STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00457345. Complaint IN00457345 - Federal/state deficiencies related to the allegations are cited at F607. Survey dates: May 5, 6, and 7, 2025 Facility number: 000134 Provider number: 155229 AIM number: 100275430 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 2 Medicaid: 49 Other: 22 Total: 73 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 13, 2025.	F 0000		
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies Based on record review and interview, the facility failed to implement their facility abuse policy when a staff member failed to report a suspicion of abuse of a cognitively impaired resident, which delayed the initiation of the facility investigation and reporting to the appropriate agencies, for 1 of 3 residents reviewed for abuse. (Resident B, RN 3	F 0607	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because The Woodlands agrees with the allegations and citations listed. The Woodlands maintains that the	05/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Spaugh	Executive Director	05/25/2025

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

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	and QMA 1) Findings include: Resident B's clinical record was reviewed on 5/6/25 at 10:00 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease-stage 4, type 2 diabetes, obstructive and reflux uropathy, and depression. The most recent significant change Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident was severely cognitively impaired. During an interview on, 5/7/25 at 1:08 p.m., LPN 2 indicated, on 4/8/25, she was having difficulty administering medications to Resident B. The resident was combative and repeatedly refused medication. RN 3 arrived and was appraised of the situation. RN 3 indicated the resident had to take the mediation due to terminal restlessness. LPN 2 told her she refused to make the resident take the medication and handed her the keys to the medication cart. RN 3 and QMA 1 took the medication cart keys. QMA 1 prepared the medication and entered the resident's room with RN 3 and shut the door. LPN 2 did not see staff interaction with the resident, but heard the resident yelling that she did not want the medication. QMA 1 came out of the resident's room and indicated they were able to get what they could inside her and the resident had been fighting and spitting out the medication. LPN 2 indicated the incident occurred approximately one month ago and she had not reported it to anyone. The Regional Vice President, Regional Clinical Director, and DON were present during the interview and indicated they had not been made aware of this incident.		alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **F 607 – Develop/Implement Abuse/Neglect Policies** **What corrective action(s) will be completed for those residents found to have been affected:** *The resident identified during the course of the survey was deceased prior to survey date.* **How other residents having the potential to be affected will be identified and what corrective action(s) will be taken:** *Residents of the facility in total have the potential to be affected, and the facility staff received education regarding reporting of suspected abuse/crime against a resident.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** *Facility associates will be educated on the*	

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	During an interview on 5/7/25 at 1:13 p.m., the Regional Vice President indicated anyone with a suspicion of abuse or mistreatment should report it to the Executive Director immediately. A current policy, dated 6/27/24, titled "Abuse-Reporting and Response- Suspicion of a Crime" was provided by Regional Clinical Director on 5/7/25 at 10:44 a.m. The policy indicated the following: " .... Reporting Procedures 1. Once an associate or other covered individual at the facility (e.g., medical director) forms a reasonable suspicion that a crime has been committed against a resident or other individual receiving services at the facility, he or she must immediately notify the Executive Director of their suspicion. ...." This citation relates to complaint IN00457345. 3.1-28(c)		*"Abuse Reporting and Response-Suspicion of a crime" policy. Any issues identified will be immediately corrected by 1 on 1 re-education and resulting in disciplinary action as determined by ED and/or DON.* **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** *The facility will audit corrective action via associate interview 5 times weekly for 2 weeks, 3 times weekly for 6 weeks, 1 time weekly for two months, and 1 time monthly for 2 months, with results of audits reviewed with QAPI committee, monthly for 3 months, then quarterly for 2 quarters.* **By what date systemic changes for deficiency will be completed:** ***May 30, 2025***	