 2/6/2025 at 5:20			full compliance has been achie	evea	
	A Nursing Progress note, dated 3/6/2025 at 5:39 P.M. indicated Resident 49 was re-admitted to the facility.				for a total of 6 months of monitoring. Re-education,		
					frequency and/or duration of		
					reviews will be increased as		
	During an interview	y, on 5/5/2025 at 1:16 P.M., the			needed, if areas of noncompli	ance	
	_	Administrator (QAA)			are identified through the inter		
		49 had been given 30 days			process.	VICW	
		subsequent interview with the			process.		
		at 3:05 P.M. indicated she was					
		mentation that Resident 49					
	had been given 30	days notice of an involunary					
	discharge.						
	On 5/2/2025 at 9:25	5 A.M., the QAA provided a					
	policy titled, "Trans	sfer or Discharge Notices," no					
		t was the policy currently					
		acility. The policy indicated,					
	"1. Except as specif	fied below, the resident and his					
	-	e are provided with a written					
	_	ling transfer or discharge at					
	least 30 days prior t	to the transfer or discharge"					
F 0677	483.24(a)(2)						
SS=D	, , , ,	ed for Dependent Residents					
Bldg. 00	ADE GAIG FIUVIUG	a for Dependent Nesidents					
514g. 00	Based on observation	on, interview and record	F 0	677	F 677 ADL Care Provided for		05/23/2025
		failed to provide showers for 1	1 0	0//	Dependent Residents		0314314043
	-	wed for ADL (Activities of			What corrective actions will	be	
	Daily Living) care.	*			accomplished for those	~-	
	, mg, tare.				residents found to have been	า	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  05/05/2025			
	PROVIDER OR SUPPLIEI AND MANOR	R	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST .RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Finding includes:			affected by the deficient		
	I maning meruaesi			practice?		
	During an observat	ion, on 4/30/2025 at 9:07 A.M.,		Resident #1 as offered a		
	_	ed to have a large amount of		shower by certified nursing sta		
		hin and her fingernails had a		during the survey process on		
	brown substance up	_		5/5/2025 and declined. She ha	as a	
				care plan in place for refusals		
	The record for Resi	ident 1 was reviewed on		take showers and a preference		
		P.M. Diagnosed included, but		bed baths.	0 101	
		quadriplegia, epilepsy,		The DON/designee will re	view	
		and non-Alzheimer's dementia.		resident bathing preferences t		
	officialities, artificial and non-razirenter's deficition.			ensure the schedule reflects the		
	A Quarterly MDS (Minimum Data Set)			preferences and are schedule		
	assessment, dated 4/22/2025, indicated the			the electronic medical record	<b>4</b> ""	
	resident had severe cognitive impairment and			accordingly to ensure preferences		
		assist of 2 staff for bed mobility		are being met.		
	transfers, toilet use	_		How other residents have the	_	
		and she wering.		potential to be affected by th		
	A current Care Plan	n, initiated on 12/7/2021,		same deficient practice will be		
		1 required assistance with		identified and what corrective		
		ognitive deficits, arthritis,		actions will be taken?		
		driplegia. Interventions		All residents who have the	e	
	_	not limited to: " I prefer to		potential to be affected		
		vith staff assist and prefer my		The DON/designee will re	view	
		nd Thursday evening."		current residents bathing		
		, ,		preferences to ensure the		
	Resident 1's showe	r schedule indicated she was		schedule reflects those		
	to receive showers	on Mondays and Thursdays		preferences and are schedule	d in	
	on the day shift.			the electronic medical record		
				accordingly.		
	The shower docum	entation, dated March 2025,		DON/designee will ensure	e	
	indicated the reside	ent had received a shower on		bathing is documented		
	the following dates	: 3/18, 3/21 and 3/28, and bed		Bathing refusals to be		
	baths on 3/11, 3/14	, 3/18, 3/21 and 3/25/2025.		documented by facility staff		
				What measures will be put ir	nto	
	The shower docum	entation, dated April 2025,		place or what systemic		
	indicated the reside	ent had received a shower on		changes will be made to		
	4/21, and bed baths	s on 4/7 and 4/17/2025.		ensure that the deficient		
				practice does not recur?		

There was no documentation to indicate Resident

The DON/designee will

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		05/05/	/2025
		<u>l</u>	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			NAPPANEE ST		
WOOD!	AND MANOR				RT, IN 46514		
VVOODL/	WAD MINIAOU			LLINIA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		wers on 4/3, 4/10, 4/14, 4/21,			provide education to nursing		
	4/24 or 4/28/2025.				associates on the requirement		
					that bathing type and frequenc	cy be	
		mentation of any shower			completed and documented		
		ing Progress Notes from			according to resident preferen	ce	
	March 1st to April 3	Sun for Resident 1.			as per the bathing schedule.	a.	
	Dunin : .	on 5/5/2025 -+ 2.27 D.M. d			Refusals are to be documente		
		v, on 5/5/2025 at 3:27 P.M., the			Newly admitted residents	WIII	
		g indicated she could not			be interviewed to determine	and	
	provide any further shower documentation for Resident 1.				bathing preference as to type frequency. The bathing sched		
	Resident 1.				will be updated to reflect those		
	On 5/5/2025 at 3:15 P.M., the Quality Assurance				preferences	7	
	Administrator provided the policy titled, "				How the corrective actions w	/ill	
	_	Living (ADL) Supporting",			be monitored to ensure the	, iii	
		nd indicated the policy was the			deficient practice will not		
		by the facility. The policy			recur, i.e., what quality		
	1	ents who are unable to carry			assurance program will be p	ut	
		ly living independently receive			into place?		
		ary to maintain good nutrition,			The DON/designee will		
		onal and oral hygiene 5.			complete routine auditing to		
	Appropriate care an	nd services are provided for			ensure that bathing is being		
	residents who are u	nable to carry out ADL's			completed and documented a	nd	
	independently, with	consent of the resident, and			that refusals are documented	per	
	in accordance with	the plan of care, including			the bathing schedule. Auditing	j to	
	appropriate support	and assistance with: a.			occur: 5 random residents we	ekly	
	hygiene (bathing, d	ressing, grooming, and oral			x's 4 wks, then 4 random		
	care)"				residents wkly x's 4 wks, then	4	
					random residents monthly x's		
	3.1-38(b)(2)				months for a total of 6 months		
					monitoring. Any findings will be	е	
					addressed.		
					The results of these revie		
					will be immediately reported if		
					concerns exist and will be		
					discussed at the monthly facili	-	
			1		Quality Assurance Committee		
					meeting monthly for three mor		
					and then quarterly thereafter of		
			1		full compliance has been achie	eved	I

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

Event ID:

203711

Facility ID: 000034

034 If

If continuation sheet Page 7 of 21

PRINTED: 06/18/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	ì í	JILDING	ONSTRUCTION  00	(X3) DATE : COMPL 05/05/	ETED
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
					for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompli are identified through the interprocess.		
F 0684 SS=D Bldg. 00	483.25 Quality of Care						
Biag. OU	failed to notify the sugars for 1 of 1 resusage. (Resident 3)  Finding includes:  During an interview Resident 3 indicated abnormally high blomg/dL (milligram properties). A record review was 5/1/2025 at 9:47 A. were not limited to: diabetes with polynfailure.  A Quarterly Minimassessment, dated 1 3 was cognitively in injections.  A current Care Plant.	as completed for Resident 3 on M. Diagnoses included, but diabetes mellitus type 2, europathy and acute kidney  um Data Set (MDS) 2/23/2024, indicated Resident stact and received insulin  a, initiated on 4/9/2021 and	F 06	584	F 684 Quality of Care What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The DON/designee notific Resident 3's physician that resident had previously had abnormal blood sugars on 12/25/24 and 12/30/24. No notice were given.  How other residents have the potential to be affected by the same deficient practice will lidentified and what corrective actions will be taken?  Residents who have blood sugar perimeters have the potential to be affected  The DON/designee has reviewed physician orders of perimeters of blood sugar. No findings were identified.	ed  ew  e ne be /e	05/23/2025
	diabetes mellitus w	24, indicated Resident 3 had ith a goal of Resident 3 would hypo/hyperglycemia.			What measures will be put in place or what systemic changes will be made to	ıto	

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

Interventions included, but were not limited to:

Event ID:

203711

Facility ID: 000034

ensure that the deficient

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155086	B. W	ING _		05/05/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			NAPPANEE ST		
WOOD! A	AND MANOR				RT, IN 46514		
	Т		1		,		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		d sugar maniforing as ordered			practice does not recur?		
	by the physician.	d sugar monitoring as ordered			The DON/designee will	ı	
	by the physician.				provide education to licensed	l	
	A Physician's Orde	er, dated 11/13/2024, indicated			nursing associates on the requirement to notify physicial	n of	
	1	receive Lantus insulin solution			blood sugars outside of perin		
		cutaneously daily at bedtime.			The DON/designee will	ICICI S	
	inject to units suot	dufficulty daily at bedtime.			complete routine auditing as	noted	
	A Physician's Orde	er, dated 12/21/2024, indicated			below to ensure that All Bloo		
	Resident 3 was to have blood sugar monitoring at				sugar results are reported if	ч	
	bedtime and to notify the physician for a blood				outside of perimeters.		
	sugar reading below 70 mg/dL or above 400				dataide of perimeters.		
	mg/dL.				How the corrective actions	will	
					be monitored to ensure the		
	Blood sugar readin	gs, outside the physician			deficient practice will not		
	_	s, were documented as follows:			recur, i.e., what quality		
	-12/25/2024 at 9:5'				assurance program will be	out	
	-12/30/2024 at 9:4:	6			into place?	= <del>=</del>	
		2			The DON/designee will a	audit	
	There was no docu	mentation the physician had			blood sugar results of 4 rand		
		e blood sugar readings below			residents 3xs weekly for one		
	70 mg/dL.	- <del>-</del>			month and monthly for 5 mor	nths	
					for a total of 6 months of		
	During an interview	w, on 5/2/2025 at 9:15 A.M.,			monitoring. The physician wil	l be	
	LPN 8 indicated R	esident 3 must have requested a			notified for values outside of		
	_	o have been obtained. She			parameters.		
		cian should have been notified			The results of these review	ews	
	of the blood sugars	below 70 mg/dL.			will be immediately reported i	if	
					concerns exist and will be		
	_	w, on 5/5/2025 at 11:15 A.M.,			discussed at the monthly faci	-	
		tor of Nursing indicated			Quality Assurance Committed		
		ten orders for when the			meeting monthly for three mo		
		e notified for abnormal blood			and then quarterly thereafter		
		indicated that a blood sugar of			full compliance has been ach	ieved	
		g/dL should have had physician			for a total of 6 months of		
	notification docum	ented.			monitoring. Re-education,		
	] , ,.	1.1. 5/5/2025 12.14 7.35			frequency and/or duration of		
		ded, on 5/5/2025 at 2:46 P.M.,			reviews will be increased as		
	1	urance Administrator. The			needed, if areas of noncompl		
	policy titled, "Acut	te Condition Changes",			are identified through the inte	rview	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/05/2025
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE DATE
F 0695 SS=D Bldg. 00	The nursing staff w on the urgency of the physician will respondent of the physician will respondent of proband status Monitors are sident's/patient's putreatment, and the paccordingly"  3.1-37(a)  483.25(i)  Respiratory/Trach Suctioning  Based on observation interview, the facility equipment in a sanity reviewed for respiration of the paccording include:  1. During an observation of the pac	eostomy Care and on, record review and ty failed to store respiratory tary manor for 2 of 3 residents atory care. (Resident 1 & 50)  ation, on 4/30/2025 at 9:11 oxygen concentrator e was dated 4/2/2025 and was e concentrator. The oxygen ed 4/28/2025 and the nasal not dated.  dent 1 was reviewed on M. Diagnoses included, but quadriplegia, blindness, lzheimer's dementia.  um Data Set (MDS) //22/2025, indicated the cognitive impairment and	F 0695	F 695 Respiratory/Trached Care and Suctioning What corrective actions waccomplished for those residents found to have waffected by the deficient practice? Resident #1's humidiff bottle was replaced dated attached to the concentrate licensed nursing staff. The tubing and bag was replace appropriately dated on 5/5 Licensed nursing staff appropriately stored Resid portable oxygen tank, nebit tubing/mask, oxygen tubin tubing/mask, changed and all respiratory tubing and shags on 5/2/25.  How other residents have potential to be affected be same deficient practice was according to the same deficient practice was accomplished.	will be  peen  ication and or by e oxygen eed and /25. ent 50s ulizer g, bipap I dated storage  e the y the

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Event ID:

203711

Facility ID: 000034

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155086	B. WING		05/05/2025
	PROVIDER OR SUPPLIE	R	343 S	r address, city, state, zip cod NAPPANEE ST ART, IN 46514	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINEDIC BLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	Resident 1's curren	t physician orders included:		identified and what corrective	9
		rs per minute per Nasal Cannula		actions will be taken?	
		eep oxygen saturation above		Other residents who requi	re l
	90%.	cop oxygen saturation accve		respiratory treatments and	
		en tubing, and humidification		equipment have the potential to	n he
		n filter, and inspect easy foam		affected. The DON/designee	o be
		piled or missing), on the night		_	on
		The oxygen tubing to be		completed a facility wide audit	OII
		weekly on night shift and as		5/5/25 to ensure respiratory	
	needed.	weekly on night shift and as		equipment and supplies were	
	needed.			stored appropriately in a sanita	· .
	, G D	1 7/20/2022		manner and was labeled/dated	1
		n, initiated on 7/29/2022,		appropriately.	
		ent had altered respiratory		What measures will be put in	to
	1	reathing related to morbidly		place or what systemic	
	1	ortness of breath) while flat.		changes will be made to	
		t risk for alterations in oxygen		ensure that the deficient	
		nes removed the oxygen tubing		practice does not recur?	
	and had to be remin	nded to leave it in place.		The DON/designee will	
				provide education to the IP and	t l
	_	tion, on 5/1/2025 at 1:29 P.M.,		licensed/certified nursing staff	on
	Resident 1's oxyge	n concentrator humidification		the requirement to ensure that	
	bottle was still dat	ed 4/2/2025 and was not		portable tanks are not placed of	on
	hooked up to the co	oncentrator. The oxygen nasal		floor, respiratory	
	cannula tubing was	s still not dated.		supplies/equipment including	
				respiratory masks/tubing are	
	During an observat	tion, on 5/1/2025 at 2:30 P.M.,		appropriately labeled and date	d
	Resident 1's oxyge	n tubing was not hooked up to		and are bagged and stored in	a
	the humidification	bottle, still dated 4/2/2025 and		sanitary manner.	
	the oxygen tubing	was still not dated.		The DON/designee will	
				complete routine auditing as no	oted
	During an observat	tion, on 5/2/2025 at 9:55 A.M.,		below to ensure that portable	
		ent 1's oxygen tubing was not		tanks are not placed on floor,	
		he humidification water bottle		respiratory supplies/equipment	
	1	not attached to the concentrator		including respiratory masks/tub	
	to provide humidif			are appropriately labeled and	/···ˈ9
	la provide numum			dated and are bagged and stor	red
	During an interview	w, on 5/2/2025 at 9:56 A.M.,		in a sanitary manner.	Cu
		e oxygen tubing should have			
				How the compating actions as	:
	been dated, the nur	nidification water bottle should		How the corrective actions w	III

have been changed, dated, and should have been

be monitored to ensure the

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	NT OF DEFICIENCIES		î ´		,
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155086	B. WING		05/05/2025
NAME OF 1	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP COD	
				NAPPANEE ST	
WOODL	AND MANOR		ELKHA	RT, IN 46514	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	placed on the conce	entrator to provide humidified		deficient practice will not	
	air. 2. During an ob	oservation on 4/29/2025 at 9:36		recur, i.e., what quality	
	A.M., Resident 50	was observed to have a		assurance program will be p	ut
	portable oxygen tar	nk, an oxygen concentrator, a		into place?	
	nebulizer machine	and a BiPap (bilevel positive		The DON/designee will	
	airway pressure) m	achine on the bedside table.		complete routine auditing as n	oted
		en tank was sitting on the floor		below to ensure that portable	
		asal cannula on the floor, the		tanks are not placed on floor,	
		or was at the bedside with an		respiratory supplies/equipmen	t
		ula tube lying in the upper		including respiratory masks/tu	bing
		de table. The visibly soiled		are appropriately labeled and	
	nebulizer mask was lying in the upper drawer of			dated and are bagged and sto	
	the bedside table and the BiPap mask was lying			in a sanitary manner. Auditing	
		wall. There were no respiratory		occur: 3 random residents who	D
	1 -	the nasal cannulas or masks		require respiratory	
	noted in the room.			supplies/equipment	
				4 days a week x's 30 days	S,
	_	ion, on 4/29/2025 at 1:54 P.M.,		then 4 random residents who	
		n tank with the nasal cannula		require respiratory	
	was observed on th			supplies/equipment wkly x's 3	
		asal cannula was observed		days then 4 random residents	who
		drawer of the bedside table,		require respiratory	
	-	ebulizer mask was observed		supplies/equipment monthly x	
		wer of the bedside table and		months for a total of 6 months	of
	_	s observed on the bedside		monitoring.	
	table against the wa	all.		The results of these revie	
	Danis . 1	: 4/20/2025 + 0.24 A.M.		will be immediately reported if	
	_	nion, on 4/30/2025 at 9:34 A.M.		concerns exist and will be	£
		8 P.M., the portable oxygen		discussed at the monthly facili	•
		sitting on the floor. The nasal		Quality Assurance Committee	
		nected to the portable oxygen		meeting monthly for three mor	
		on the floor. The oxygen		and then quarterly thereafter of	
		the oxygen concentrator was		full compliance has been achie	eveu
		he upper drawer of the bedside		for a total of 6 months of	
	table.			monitoring. Re-education,	
	During on abase	ion on 5/5/2025 at 0:10 A M		frequency and/or duration of	
		ion, on 5/5/2025 at 9:10 A.M., was observed lying in the top		reviews will be increased as	2000
		was observed lying in the top		needed, if areas of noncomplia	
	I GLAWEL OF DEGISION I	ALDE AUGUS VYCH	·	I ALE ICIENTIFIC MICHIGINI ME INIER	VIEW I

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concentrator nasal cannula tubing was observed

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process.

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155086	B. W	ING		05/05/2	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			NAPPANEE ST		
WOODL	AND MANOR				RT, IN 46514		
	1		1		, 	Т	77.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	_	pedside table drawer's			IDR info-		
	hardware.				Woodland Manor respectfully		
	A managed marriage for	Davidant 50 was samulated an			requests that citation F622 be		
		Resident 50 was completed on			reviewed under the Informal		
	5/1/2025 at 9:13 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary				Dispute Process alleging the		
					facility failure to ensure inform		
	disease (COPD), chronic bronchitis and anxiety.				regarding a resident's transfer		
	An Annual Minimum Data Set (MDS) assessment,				the hospital was documented	""	
	dated 3/19/2025, indicated Resident 30 was				the electronic medical record.		
	cognitively intact and received oxygen therapy.				Although we disagree that pro		
	cognitively intact an	nd received oxygen merapy.			procedure was not followed, the		
	Dhysician Ondons in slyded the fellowing andons on				facility will continue to work the	e	
	Physician Orders included the following orders on				plan of correction.	_	
	3/10/2025:	erol Solution 0.5-2.5 milligrams			According to the 2567 F622, "		
		e vial inhalation via nebulizer			review of Nursing Progress no		
	_	eded shortness of breath and			indicated on 4/30/2025 Reside	ent	
	wheezing related to				63 had been transferred to		
	-	ers of oxygen bled in when			(hospital name) and returned	10	
	_	day and sleeping at night			the facility on 4/30/2025". In	-:4-1	
		piratory failure with hypoxia			actuality, there was not a hosp		
	and COPD.	matory famule with hypoxia			transfer on 4/30/25. The resid		
		oing every night shift on			was transferred to the hospita		
	Wednesday.	ong every night shift on			4/3/25 and returned on 4/14/2 According to the citation, the	J.	
	· ·	rs per nasal cannula			record lacked documentation	that	
		intain oxygen saturations			a transfer/discharge assessme		
	-	elated to acute respiratory			indicating where the resident I		
	failure with hypoxia	1 -			been transferred to, who had		
	Tanaic with hypoxic	a and COI D.			notified of the resident's trans		
	A current Care Plan	n, initiated 9/1/2023 and revised			and the reason the resident w		
		cated Resident 30 had an			being transferred had been	u3	
		status with difficulty breathing			completed for Resident 63.		
		s, COPD and asthma.			Upon record review, it is noted	,	
		led, but were not limited to:			there was an assessment	1	
		ation/puffers as ordered.			completed by the NP (nurse		
	-BiPap as ordered.	mon pariers as ordered.			practitioner) on 4/3/25 that is		
	-Nebulizer treatmer	nts as directed			present in the medical record.		
	-Oxygen as ordered				Included in the assessment w		
	Oxygen as ordered	<del>.</del>			recommendation for psychiatr		
	During an interview	v. on 5/5/2025 at 11:37 A.M			hospitalization due to paranoi		

	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 CO		(X3) DATE SURVEY COMPLETED 05/05/2025		
NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR  (YO ID SUMMARY STATEMENT OF DEFICIENCIE		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Qualified Medication indicated respirator	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  on Assistant (QMA) 9  y equipment (masks, nasal  stored on a clean surface and	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  thoughts. A progress note writ by the facility Social Worker o	DATE tten
	stored in a respirato was not in use  A policy was provide by the Quality Assurpolicy titled, "Respirated in the procedure is to guide associated with respective equipment, including and staffInfection Related to Oxygen oxygen cannulae and needed} in a plasticeInfection Control Medication Nebuliz	estored on a clean surface and ry bag when the equipment ded, on 5/5/2025 at 2:46 P.M., trance Administrator. The firatory Therapy-Prevention of d, "The purpose of this le prevention of infection biratory therapy tasks and ag ventilators, among residents a Control Considerations Administration8. Keep the d tubing used PRN [as bag when not in use Considerations Related to ters/Continuous Aerosol:7. a plastic bag, marked with date to the ters/Continuous en uses"		4/3/25 states resident was discharged to Neuropsychiatri Hospital of Crown Point. According to the medical recording to the medical recording to the medical recording to the resident is her own responsible party and A/R guarantor. On 4/4/25, a petitic guardianship was submitted to Elkhart County Superior Courappoint a permanent guardian resident.  Transfer paperwork was sent the resident to the receiving factor upon hospitalization, which included a copy of the order with the name of the facility transfer to and the reason for transfer, notice of transfer/discharge are state form 49831, the bed hole policy and a copy of the assessment completed by the NP. Although copies of the paperwork were not scanned the chart at the time of the surveyors and subsequently scanned into the chart.  With the facts stated above, please consider the actions by facility were followed in fulfilling transfer/discharge requirements.	on for to the to to in for with earlity with erring the end decrees, was early the g the
F 0758 SS=D Bldg. 00	Use Based on observation	Psychotropic Meds/PRN on, record review and	F 0758	F 758 Free from Unnecessary	05/23/2025
	interview, the facili	ty failed to attempt a gradual		Psychotropic Meds/PRN Use	

		X1) PROVIDER/SUPPLIER/CLIA		JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
AND PLAN OF CORRECTION		155086	B. WI	NG		05/05/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ER			NAPPANEE ST		
WOODLAND MANOR					NRT, IN 46514		
				LLIXII	10014		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		an antipsychotic medication for			What corrective actions will	be	
		viewed for unnecessary			accomplished for those		
	medications. (Resi	ident 20)			residents found to have bee	n	
					affected by the deficient		
	Finding includes:				practice?		
					Resident #20's physician	I .	
	_	tion, on 4/30/2025 at 9:34 A.M.,			gave orders for an attempted	I .	
		.M. and 5/5/2025 at 10:24 A.M.,			on the current Risperdal orde	r on	
		bserved seated in the doorway			5/20/2025.		
	of his room lookin	ig into the hallway			How other residents have th		
					potential to be affected by the	I .	
	A record review for Resident 20 was completed on 5/1/2025 at 10:40 A.M. Diagnoses included, but				same deficient practice will	I .	
					identified and what corrective	/e	
		o: post-traumatic stress disorder			actions will be taken?		
		pressive disorder, alcohol			Other residents who rece		
	-	alcohol-induced dementia and			psychotropic medications hav	e the	
	other sexual disfur	action.			potential to be affected.		
	A Ossantanlar Minin	Data Cat (MDC)			The DON/designee has		
		mum Data Set (MDS)			reviewed pharmacy		
	·	4/14/2025, indicated Resident			recommendations x's last 60	-	
		ognitive impairment and			to ensure GDRs that have be		
	medications.	ychotic and antidepressant			declined and/or contraindicate		
	medications.				the physician have appropriat	.e	
	A current Core Die	on initiated on 1/25/2024 and			supporting documentation in		
	A current Care Plan, initiated on 1/25/2024 and revised on 10/6/2024, indicated Resident 20 was at risk for yelling and cursing at staff due to a history of these behaviors and dementia.  Interventions included, but were not limited to: -Administer medications as neededOffer resident snacks and drinks especially Pepsi, chips, and cookies.				place. What measures will be put in	nto	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					The DON/designee will		
					provide education to the phys	ician	
		en by in-house psych services.			on the requirement to ensure		
		r the resident's behaviors			GDRs that have been decline	d	
	-5tan win monitor the resident's behaviors				and/or contraindicated by the		
	A current Care Pla	an, initiated on 10/21/2021 and			physician have appropriate		
		224, indicated Resident 20 had a			supporting documentation in		
		inappropriate comments and			place.		
		to staff. Interventions included,			The DON/designee will a	<sub>udit</sub>	
	but were not limite				random residents with		

203711

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
AND PLAN OF CORRECTION		155086	B. WING			05/05/2025	
		<u>l</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			IAPPANEE ST		
WOODLA	WOODLAND MANOR				RT, IN 46514		
VVOODL/				ELNHA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		psychological services.			psychotropic medications to		
	-Educate resident.				ensure GDR's have been		
		cks particularly Pepsi, pretzels,			discussed with appropriate		
	chips, and cookies.				documentation to support.		
		by changing topic to golf,					
	sports, current even				How the corrective actions w	/ill	
		y encouraging him to			be monitored to ensure the		
		vorite activities including cross			deficient practice will not		
	_	watching, and watching			recur, i.e., what quality		
		y westerns and action movies.	1		assurance program will be p	ut	
	-The interdisciplinary team to review behavior management program quarterly and as needed.				into place?		
					The DON/designee will		
					complete routine auditing of		
	A previous Physicia				pharmacy recommendations t	0	
		24, indicated an order for			ensure GDRs that have been		
		ive risperidone one milligram			declined and/or contraindicate	-	
	three times daily for	r major depressive disorder.			the physician have appropriate	Э	
					supporting documentation in		
	-	r, dated 7/27/2024-2/24/2025,			place. Auditing to occur on		
	_	ne 0.5 milligrams three times			residents with a declined GDF	2	
	daily for major depr	ressive disorder.			recommendation and/or		
					contraindications: 6 residents		
	A previous Physicia				30 days, then 4 residents x's 3	30	
	2/24/2025-3/10/2025, indicated an order for Resident 20 to receive risperidone 0.5 milligrams three times daily for alcohol induced-persisting dementia.				days then 2 residents x's 4	_	
					months for a total of 6 months	of	
					monitoring		
					The results of these reviews w		
	A 0118mant D1:-	No Order dated 2/10/2025			immediately reported if concer		
		a's Order, dated 3/10/2025,			exist and will be discussed at		
	indicated Resident 20 was to receive risperidone 0.5 milligrams three times daily for alcohol induced-persisting dementia.  A review of Resident 20's behaviors indicated the				monthly facility Quality Assura		
					Committee meeting monthly for		
					three months and then quarter	•	
					thereafter once full compliance has been achieved for a total of		
		s were documented from				טו ט	
	December 2024 three				months of monitoring.	or	
		xual behaviors six times with			Re-education, frequency and/oduration of reviews will be	JI .	
	redirection and char					of	
		nged environment ther behaviors had been	1		increased as needed, if areas	UI	
					noncompliance are identified		
	documented during	uns ume perioa.			through the interview process.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/05/2025				
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					
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION			
	1/17/2025 at 12:00 have montiored for changes in mood or	h Encounter Note, dated A.M., indicated staff were to any clinically significant behaviors.  h Encounter Note, dated						
	1/27/2025 at 12:00 observed minimal n care or safety. Residence of safety. Resident 20 showed	A.M., indicated staff had legative behaviors affecting dent 20 had recently changed on with his previous roommate. It subdued, constricted affect,						
	A Behavioral Healt 1/30/2025 at 12:00 discussed in the beh meeting with the fa Staff had reported t making inappropria staff and had a rece exhibited behaviors locked memory car clinical contraindictiongoing concerns a	h Encounter Note, dated A.M., indicated Resident 20 was navior/gradual dose reduction cility's interdisciplinary team. hat Resident 20 had been te sexual comments toward nt improvement regarding since being moved from the e unit. The note indicated a ation would be noted due to nd condition the resident's well controlled or stable.						
	A Behavioral Healt 2/24/2025 at 12:00 subdued to somnole minimally cooperat signs of agitation or Resident 20 continu had been able to be regimen and interve were to continue with	h Encounter Note, dated A.M., indicated Resident 20 was ent, difficult to rouse and ive. Resident 20 showed no distress. Staff reported ned to be stable overall and managed with his current entions. Behavioral services th another provider.						
	2/27/2025 at 12:00	h Encounter Note, dated A.M., indicated Resident 20 was navior/gradual dose reduction						

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	OF CORRECTION	IDENTIFICATION NUMBER  155086	A. BUILDING B. WING	00	COMPLETED 05/05/2025			
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					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	The note indicated trecommendations to 20 was continued on three times a day wireduction attempted	cility's interdisciplinary team. here were no pharmacy o review on this date. Resident or risperidone 0.5 milligrams ith the last gradual dose on 7/25/2024.  y Consult Note, on 3/12/2025						
	at 11:59 P.M., indic reported as okay du- indicated there wou current medication is continue to be moni	ated Resident 20's mood was ring the visit. The note ld not be any changes to the regimen. Resident 20 would						
	indicated a dose red psychotropic medical handwritten on the landwritten on the landwritten form which indicate There was no indicate	amendation, dated 3/31/2025, uction for Resident 20's ations was due. A reply was cottom of hte recommendation and "no changes at this time." utions as to why a gradual not being attempted.						
	4/15/2025 at 11:59 be reported satisfaction. The note indicated I monitored for mood the treatment was to was no specific con-	h Encounter Note, dated P.M., indicated Resident 20 n with his current life situation. Resident 20 was to be I issues and adjustments to be made if necessary. There traindication documented n for not attempting to reduce yechotic medication.						
	Social Service Assis months, a gradual d medications was to the psychiatrist had	s, on 5/5/2025 at 2:04 P.M., the stant indicated every three ose reduction of psychotropic be attempted. She indicated not wanted to reduce rations since his symptoms						

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

PRINTED: 06/18/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	r í	UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 05/05/	ETED		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP COD  343 S NAPPANEE ST  ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
TAU	were stable. She inc Resident 20 was on risperidone to achie There was no further regarding a reason of attempting to reduce medication.  A policy was provide by the Quality Assurpolicy titled, "Antip indicated, " 1. Res antipsychotic medic specific conditions and effective. Contit the medication will 2. The Attending Pl gather and document resident's behavior, condition, symptom Attending Physician document, with input consultants as needed warrant the use of a Residents receiving will be reviewed at Interdisciplinary tea [GDR] will occur a contraindicated. A of the 1st year of admit initiation of the anti- quarters with at lease	dicated she did not know if the lowest amount of the ve the same symptom control. For documentation provided for contraindication for not the ethe resident's antipsychotic ded, on 5/5/2025 at 2:46 P.M., for ance Administrator. The psychotic Medication Use", sidents will only receive the eation when necessary to treat for which they are indicated nues [sic Continued] use of the reviewed at least quarterly. The psychotic medical and other staff will not information to clarify a mood, function, medical as, and risks5. The in will identify, evaluate and the trom other disciplines and the ed, symptoms that may not provide medications least quarterly by the term. Gradual dose reductions is required, unless clinically GDR will be attempted within thance to the facility [or psychotic] in 2 separate at 1 month in between st year, A GDR will be		IAU			DATE		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs								

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review, the facility failed to ensure medication storage areas were clean and free from loose medications and failed to ensure medications were labeled and dated when opened, during medication storage review in 2 of 2 medication carts reviewed. (medication cart 1 on 100/200 hall and Memory Care 400 medication cart).  Findings include:  1. During a medication storage observation, on 5/5/25 to ensure appropriate labeling/dating and appropriately disposed of loose pills in carts. with LPN 2 the following was observed:  - An unopened tube of glucose for a discharged resident An opened and undated bottle of Milk of Magnesia An opened bottle of ant-acid tablets with no resident label on the container Fourteen loose pills in the medication cart An opened package of Albuterol inhalation vials with no resident identifiers on the box.  During an interview, on 5/5/2025 at 10:48 A.M.,  Biologicals  What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  The DON/designee cleaned and organized all facility medication storage areas on 5/5/25 to ensure appropriate labeling/dating and appropriately disposed of loose pills in carts.  What measures will be incarts will be accomplished for those residents found to have been affected by the deficient practice?  The DON/designee cleaned and organized all facility medication storage areas on 5/5/25 to ensure appropriate labeling/dating and appropriately disposed of loose pills in carts.  What measures will be put into	CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OMB	NO. 0938-039
MAME OF PROVIDER OR SUPPLIER   343 S NAPPANEE ST ELKHART, IN 46514	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED		
PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION  Based on observation, interview and record review, the facility failed to ensure medication storage areas were clean and free from loose medications and failed to ensure medication eart 1 on 100/200 hall and Memory Care 400 medication carts reviewed. (medication cart).  Findings include:  1. During a medication storage observation, on 5/2/2025 at 10:30 A.M., on the medication cart 1 with LPN 2 the following was observed:  - An unopened tube of glucose for a discharged resident An opened bottle of ant-acid tablets with no resident label on the container Fourteen loose pills in the medication cart An opened box of Omeprazole tablets with no resident identifiers on the box.  During an interview, on 5/5/2025 at 10:48 A.M.,  PREFIX TAG  PREF	WOODLAND MANOR			343 S I	NAPPANEE ST			
Based on observation, interview and record review, the facility failed to ensure medication storage areas were clean and free from loose medications and failed to ensure medications were labeled and dated when opened, during medication storage review in 2 of 2 medication carts reviewed. (medication cart 1 on 100/200 hall and Memory Care 400 medication cart).  Findings include:  1. During a medication storage observation, on 5/5/225 at 10:30 A.M., on the medication cart 1 with LPN 2 the following was observed: - An unopened tube of glucose for a discharged resident An opened and undated bottle of Milk of Magnesia An opened bottle of ant-acid tablets with no resident label on the container Fourteen loose pills in the medication cart An opened package of Albuterol inhalation vials with no resident identifiers on the box.  During an interview, on 5/5/2025 at 10:48 A.M.,	PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	B MATE	COMPLETION
been labeled and dated when opened, and there should be labels on the medication bottles. LPN 2 indicated there should have not been loose pills in the medication cart.  The DON/designee will provide education to associates  2. During a medication storage observation, on 5/5/2025 at 11:02 A.M., on the Memory Care Unit  changes will be made to ensure that the deficient practice does not recur?  The DON/designee will provide education to associates who administer medications on the requirement to ensure loose	Bldg. 00	review, the facility storage areas were emedications and failabeled and dated with medication storage carts reviewed. (meand Memory Care 2)  Findings include:  1. During a medicate 5/2/2025 at 10:30 A with LPN 2 the foll - An unopened tube resident.  - An opened and un Magnesia.  - An opened bottle resident label on the Fourteen loose pill - An opened package with no resident idea.  The over flow medicate the beautifiers on the both During an interview LPN 2 indicated the been labeled and dashould be labels on indicated there shout the medication cart.	failed to ensure medication clean and free from loose led to ensure medications were when opened, during review in 2 of 2 medication edication cart 1 on 100/200 hall 400 medication cart).  tion storage observation, on a.M., on the medication cart 1 owing was observed: e of glucose for a discharged edated bottle of Milk of of ant-acid tablets with no econtainer. Is in the medication cart. ge of Albuterol inhalation vials entifier.  dication cart had an unopened tablets with no resident ox.  a. on 5/5/2025 at 10:48 A.M., emedications should have the medication bottles. LPN 2 all have not been loose pills in the edication storage observation, on	F 07	761	Biologicals What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The DON/designee clean and organized all facility medication storage areas on 5/5/25 to ensure appropriate labeling/dating and appropriate labeling to be affected by the same deficient practice will identified and what correcting actions will be taken?  Other residents who have medications stored in medications at the potential to be affected.  The DON/designee clean and organized all facility medication storage areas on 5/5/25 to ensure appropriate labeling/dating and ap	I be en ned ately ts. he the dive ation en ned ately ts. into	05/23/2025

with LPN 7, the following was observed:

- Four loose pills in the 2nd and 3rd drawers.

pills are appropriately disposed of,

medications are appropriately

		X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155086	B. W	ING		05/05/	2025
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
WOODLAND MANOR					IAPPANEE ST RT, IN 46514		
			1	<u> </u>	, +001+	1	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
	·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
PREFIX TAG	During an interview LPN 7 indicated the in the cart.  On 5/5/2025 at 1:58 Adminiww3ws22qs titled, "Medication undated, and indicate currently used by th " Medication Stor responsible for main and preparation area manner Medication and bid pharmacy is consist state requirements a pharmaceutical practice containers have mis incorrect labels, con	CY MUST BE PRECEDED BY FULL ALSO IDENTIFYING INFORMATION  7, on 5/5/2025 at 11:10 A.M., cloose pills should have not be  8 P.M., the Quality Assurance strator provided the policy Labeling and Storage", ted the policy was the one are facility. The policy indicated age 2. The nursing staff is intaining medication storage as in a clean, safe, and sanitary on Labeling 1. Labeling of pological's dispensed by the cent with applicable federal and und currently accepted exices 8. If medication using, incomplete, improper or intact the dispensing pharmacy arding returning or destroying		PREFIX TAG	labeled, and meds that are required to be dated are appropriately dated.  DON/designee will complete routine auditing as noted below the monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place?  DON/designee will complete routine auditing of medication carts to ensure loose pills are appropriately disposed of, medications are appropriately labeled, and meds that are required to be dated are appropriately dated. Auditing to occur on random carts 3 x's w x's 30 days, wkly x;s 30 days then monthly x's 4 months for total of 6 months of monitoring. The results of these reviewill be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three mor and then quarterly thereafter of full compliance has been achief or a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncomplicare identified through the interprocess.	w.  vill  ut  ete  o kly  a l.  ws  ty  nths once eved	DATE

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