STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	05/05/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure survey. This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR completed on 4/11/2025 to the Investigation of Complaint IN00453447 completed on February 28, 2025. Survey dates: April 28 and 29, 2025 and May 1, 2 and 5, 2025. Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 3 Medicaid: 47 Other: 19 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality Review completed on 5/14/2025	F 0000		
F 0576 SS=C Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy Based on interview and record review, the facility failed to provide mail delivery on Saturdays. This deficient practice affected 10 of 10 residents who attended the resident /surveyor group meeting.	F 0576	*Requesting a Desk Review on all 8 citations please-* *F 576 Right to Forms of*	05/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Finding includes: During the resident/surveyor group meeting on 4/30/2025 at 1:30 P.M., 10 of 10 participating residents indicated mail was not delivered to them on Saturdays. Resident 271 indicated she delivered the mail during the week to the residents, but the Saturday mail was not available for delivery to the residents. She indicated she never delivers the mail to residents on Saturdays. During an observation on Monday, 5/5/2025 at 8:25 A.M., staff was observed to remove a large amount of mail from an outside mailbox. During an interview, on 5/5/2025 at 3:58 P.M., the Business Office Manager indicated the facility and resident mail was delivered Monday through Friday to the receptionist who separated out the resident's mail for Resident 271 to deliver to the residents. The Business Office Manger indicated the receptionist only worked during the weekdays and the BOM did not know who, if any staff, retrieved the mail on Saturdays. She thought on 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		*Communication w/ Privacy* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** 2567 states 10 residents were affected via indicating mail delivery not avail on Saturdays, but none were specifically identified **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who may send or receive mail on Saturdays have the potential to be affected. Admin/designee will hold a resident council meeting and will notify residents that mail will be available on Saturdays to send and receive. **What measures will be put into place or what systemic changes will be made to ensure that the deficient 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**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? Weekend Manager/designee will complete an audit form indicating that mail has been passed out and picked up to be sent out on Saturdays. Auditing to occur: q Saturdays x's 30 days, then every other Saturday x's 30 days, then monthly on Saturdays x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure residents were provided proper notice prior to an involuntary transfer or discharge for 1 of 4 residents reviewed for hospitalizations (Resident 49). Finding includes:	F 0623	*F 623 Notice Requirements Before Transfer/DIscharge* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	05/23/2025

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	A record review was completed for Resident 49 on 5/1/2025 at 11:32 A.M. Diagnoses included, but were not limited to: anxiety and depression. An Admission Minimum Data Set (MDS) assessment, dated 3/13/2025, indicated Resident 49's cognition was mildly impaired and the resident was a current tobacco user. A review of Resident 49's census indicated she was discharged from the facility on 3/3/2025 and re-admitted to the facility on 3/6/2025. A Discharge assessment, dated 3/3/2025 indicated the resident was being discharged to (a local hotel name). A Physician's Order, dated 3/3/25 indicated to discharge the resident home with medications and discharge instructions. A review of a Nursing Progress note, dated 3/3/2025 at 11:25 A.M., indicated Resident 49 was informed due to her being a danger to others by smoking in the facility. The note indicated she was being immediately discharged. The resident was discharged to the (local hotel name). The note also indicated the facility had paid for the resident to stay at (local hotel name) for three nights. A Nursing Progress note, dated 3/3/2025 at 11:47 A.M. indicated Resident 49 had been notified of her pending discharge and was to be transported out of the facility on 3/3/2025 at 1:30 P.M. Resident 49's record lacked documentation that she received a 30 days notice prior to her involuntary discharge.		Resident #49 was readmitted to the facility prior to the survey process on __3/6/2025___ **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The Administrator/designee has reviewed all discharged resident's x's last 6 months with no findings r/t improper notice prior to involuntary transfer/discharge. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Quality Assurance Administrator/designee will provide education to the new facility Administrator on the requirement to give proper notice prior to an involuntary transfer/discharge. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will complete routine auditing of future residents who may receive an involuntary transfer/discharge to ensure proper notice was given. Auditing to occur: prior to each involuntary transfer/discharge x's 6	

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	A Nursing Progress note, dated 3/6/2025 at 4:49 P.M. indicated the Social Services Director went to (local hotel name) to make contact with Resident 49. SSD was informed the resident had not been compliant with the hotel's smoking policy and was being kicked out. The note indicated Resident 49 was returning to the facility for a short term stay due to being removed from the hotel. A Nursing Progress note, dated 3/6/2025 at 5:39 P.M. indicated Resident 49 was re-admitted to the facility. During an interview, on 5/5/2025 at 1:16 P.M., the Quality Assurance Administrator (QAA) indicated Resident 49 had been given 30 days notice. However, a subsequent interview with the QAA, on 5/5/2025 at 3:05 P.M. indicated she was unable to find documentation that Resident 49 had been given 30 days notice of an involunary discharge. On 5/2/2025 at 9:25 A.M., the QAA provided a policy titled, "Transfer or Discharge Notices," no date and indicated it was the policy currently being used by the facility. The policy indicated, "1. Except as specified below, the resident and his or her representative are provided with a written notice of an impending transfer or discharge at least 30 days prior to the transfer or discharge...."		months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to provide showers for 1 of 7 residents reviewed for ADL (Activities of Daily Living) care. (Resident 1)	F 0677	*F 677 ADL Care Provided for Dependent Residents* **What corrective actions will be accomplished for those residents found to have been**	05/23/2025

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	Finding includes: During an observation, on 4/30/2025 at 9:07 A.M., Resident 1 was noted to have a large amount of facial hair on her chin and her fingernails had a brown substance underneath them.. The record for Resident 1 was reviewed on 5/01/2025 at 1:25 P.M. Diagnosed included, but were not limited to quadriplegia, epilepsy, blindness, arthritis and non-Alzheimer's dementia. A Quarterly MDS (Minimum Data Set) assessment, dated 4/22/2025, indicated the resident had severe cognitive impairment and required extensive assist of 2 staff for bed mobility transfers, toilet use and showering. A current Care Plan, initiated on 12/7/2021, indicated Resident 1 required assistance with ADL's due to her cognitive deficits, arthritis, blindness, and quadriplegia. Interventions included, but were not limited to: " I prefer to complete bathing with staff assist and prefer my showers Monday and Thursday evening." Resident 1's shower schedule indicated she was to receive showers on Mondays and Thursdays on the day shift. The shower documentation, dated March 2025, indicated the resident had received a shower on the following dates: 3/18, 3/21 and 3/28, and bed baths on 3/11, 3/14, 3/18, 3/21 and 3/25/2025. The shower documentation, dated April 2025, indicated the resident had received a shower on 4/21, and bed baths on 4/7 and 4/17/2025. There was no documentation to indicate Resident		**affected by the deficient practice?** Resident #1 as offered a shower by certified nursing staff during the survey process on 5/5/2025 and declined. She has a care plan in place for refusals to take showers and a preference for bed baths. The DON/designee will review resident bathing preferences to ensure the schedule reflects those preferences and are scheduled in the electronic medical record accordingly to ensure preferences are being met. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who have the potential to be affected The DON/designee will review current residents bathing preferences to ensure the schedule reflects those preferences and are scheduled in the electronic medical record accordingly. DON/designee will ensure bathing is documented Bathing refusals to be documented by facility staff **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will	

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	1 had received showers on 4/3, 4/10, 4/14, 4/21, 4/24 or 4/28/2025. There was no documentation of any shower refusals in the Nursing Progress Notes from March 1st to April 30th for Resident 1. During an interview, on 5/5/2025 at 3:27 P.M., the Director of Nursing indicated she could not provide any further shower documentation for Resident 1. On 5/5/2025 at 3:15 P.M., the Quality Assurance Administrator provided the policy titled, " Activities of Daily Living (ADL) Supporting", dated April 2025, and indicated the policy was the one currently used by the facility. The policy indicated ..." Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene... 5. Appropriate care and services are provided for residents who are unable to carry out ADL's independently, with consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care)...." 3.1-38(b)(2)		provide education to nursing associates on the requirements that bathing type and frequency be completed and documented according to resident preference as per the bathing schedule. Refusals are to be documented. Newly admitted residents will be interviewed to determine bathing preference as to type and frequency. The bathing schedule will be updated to reflect those preferences **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing to ensure that bathing is being completed and documented and that refusals are documented per the bathing schedule. Auditing to occur: 5 random residents weekly x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved	

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			for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to notify the physician of abnormal blood sugars for 1 of 1 resident reviewed for insulin usage. (Resident 3) Finding includes: During an interview, on 4/29/2025 at 11:25 A.M., Resident 3 indicated she had recently had an abnormally high blood sugar reading of over 300 mg/dL (milligram per deciliter). A record review was completed for Resident 3 on 5/1/2025 at 9:47 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, diabetes with polyneuropathy and acute kidney failure. A Quarterly Minimum Data Set (MDS) assessment, dated 12/23/2024, indicated Resident 3 was cognitively intact and received insulin injections. A current Care Plan, initiated on 4/9/2021 and revised on 10/6/2024, indicated Resident 3 had diabetes mellitus with a goal of Resident 3 would not exhibit signs of hypo/hyperglycemia. Interventions included, but were not limited to:	F 0684	*F 684 Quality of Care* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee notified Resident 3's physician that resident had previously had abnormal blood sugars on 12/25/24 and 12/30/24. No new orders were given. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who have blood sugar perimeters have the potential to be affected The DON/designee has reviewed physician orders of call perimeters of blood sugar. No findings were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	05/23/2025

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	administer medications as ordered by the physician and blood sugar monitoring as ordered by the physician. A Physician's Order, dated 11/13/2024, indicated Resident 3 was to receive Lantus insulin solution inject 10 units subcutaneously daily at bedtime. A Physician's Order, dated 12/21/2024, indicated Resident 3 was to have blood sugar monitoring at bedtime and to notify the physician for a blood sugar reading below 70 mg/dL or above 400 mg/dL. Blood sugar readings, outside the physician ordered parameters, were documented as follows: -12/25/2024 at 9:57 A.M. 60 mg/dL -12/30/2024 at 9:45 A.M. 59 mg/dL There was no documentation the physician had been notified of the blood sugar readings below 70 mg/dL. During an interview, on 5/2/2025 at 9:15 A.M., LPN 8 indicated Resident 3 must have requested a blood sugar level to have been obtained. She indicated the physician should have been notified of the blood sugars below 70 mg/dL. During an interview, on 5/5/2025 at 11:15 A.M., the Assistant Director of Nursing indicated residents have written orders for when the physician should be notified for abnormal blood sugar readings. He indicated that a blood sugar of 59 mg/dL or 60 mg/dL should have had physician notification documented. A policy was provided, on 5/5/2025 at 2:46 P.M., by the Quality Assurance Administrator. The policy titled, "Acute Condition Changes",		**practice does not recur?** The DON/designee will provide education to licensed nursing associates on the requirement to notify physician of blood sugars outside of perimeters The DON/designee will complete routine auditing as noted below to ensure that All Blood sugar results are reported if outside of perimeters. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will audit blood sugar results of 4 random residents 3xs weekly for one month and monthly for 5 months for a total of 6 months of monitoring. The physician will be notified for values outside of parameters. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview	

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	indicated, " ...Assessment and Recognition ...8. The nursing staff will contact the physician based on the urgency of the situation ...9. The attending physician will respond in a timely manner to notification of problems or changes in condition and status ...Monitoring and Follow-Up ...1. The staff will monitor and document the resident's/patient's progress and responses to treatment, and the physician will adjust treatment accordingly ...." 3.1-37(a)		process.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to store respiratory equipment in a sanitary manor for 2 of 3 residents reviewed for respiratory care. (Resident 1 & 50) Findings include: 1. During an observation, on 4/30/2025 at 9:11 A.M., Resident 1's oxygen concentrator humidification bottle was dated 4/2/2025 and was not hooked up to the concentrator. The oxygen storage bag was dated 4/28/2025 and the nasal cannula tubing was not dated. The record for Resident 1 was reviewed on 5/1/2025 at 1:25 P.M. Diagnoses included, but were not limited to quadriplegia, blindness, arthritis, and non-Alzheimer's dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 4/22/2025, indicated the resident had severe cognitive impairment and required the use of oxygen.	F 0695	*F 695 Respiratory/Tracheostomy Care and Suctioning* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #1's humidification bottle was replaced dated and attached to the concentrator by licensed nursing staff. The oxygen tubing and bag was replaced and appropriately dated on 5/5/25. Licensed nursing staff appropriately stored Resident 50s portable oxygen tank, nebulizer tubing/mask, oxygen tubing, bipap tubing/mask, changed and dated all respiratory tubing and storage bags on 5/2/25. **How other residents have the potential to be affected by the same deficient practice will be**	05/23/2025

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	Resident 1's current physician orders included: - Oxygen at 2 Liters per minute per Nasal Cannula on continuous to keep oxygen saturation above 90%. - Change the oxygen tubing, and humidification bottle; clean oxygen filter, and inspect easy foam wraps (replace if soiled or missing), on the night shift every Sunday. The oxygen tubing to be changed and dated weekly on night shift and as needed. A current Care Plan, initiated on 7/29/2022, indicated the resident had altered respiratory status: Difficulty breathing related to morbidly obese and SOB (shortness of breath) while flat. The resident was at risk for alterations in oxygen levels and sometimes removed the oxygen tubing and had to be reminded to leave it in place. During an observation, on 5/1/2025 at 1:29 P.M., Resident 1's oxygen concentrator humidification bottle was still dated 4/2/2025 and was not hooked up to the concentrator. The oxygen nasal cannula tubing was still not dated. During an observation, on 5/1/2025 at 2:30 P.M., Resident 1's oxygen tubing was not hooked up to the humidification bottle, still dated 4/2/2025 and the oxygen tubing was still not dated. During an observation, on 5/2/2025 at 9:55 A.M., with LPN 2, Resident 1's oxygen tubing was not dated, the date on the humidification water bottle was 4/2/2025 and not attached to the concentrator to provide humidified oxygen. During an interview, on 5/2/2025 at 9:56 A.M., LPN 2 indicated the oxygen tubing should have been dated, the humidification water bottle should have been changed, dated, and should have been		**identified and what corrective actions will be taken?** Other residents who require respiratory treatments and equipment have the potential to be affected. The DON/designee completed a facility wide audit on 5/5/25 to ensure respiratory equipment and supplies were stored appropriately in a sanitary manner and was labeled/dated appropriately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to the IP and licensed/certified nursing staff on the requirement to ensure that portable tanks are not placed on floor, respiratory supplies/equipment including respiratory masks/tubing are appropriately labeled and dated and are bagged and stored in a sanitary manner. The DON/designee will complete routine auditing as noted below to ensure that portable tanks are not placed on floor, respiratory supplies/equipment including respiratory masks/tubing are appropriately labeled and dated and are bagged and stored in a sanitary manner. **How the corrective actions will be monitored to ensure the**	

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	placed on the concentrator to provide humidified air. 2. During an observation on 4/29/2025 at 9:36 A.M., Resident 50 was observed to have a portable oxygen tank, an oxygen concentrator, a nebulizer machine and a BiPap (bilevel positive airway pressure) machine on the bedside table. The portable oxygen tank was sitting on the floor with the undated nasal cannula on the floor, the oxygen concentrator was at the bedside with an undated nasal cannula tube lying in the upper drawer of the bedside table. The visibly soiled nebulizer mask was lying in the upper drawer of the bedside table and the BiPap mask was lying upright against the wall. There were no respiratory bags for storage of the nasal cannulas or masks noted in the room. During an observation, on 4/29/2025 at 1:54 P.M., the portable oxygen tank with the nasal cannula was observed on the floor, the oxygen concentrator and nasal cannula was observed draped over the top drawer of the bedside table, the visibly soiled nebulizer mask was observed lying in the top drawer of the bedside table and the BiPap mask was observed on the bedside table against the wall. During an observation, on 4/30/2025 at 9:34 A.M. and 5/1/2025 at 1:28 P.M., the portable oxygen tank was observed sitting on the floor. The nasal cannula tubing connected to the portable oxygen tank was also lying on the floor. The oxygen tubing connected to the oxygen concentrator was observed lying in the upper drawer of the bedside table. During an observation, on 5/5/2025 at 9:10 A.M., the nebulizer mask was observed lying in the top drawer of bedside table and the oxygen concentrator nasal cannula tubing was observed		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing as noted below to ensure that portable tanks are not placed on floor, respiratory supplies/equipment including respiratory masks/tubing are appropriately labeled and dated and are bagged and stored in a sanitary manner. Auditing to occur: 3 random residents who require respiratory supplies/equipment 4 days a week x's 30 days, then 4 random residents who require respiratory supplies/equipment wkly x's 30 days then 4 random residents who require respiratory supplies/equipment monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	155086	A. BUILDING 00 B. WING	05/05/2025

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	draped around the bedside table drawer's hardware. A record review for Resident 50 was completed on 5/1/2025 at 9:13 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), chronic bronchitis and anxiety. An Annual Minimum Data Set (MDS) assessment, dated 3/19/2025, indicated Resident 30 was cognitively intact and received oxygen therapy. Physician Orders included the following orders on 3/10/2025: -Ipratropium-Albuterol Solution 0.5-2.5 milligrams per 3 milliliters one vial inhalation via nebulizer every 6 hours as needed shortness of breath and wheezing related to COPD. -BiPap with two liters of oxygen bled in when napping during the day and sleeping at night related to acute respiratory failure with hypoxia and COPD. -Change oxygen tubing every night shift on Wednesday. -Oxygen at two liters per nasal cannula continuously to maintain oxygen saturations above 90 percent related to acute respiratory failure with hypoxia and COPD. A current Care Plan, initiated 9/1/2023 and revised on 12/19/2024, indicated Resident 30 had an altered respiratory status with difficulty breathing related to bronchitis, COPD and asthma. Interventions included, but were not limited to: -Administer medication/puffers as ordered. -BiPap as ordered. -Nebulizer treatments as directed. -Oxygen as ordered. During an interview, on 5/5/2025 at 11:37 A.M.,		IDR info- Woodland Manor respectfully requests that citation F622 be reviewed under the Informal Dispute Process alleging the facility failure to ensure information regarding a resident's transfer to the hospital was documented in the electronic medical record. Although we disagree that proper procedure was not followed, the facility will continue to work the plan of correction. According to the 2567 F622, “a review of Nursing Progress notes indicated on 4/30/2025 Resident 63 had been transferred to (hospital name) and returned to the facility on 4/30/2025”. In actuality, there was not a hospital transfer on 4/30/25. The resident was transferred to the hospital on 4/3/25 and returned on 4/14/25. According to the citation, the record lacked documentation that a transfer/discharge assessment indicating where the resident had been transferred to, who had been notified of the resident's transfer and the reason the resident was being transferred had been completed for Resident 63. Upon record review, it is noted there was an assessment completed by the NP (nurse practitioner) on 4/3/25 that is present in the medical record. Included in the assessment was a recommendation for psychiatric hospitalization due to paranoid	

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	Qualified Medication Assistant (QMA) 9 indicated respiratory equipment (masks, nasal cannulas) should be stored on a clean surface and stored in a respiratory bag when the equipment was not in use A policy was provided, on 5/5/2025 at 2:46 P.M., by the Quality Assurance Administrator. The policy titled, "Respiratory Therapy-Prevention of Infection", indicated, " ...The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff ...Infection Control Considerations Related to Oxygen Administration ...8. Keep the oxygen cannulae and tubing used PRN [as needed} in a plastic bag when not in use ...Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol:..7. Store the circuit in a plastic bag, marked with date and resident's name, between uses ...." 3.1-47(a)(6)		thoughts. A progress note written by the facility Social Worker on 4/3/25 states resident was discharged to Neuropsychiatric Hospital of Crown Point. According to the medical record, the resident is her own responsible party and A/R guarantor. On 4/4/25, a petition for guardianship was submitted to the Elkhart County Superior Court to appoint a permanent guardian for resident. Transfer paperwork was sent with the resident to the receiving facility upon hospitalization, which included a copy of the order with the name of the facility transferring to and the reason for transfer, the notice of transfer/discharge and state form 49831, the bed hold policy and a copy of the assessment completed by the NP. Although copies of the paperwork were not scanned into the chart at the time of the survey, evidence of completion was provided to the surveyors and was subsequently scanned into the chart. With the facts stated above, please consider the actions by the facility were followed in fulfilling the transfer/discharge requirements.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, record review and interview, the facility failed to attempt a gradual	F 0758	*F 758 Free from Unnecessary Psychotropic Meds/PRN Use*	05/23/2025

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	dose reduction of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 20) Finding includes: During an observation, on 4/30/2025 at 9:34 A.M., 5/1/2025 at 2:46 P.M. and 5/5/2025 at 10:24 A.M., Resident 20 was observed seated in the doorway of his room looking into the hallway A record review for Resident 20 was completed on 5/1/2025 at 10:40 A.M. Diagnoses included, but were not limited to: post-traumatic stress disorder (PTSD), major depressive disorder, alcohol dependence with alcohol-induced dementia and other sexual disfunction. A Quarterly Minimum Data Set (MDS) assessment, dated 4/14/2025, indicated Resident 20 had moderate cognitive impairment and received an antipsychotic and antidepressant medications. 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 needed. -Offer resident snacks and drinks especially Pepsi, chips, and cookies. -Resident to be seen by in-house psych services. -Staff will monitor the resident's behaviors A current Care Plan, initiated on 10/21/2021 and revised on 10/6/2024, indicated Resident 20 had a history of sexually inappropriate comments and exposing himself to staff. Interventions included, but were not limited to:		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #20's physician gave orders for an attempted GDR on the current Risperdal order on 5/20/2025. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who receive psychotropic medications have the potential to be affected. The DON/designee has reviewed pharmacy recommendations x's last 60 days to ensure GDRs that have been declined and/or contraindicated by the physician have appropriate supporting documentation in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to the physician on the requirement to ensure GDRs that have been declined and/or contraindicated by the physician have appropriate supporting documentation in place. The DON/designee will audit random residents with	

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	-Continue in-house psychological services. -Educate resident. -Offer resident snacks particularly Pepsi, pretzels, chips, and cookies. -Redirect resident by changing topic to golf, sports, current events, and food. -Redirect resident by encouraging him to participate in his favorite activities including cross word puzzles, bird watching, and watching television especially westerns and action movies. -The interdisciplinary team to review behavior management program quarterly and as needed. A previous Physician's Order, dated 4/19/2024-7/26/2024, indicated an order for Resident 20 to receive risperidone one milligram three times daily for major depressive disorder. A Physician's Order, dated 7/27/2024-2/24/2025, indicated risperidone 0.5 milligrams three times daily for major depressive disorder. A previous Physician's Order, dated 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. A current Physician's Order, dated 3/10/2025, 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 following behaviors were documented from December 2024 through May 5, 2025: -January 7, 2025 sexual behaviors six times with redirection and changed environment interventions. No other behaviors had been documented during this time period.		psychotropic medications to ensure GDR's have been discussed with appropriate documentation to support. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of pharmacy recommendations to ensure GDRs that have been declined and/or contraindicated by the physician have appropriate supporting documentation in place. Auditing to occur on residents with a declined GDR recommendation and/or contraindications: 6 residents x's 30 days, then 4 residents x's 30 days then 2 residents x's 4 months for a total of 6 months of monitoring The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	A Behavioral Health Encounter Note, dated 1/17/2025 at 12:00 A.M., indicated staff were to have montiored for any clinically significant changes in mood or behaviors. A Behavioral Health Encounter Note, dated 1/27/2025 at 12:00 A.M., indicated staff had observed minimal negative behaviors affecting care or safety. Resident 20 had recently changed rooms due to friction with his previous roommate. Resident 20 showed subdued, constricted affect, slowed processing speed and was cooperative. A Behavioral Health Encounter Note, dated 1/30/2025 at 12:00 A.M., indicated Resident 20 was discussed in the behavior/gradual dose reduction meeting with the facility's interdisciplinary team. Staff had reported that Resident 20 had been making inappropriate sexual comments toward staff and had a recent improvement regarding exhibited behaviors since being moved from the locked memory care unit. The note indicated a clinical contraindication would be noted due to ongoing concerns and condition the resident's condition was not well controlled or stable. A Behavioral Health Encounter Note, dated 2/24/2025 at 12:00 A.M., indicated Resident 20 was subdued to somnolent, difficult to rouse and minimally cooperative. Resident 20 showed no signs of agitation or distress. Staff reported Resident 20 continued to be stable overall and had been able to be managed with his current regimen and interventions. Behavioral services were to continue with another provider. A Behavioral Health Encounter Note, dated 2/27/2025 at 12:00 A.M., indicated Resident 20 was discussed in the behavior/gradual dose reduction			

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	meeting with the facility's interdisciplinary team. The note indicated there were no pharmacy recommendations to review on this date. Resident 20 was continued on risperidone 0.5 milligrams three times a day with the last gradual dose reduction attempted, on 7/25/2024. An Initial Psychiatry Consult Note, on 3/12/2025 at 11:59 P.M., indicated Resident 20's mood was reported as okay during the visit. The note indicated there would not be any changes to the current medication regimen. Resident 20 would continue to be monitored for mood and adjustment to treatment will be made as necessary. A Pharmacy Recommendation, dated 3/31/2025, indicated a dose reduction for Resident 20's psychotropic medications was due. A reply was handwritten on the bottom of hte recommendation form which indicated "no changes at this time." There was no indications as to why a gradual dose reduction was not being attempted. A Behavioral Health Encounter Note, dated 4/15/2025 at 11:59 P.M., indicated Resident 20 reported satisfaction with his current life situation. The note indicated Resident 20 was to be monitored for mood issues and adjustments to the treatment was to be made if necessary. There was no specific contraindication documented regarding the reason for not attempting to reduce the resident's antipsychotic medication. During an interview, on 5/5/2025 at 2:04 P.M., the Social Service Assistant indicated every three months, a gradual dose reduction of psychotropic medications was to be attempted. She indicated the psychiatrist had not wanted to reduce Resident 20's medications since his symptoms			

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	were stable. She indicated she did not know if Resident 20 was on the lowest amount of the risperidone to achieve the same symptom control. There was no further documentation provided regarding a reason or contraindication for not attempting to reduce the resident's antipsychotic medication. A policy was provided, on 5/5/2025 at 2:46 P.M., by the Quality Assurance Administrator. The policy titled, "Antipsychotic Medication Use", indicated, " ...1. Residents will only receive antipsychotic medication when necessary to treat specific conditions for which they are indicated and effective. Continues [sic Continued] use of the medication will be reviewed at least quarterly. 2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks ...5. The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications ...13. Residents receiving antipsychotic medications will be reviewed at least quarterly by the Interdisciplinary team. Gradual dose reductions [GDR} will occur as required, unless clinically contraindicated. A GDR will be attempted within the 1st year of admittance to the facility [or initiation of the antipsychotic] in 2 separate quarters with at least 1 month in between attempts. Ater the 1st year, A GDR will be attempted annually unless clinically contraindicated...." 3.1-48(b)(2)			
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	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 5/2/2025 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 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 identifier. The over flow medication cart had an unopened box of Omeprazole tablets with no resident identifiers on the box. During an interview, on 5/5/2025 at 10:48 A.M., LPN 2 indicated the medications should have 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. 2. During a medication storage observation, on 5/5/2025 at 11:02 A.M., on the Memory Care Unit with LPN 7, the following was observed: - Four loose pills in the 2nd and 3rd drawers.	F 0761	*F 761 Label/Store Drugs and 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. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who have medications stored in medication carts have the potential to be affected. 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 place or what systemic 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 pills are appropriately disposed of, medications are appropriately	05/23/2025

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	During an interview, on 5/5/2025 at 11:10 A.M., LPN 7 indicated the loose pills should have not be in the cart. On 5/5/2025 at 1:58 P.M., the Quality Assurance Adminiww3ws22qstrator provided the policy titled, "Medication Labeling and Storage", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Medication Storage... 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner... Medication Labeling 1. Labeling of medications and biological's dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices... 8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items...." 3.1-25(j) 3.1-25(r)		labeled, and meds that are required to be dated are appropriately dated. DON/designee will complete routine auditing as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete routine 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 wkly x's 30 days, wkly x;s 30 days then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	