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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/09/2023	
	ROVIDER OR SUPPLIER		•	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514	•	
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00414158, IN004 IN00407753 and IN Complaint IN00414 related to the allega Complaint IN00411 the allegations are complaint IN00408 the allegations are complaint IN00408 related to the allega Complaint IN00408 related to the allega Complaint IN00408 the allegations are complaint IN00408 the allegations are complaint IN00408 the allegations are complaint IN00408	1158 - Federal/State deficiencies tions are cited at F602. 1541 - No deficiencies related to cited. 1930 - No deficiencies related to cited. 18204 - Federal/State deficiencies tions are cited at F602. 1753 - No deficiencies related to cited. 16416 - No deficiencies related to cited.	F 00	000	Woodland Manor Nursing and Rehab request for a paper refor compliance.		
	Facility number: 00 Provider number: 15 AIM number: 1002 Census Bed Type: SNF/NF: 67 Total: 67	55086					
	Census Payor Type Medicare: 3	:					

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

(X6) DATE

TITLE

Linda Lewis Administrator 09/01/2023

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 disclodays 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: 5XJE11 Facility ID: 000034 If continuation sheet Page 1 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SI		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155086	B. WI	NG		08/09/2023	
	ROVIDER OR SUPPLIER		•	343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG C C C C C C C C C C C C C		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
F 0602 SS=D Bldg. 00	Medicaid: 56 Other: 8 Total: 67 These deficiencies raccordance with 410 Quality review com 483.12 Free from Misappre §483.12 The resident has tabuse, neglect, miproperty, and explosubpart. This inclustreedom from corpinvoluntary seclus chemical restraint resident's medical Based on interview failed to prevent the for 3 of 4 residents administered narcotand Resident K) Findings includes: During an interview indicated approximal had a missing Contresident had approximated approximated the form of the form her on July 16 was to early to have 6:00 A.M. The residenter received a paid	reflect State Findings cited in 0 IAC 16.2-3.1. pleted 8/18/2023. ropriation/Exploitation the right to be free from isappropriation of resident oitation as defined in this udes but is not limited to oral punishment, ion and any physical or not required to treat the symptoms. and record review, the facility emisappropriation of narcotics reviewed who were being ics. (Resident G, Resident F 7, on 8/3/23 at 1:58 P.M., LPN 4 ately 2 weeks ago Resident G rolled Drug Record and the imately 10-12 tables left on the imately 10-12 tables left on the imately 10-12 tables left on the opplied LPN 3 had wasted them ther witnesses. LPN 4 F had requested a pain pill the and she explained to him it as a dose, since he had one a dent indicated to her he had in pill at 6:00 A.M. on the	F 06		F 602 Free from Misappropriation/Exploitation It is the practice of Woodland Manor to ensure there is no misappropriation of narcotics f facility residents. · What corrective action(s) will accomplished for those reside found to have been affected by deficient practice: Resident K reports no concerns with recei pain medications and his CDR form and medication sheet hav been audited for accuracy. Residents G and F no longer reside at the facility. Medicatio error reports were completed f residents K, G and F for narco medications that were identifie	be ints y the ving vie vie	09/15/2023
	6:00 A.M. The resid	lent indicated to her he had in pill at 6:00 A.M. on the			error reports were completed f residents K, G and F for narco	or tic	

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet Page 2 of 25

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155086	B. W	ING		08/09/2023	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			NAPPANEE ST		
WOODL	AND MANOR						
VVOODLA	AND MANOR			ELKHA	RT, IN 46514		
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					documentation or not signed of	out	
	1. On 8/4/223 at 10	:15 A.M., a review of the clinical			on the CDR form and the		
	record for Resident G was conducted. The record				physician and responsible par	ties	
	indicated the reside	ent was admitted to the facility			notified.		
	on 6/12/23. The res	ident's diagnoses included, but			· How other residents having t	he	
		unspecified pain and dementia			potential to be affected by the		
	with anxiety.				same deficient practice will be		
					identified and what corrective		
	1	ers indicated the resident was			action(s) will be taken: All		
	to be administered Hydrocodone-Acetaminophen				residents with orders for narco	otic	
	5/325 milligrams (r	ng). Order stated to give 1 tablet,			medications have the potentia	l of	
by mouth, every 4 hours as needed for pain. The					being affected by the deficient		
	start date was $6/14/23$ with a stop date of $6/29/23$,				practice. An audit has been		
	then updated on 6/2	29/23 to continue order until			completed on all residents wit	h	
	7/13/23. The curren	nt order, started on 7/17/23,			orders for narcotic medication	and	
	indicated to admini	ster			medication error reports		
	Hydrocodone/Aceta	aminophen 5/325 mg tablet, by			completed on those found with	า	
	mouth, four times a	ı day.			discrepancies in documentation	n.	
					Education on narcotic		
	The June 2023 Med	dication Administration Record			documentation and destruction	n	
	(MAR) indicated th	ne resident was being			was provided to the licensed		
	administered, as ne				nurses/QMA's responsible for	the	
		aminophen 5/325 mg. tablet on			errors.		
	the following dates	and times:			· What measures will be put ir	nto	
	- 6/17 at 7:15 A.M.	and 2:00 P.M.			place and what systemic chan	iges	
	- 6/18 at 7:36 A.M.				will be made to ensure that the	е	
	- 6/21 at 6:57 A.M.	, 12:22 P.M. and 8:02 P.M.			deficient practice does not rec	ur:	
	- 6/22 at 8:30 A.M.				The policies on "Controlled		
	- 6/23 at 7:05 P.M.				Medication Destruction,		
	- 6/24 at 6:05 A.M.				Medication Administration Ge	neral	
	- 6/25 at 12:03 A.M				Guidelines and the Long-Term	า	
	- 6/26 at 2:20 A.M.	, 6:45 P.M., 12:00 P.M. and 7:50			Care Abuse and Incident		
	P.M.				Reporting Policy" were review		
		, 12:30 P.M., 4:15 P.M. and 10:00			by the IDT. An in-service was		
	P.M.		1		with all nursing staff who pass		
	- 6/28 at 4:40 P.M. and 11:28 P.M.				medications on the policies. A		
	- 6/29 at 8:00 P.M.				performance improvement too	l has	
		orm cut off minutes)			been developed to monitor		
	This equaled 24 tab	plets administered.			narcotic medications are		
			1		documented and destroyed as	per	

09/08/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 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 08/09/2023 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The July 2023 MAR indicated the resident was administered, as needed, a · How the corrective action(s) will

be monitored to ensure the

five (5) residents to endure narcotic medications are signed

documentation is completed

performed as per policy. This

Quality Assurance Audit Tool will

Nursing/Designee weekly for three

months, then quarterly x three. In

the event any further concerns are

additional training will be initiated. Results of the audit will be

reviewed at the Quality Assurance

be completed by the Director of

weeks; then monthly for three

identified the issue will be

immediately corrected and

accurately, and narcotic

medication destruction is

deficient practice will not recur: A

performance improvement tool has

been initiated that randomly audits

off on the CDR when administered,

A Controlled Drug Records (CDR) form for June and July of 2023, were provided by the Director of Nursing. The CDR indicated LPN 6 signed for the receipt of 28 tablets of Hydrocodone/Acetaminophen 5/325 mg from the pharmacy, on 6/14/23. Documentation of those 28 tablets, being removed for administration, started on 6/17/23, with first dose removed on 6/17/23, by LPN 3 and last dose removed on 7/2/23 by LPN 6. This CDR form indicated 28 tablets were removed for administration, however the CDR indicated LPN 6 had removed a tablet for administration on 6/30 at 2:00 AM but did not document as administered, to the resident, on the MAR.

Hydrocodone/Acetaminophen 5/325 mg. tablet on

the following dates and times:

- 7/2 at 6:22 A.M.

- 7/1 at 8:46 AM and 8:04 P.M.

This equaled 3 tablets administered.

administered, as needed, Hydrocodone/Acetaminophen 5/325 mg tablet on the following dates and times: - 7/4 at 7:06 P.M.

The July 2023 MAR indicated the resident was

- 7/5 at 12:58 A.M., 9:30 A.M. and 3:59 P.M.
- 7/6 at 2:54 A.M. and 8:00 P.M.
- 7/7 at 12:58 A.M.
- 7/8 at 12:23 P.M. and 9:58 P.M.
- 7/9 at 7:03 A.M.
- 7/10 at 1:07 P.M. and 8:25 P.M.
- 7/11 at 2:11 A.M. and 7:30 P.M.
- 7/12 at 2:58 A.M. and 7:22 P.M.
- 7/13 at 1:39 P.M.

The order indicated a stop date of 7/13/23. This equaled 17 tablets administered.

Facility ID: 000034

Meeting

Page 4 of 25 If continuation sheet

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/09/2023	
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
		form indicating the removal of cetaminophen 5/325 mg from /23.				
	Director of Nursing provided all the CD indicated a new Co have been started at signature, of the recof tablets received. amount of of tablets the next CDR form missing. The DON all the remaining m card and had anothed destruction. The DC placed in the medicand was never foun. A typed Investigation indicated on 6/16/2 missing for Resider conducted with LPP "disposed of the medication was [electronic medication was [electronic medication indicated at the medication was presented at the medication indicated at the medication i	DN indicated the CDR was al records box/folder by LPN 3, d. on, dated 7/16-7/21/23, 3 a narcotic record (CDR) was at G. An interview was N 3. LPN 3 indicated she nedication with a witness as completed per the EMR fron record] she was the only g and had a CAN (sic) de] witness this" The ted LPN 4 was concerned LPN on and did not destroy them, icated she had seen the form in observed her to walking to the in left the building. The DON g to check the medical records as not in the box. The DON for searched everywhere but				

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 5 of 25

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/09/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	(Hydrocodone/Acet 3 indicated she was G, a dose of the No- been discontinued.) else made an error, count of the remain tablets, with her. St them in water and d drain, in the shower should not of had th the destruction of th she might have been and/or the facility. the destruction form placed in the Medic leaving the facility. 2. On 8/4/223 at 2:0 record for Resident indicated the reside on 6/7/23. The resid were not limited to: fracture of the of cla ribs, motorcycle dri stimulant abuse. A Care Plan, dated had pain related to th The interventions in to: administer analg and monitor/record/ pain or requests for The Physician Orde Oxycodone/Acetam tablet by mouth ever pain.	destroyed Resident G's Norco aminophen) with CNA 7. LPN going to administer, Resident reo, but realized the order had So to ensure she nor anyone she had CNA 7 witness the ing pills, approximately 10 ne then crushed them, put isposed of them, down the room. She was aware she are CNA 7 sign the count for rose medications, she thinks in the only nurse on the unit. She indicated she had taken in (CDR) to the front office and al Records box as she was 10 P.M., a review of the clinical F was conducted. The record in the was admitted to the facility dent's diagnoses included, but left tibia fracture, non-displace avicle, multiple fractures of the ver injuries, alcohol abuse and 16/11/23, indicated the resident fractures and surgical wounds. Included, but were not limited the resident fractures are complaints of pain medication. 17. dated 6/7/23, indicated inophen 7.5/325 mg. Give 1 rry 12 hours as needed for Record (CDR), dated 6/27/23, Record (CDR), dated 6/27/23, Record (CDR), dated 6/27/23,					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 6 of 25

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/09/2023		
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION		
		6 had received 30 tablets of ninophen 7.5/325 mg from the					
	resident was admin Ocycodone/Acetan the following dates - 6/27 at 4:10 A.M. - 6/28 at 1:30 A.M. - 6/29 at 12:57 A.M P.M.	ninophen 7.5/325 mg. tablet on and times: , 10:30 A.M. and 4:18 P.M. and 3:32 P.M. 1., 9:08 A.M. 4:22 P.M. and 11:55 attes cut of form) and 3:??					
	had been removed container/card on the container/card of container/card on the container	ninophen 7.5/325 mg. tablet from the narcotic ne following dates and times: , 10:30 A.M. and 2 tablets at order was for 1 tablet, 2) , 9:00 A.M. and 3:30 P.M. (the tration was not document on					
	resident was admin Ocycodone/Acetan the following dates - 7/1 at 2:31 A.M., - 7/2 at 7:32 A.M. a	ninophen 7.5/315 mg. tablet on and times: 8:30 A.M. and 2:30 P.M.					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 7 of 25

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155086	B. W	ING		08/09/2023	
		.		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			IAPPANEE ST		
WOODL	AND MANOR				RT, IN 46514		
WOODL	AND MANUR			ELNHA	K1, IN 40514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T		TF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 7/4 at 12:06 P.M.	and 6:20 P.M.					
	- 7/5 at 12:24 A.M.,	, 8:01 A.M., 3:41 P.M. and 11:05					
	P.M.						
	- 7/6 at 8:12 A.M.,	3:00 P.M. and 10:00 P.M.					
	- 7/7 at 15:27 P.M.						
	- 7/8 at 12:50 P.M.,	9:04 A.M., 3:45 P.M. and 10:14					
	P.M.						
	- 7/9 at 8:17 P.M. at	nd 4:39 P.M.					
	- 7/10 at 12:28 A.M	I., 8:40 A.M., 4:15 P.M. and					
	11:30 P.M.						
	- 7/11 at 8:14 A.M., and 4:20 P.M.						
	- 7/12 at 1:08 P.M., 8:43 A.M., 4:10 P.M. and 10:42						
	P.M.						
	- 7/13 at 8:32 A.M.	and 4:00 P.M.					
	- 7/14 at 11:15 P.M	•					
	- 7/15 at 7:50 P.M.	and 9:00 P.M.					
	- 7/16 at 3:02 A.M.,	, 12:00 P.M. and 6:25 P.M.					
	- 7/17 at 12:11 A.M	I. and 9:19 A.M.					
	- 7/18 at 8:25 A.M.	and 3:18 P.M.					
	- 7/19 no doses doc	umented as administered.					
	This equaled 46 tab	elets recorded as administered.					
	The CDRs indicated	d an					
	Ocycodone/Acetam	ninophen 7.5/325 mg. tablet					
	had been removed f	from the narcotic					
	container/card on th	ne following dates and times:					
	- 7/1 at 2:30 A.M.,	8:30 A.M., and 2:30 P.M. with					
	one dose sent with i	resident, at 6:30 P.M.,he was					
	attending a wedding	g.					
	- 7/2 at 8:00 A.M.,	2:00 P.M. and 8:38 P.M. (2 tabs					
	removed at 2:00 P.M	M1 dropped and destroyed by					
	LPN 3 & LPN 4 and	d 1 tab not recorded as					
	administered by LP	PN 3)					
	- 7/3 at 4:00 A.M.,	1:30 P.M. and 8:50 P.M.					
	- 7/4 at 4:30 A.M.,	12:06 P.M. and 6:20 P.M. (4:30					
	A.M. tablet was not	t documented, as administered,					
	on the MAR, by QN						
		, 8:00 A.M. and 4:00 P.M.					
		CDR was not received from the					

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

DON

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 8 of 25

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 08/09			
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	- 7/16 at 3:00 AM, (6:00 A.M. adminishours to early, by L - 7/17 at 12:00 A.M. P.M. tablet was not on the MAR, by LF - 7/18 at 8:20 A.M. 10:45 P.M. tablet wadministered, on th - 7/19 at 7:30 A.M. were not document by LPN 12) This equaled 30 tab The final CDR indiwith the resident. A typed Investigati indicated on 7/16/2 he received the medications at the rinvestigation result investigation result investigation the famisconduct. LPN 3 education, given a will have another n narcotics administed. During an interview 3 indicated she had Resident F because pill around 6:00 A.J. give him another on stated "the man had pain so gave it to him. On 8/9/23 at 11:18	I., 9:00 A.M. and 3:00 P.M. (3:00 documented, as administered, PN 10) 3:20 P.M. and 10:45 P.M. (vas not documented, as e MAR, by LPN 11) and 2:30 P.M. (Both tablets ed, as administered, on MAR, olets recorded as removed. Cated 16 tablets were sent home on, dated 7/16-7/21/23, 3 Resident F could not recall if dication or not. On 7/17/23, wed as part of the investigation he had administered resident's request. The sindicated results of the cility was unable to prove any was provided one on one final notice and going forward turse or QMA sign out all red. v, on 8/7/23 at 12:08 P.M., LPN done a medication error with he came and asked for a pain M., however it was to early to me. LPN 3 thought about it and I several fractures and was in tim early". A.M., the DON indicated there						
	was no medication	error form or documentation						

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

Event ID:

5XJE11 Fa

Facility ID: 000034

If continuation sheet

Page 9 of 25

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLETED	
		155086	B. W	ING		08/09/2023	
				CTREET	DDDEGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
14/00DL	AND MANOD				IAPPANEE ST		
WOODLA	AND MANOR			ELKHAI	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	DDEELY (EACH CORRECTIVE ACT		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		16	DATE
	regarding the medication error for Resident F,						
	performed by LPN	3.					
	3. On 8/7/23 at 11:5	50 A.M., a review of the clinical					
		K was conducted. The record					
		nt was admitted to the facility					
		ident's diagnoses included, but					
		fusion of spine-lumbar region					
		udication and vertebrogenic					
	low back pain.	· -					
	A Care Plan, dated	7/15/23, indicated the resident					
	· ·	nic pain. The interventions					
		not limited to: administer					
	analgesic (pain relie						
		ort to nurse complaints of pain					
	-	medication and evaluate the					
	effectiveness of pair						
	effectiveness of par	in interventions.					
	A Physician's Order	c, dated 7/15/23, indicated the					
	-	er for Oxycotin 10 mg.					
		R), by mouth, every 12 hours for					
	· ·	order, dated 7/15/23, for					
	_	very 4 hours as needed for					
	pain.	rery 4 hours as needed for					
	Pain.						
	Progress Note data	d 7/15/23 at 9:35 P.M.,					
	-	ne 5 mg was administered to					
	-	. Resident rated pain a 6 out					
	of 10 on the 1-10 pa	-					
	or 10 on the 1-10 pa	ini scale.					
	Another Dragges M	ote, dated 7/15/23 at 10:51					
	_	administration of the pain					
		ective as the resident rated his					
	pain a 2 on the pain	Scarc.					
	An Emoranau D	a Vit (EDV) Donlessmant Esser-					
		g Kit (EDK) Replacement Form, cated 1 dose of Oxycodone 5					
		<u> </u>					
	_	n 7/15/23 at 10:00 P.M., for					
	Kesident K. The 2 r	nurses who signed the removal					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet Page 10 of 25

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155086	B. WI	NG		08/09/	2023
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				IAPPANEE ST		
WOODL /	AND MANOR				RT, IN 46514		
WOODLA	AND MANOR			ELKHAI	R1, IN 40514		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				· L	DATE
	was LPN 3 and QM	A 13.					
	The MAR from 7/1:	5/23 - 7/31/23, indicated the					
		stered Oxycotin 10 mg. tablet					
	on the following dat						
	_	ments, on the MAR, the					
		s not available at 8:00 P.M.					
	- 7/16 at 8:00 P.M.						
	- 7/17 at 8:00 A.M.	and 8:00 P.M.					
	- 7/18 at 8:00 A.M.						
	- 7/19 at 8:00 A.M.						
	- 7/20 at 8:00 A.M.						
	- 7/21 at 8:00 A.M.						
	- 7/22 at 8:00 A.M.						
	- 7/23 at 8:00 A.M.						
		PN 6 documents, on the MAR,					
		ot available, at 8:00 A.M. &					
	8:00 P.M.	or available, at 0.00 Thivi.					
		LPN 6 documents, on the					
	· ·	was not available, at 8:00 P.M.					
		LPN 6 documents, on the					
		was not available, at 8:00 P.M.					
		LPN 11 documents, on the					
		was not available, at 8:00 P.M.					
		LPN 14, documents, on the					
		was not available, at 8:00					
	A.M.	mas not available, at 0.00					
		N 15, documents, on the MAR,					
		ot available, at 8:00 A.M. &					
	8:00 P.M.	or available, at 0.00 A.W. &					
		LPN 6 documents, on the					
		was not available, at 8:00 P.M.					
		lets recorded as administered,					
	to the resident.	icis recorded as administered,					
	to the resident.						
	A CDD doted 7/15	23, signed by QMA 13,					
		y had received 12 tablets of the					
	Oxycotin.	y mad received 12 tablets of the					
	Oxycom.						
	The CDD indicated	an Ocycotin 10 mg. extended					
	The CDK indicated	an Ocyconn 10 mg. extended					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet Page 11 of 25

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/09/2023	
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION	
IAU	release tablet had b container/card on the container of t	een removed from the narcotic me following dates and times: a. (not documented on the MAR LPN 3) and 8:00 P.M. and 8:00 P.M. and 8:00 P.M. and 9:00 P.M. alets recorded as removed. ceive the next CDR as the next d in August. /23, signed by QMA 13, y had received 10 tablets of the Another CDR, undated and the facility received 30 more odone 5 mg. d an Oxycodone 5mg tablet had the narcotic container/card on and times. (Some nurses of the Oxycodone to replace mg extended release. Oxycodone d be the same except for the ature for the 10 mg dose) and was documented on MAR, LPN 3. (She had removed a rom the EDK also) and 4:15 P.M. and 3:00 P.M. removed by LPN to MAR as administering 1	IAG		DATE	

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet Page 12 of 25

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA X2) MULTIPLE CONSTRUCTION X3) DATE SUF		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155086	B. W	ING		08/09/	2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					IAPPANEE ST		
WOODL	AND MANOR			ELKHAI	RT, IN 46514		
(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	DEFICIENCY		DATE
	- 7/23 at 8:00 A.M. - 7/24 at 7:30 P.M.						
		, and 3:00 P.M., LPN removed					
		t each time, documents on					
		ring 1 dose of Oxycotin 10 mg					
	as administered at 8						
		, LPN 18 removed 1 Oxycodone					
		n MAR as administering 1					
	Oxycotin 10 mg	5					
	- 7/26 at 19:26 P.M	[.					
	- 7/27 at 8:00 A.M.	, LPN 14 removed 1 Oxycodone					
	5 mg, documents or	n MAR as administering 1					
	Oxycotin 10 mg						
	- 7/28 at 8:30 P.M.						
		, LPN 10 removed 1 Oxycodone					
	-	n MAR as administering 1					
	Oxycotin 10 mg						
		LPN 10 removed 1 Oxycodone					
	-	MAR as administering 1					
	Oxycotin 10 mg						
	- 7/31 at 7:00 P.M.						
	During an interview	v, on 8/4/23 at 2:10 P.M., the					
	_	ycodone 5 mg had been					
	removed from the I	EDK for Resident K and it's					
	removal should be	documented in the Progress					
	Notes.						
	During an interview	v, on 8/7/23 at 12:08 P.M., LPN					
	_	as a medication error incident					
	with Resident K wa						
		ablet out of the EDK for him and					
		came from the pharmacy and					
		he Oxycotin 10 mg.					
	During an interview	v, on 8/8/23 at 11: 05 A.M., the					
	_	ility was having difficulty					
		10 mg ER from pharmacy and					
		e 5 mg-giving 2 at a time. She					
		have documented the dosage					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 13 of 25

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 9/2023
	PROVIDER OR SUPPLIER		343 S N	ADDRESS, CITY, STATE, ZIP CO NAPPANEE ST RT, IN 46514	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION es.	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	All Progress Notes had no documentati administered 2 table instead of the Oxyc documentation indicates the control of the cont	reviewed from 7/15-7/31/23 on indicating a nurse had ets of the Oxycodone 5 mg. otin 10 mg. ER. There was cating the medication wasn't				
	6/9/23, indicated the Director of Nursing audit due to heresay missing. The Event on the counting of r making sure the cou	e DON and ADON (Assistant b) were conducting a narcotic regarding narcotics were indicated staff were educated narcotics, the significance of ant is correct and to ensure if tic form (CDR) it is also				
	a narcotic from the nurse present and B nurse and QMA [Qi Assistant]" With In-Service Attendar 6/9/23 and 6/10/23. following staff had	this undated form was an nee form, dated 6/7/23, 6/8/23, The form indicated the attended the in-service: LPN, QMA 9, LPN 11, LPN 12, QMA				
	indicated LPN 3 wa discrepancy in narc	n Form, dated 7/21/23, as suspended, on 7/21/22, for otic audits while issue was and given a final warning.				
	titled, "Abuse Polic revision on 9/22, an one currently used b	.M., the DON provided a policy y", dated 11/28/16 with a ad indicated the policy was the by the facility. The policy propriation of resident				

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 14 of 25

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

PRINTED: 09/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION DEPTICIENT (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DEPTICIENT (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			COMPLETED 08/09/2023			
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD		
WOODLA	AND MANOR			RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	temporary, or permabelongings or witho On 8/8/23 at 12:33 I provided a policy tit Medications", dated 6/23/23 and indicate currently used by th "4. When a control administered, the lic medication immedia information on the amedication record (I administration B. A Signature of the administered"	potation, or wrongful, anent use of a resident's at the resident consent" P.M., the Administrator and the policy was the one of a facility. The policy indicated colled medication is a tensed nurse administering the ately enters the following accountability record and the MAR): a. Date and time of amount administered ac.				
F 0755 SS=D Bldg. 00	§483.45 Pharmacy The facility must p emergency drugs residents, or obtain described in §483. permit unlicensed drugs if State law general supervision §483.45(a) Process	/Pharmacist/Records y Services rovide routine and and biologicals to its n them under an agreement .70(g). The facility may personnel to administer permits, but only under the n of a licensed nurse. dures. A facility must utical services (including				

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 15 of 25

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/09/2023
	PROVIDER OR SUPPLIER	2	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	acquiring, receivir administering of a meet the needs of \$483.45(b) Service must employ or of licensed pharmace \$483.45(b)(1) Proposed aspects of the proposed in the facility. \$483.45(b)(2) Est records of receipt controlled drugs in an accurate record service in order and the controlled drugs is periodically recond Based on interview failed to establish a accounted for, periodically recond the dispositive related to incomple documentation of no residents reviewed	ng, dispensing, and Il drugs and biologicals) to f each resident. e Consultation. The facility otain the services of a ist who- vides consultation on all evision of pharmacy services ablishes a system of and disposition of all in sufficient detail to enable inciliation; and ermines that drug records that an account of all is maintained and ciled. and record review, the facility ind/or maintain a system that odically reconciled and tion of all controlled drugs,	F 0755	It is the practice of Woodland Manor to establish a system receipt and disposition of all controlled drugs in sufficient to enable an accurate reconciliation, maintain drug records in order and that an account of all controlled drug maintained and periodically reconciled. What corrective action(s) will be accomplishe	d 09/15/2023 of detail sis is
	record for Resident indicated the reside on 6/12/23. The res	:15 A.M., a review of the clinical G was conducted. The record nt was admitted to the facility ident's diagnoses included, but unspecified pain and dementia		those residents found to have been affected by the deficient practice: Resident G and rest F no longer reside in the facion Medication error reports were completed for residents K, G F for narcotic medications the were identified as lacking	it ident lity. e and

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 16 of 25

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 08/09/2023 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 The Physician Orders indicated the resident was administration documentation or to be administered Hydrocodone-Acetaminophen not signed out on the CDR form 5/325 milligrams (mg). Order stated to give 1 tablet, and the physician and responsible by mouth, every 4 hours as needed for pain. The parties notified. start date was 6/14/23 with a stop date of 6/29/23, How other residents having the then updated on 6/29/23 to continue order until potential to be affected by the 7/13/23. same deficient practice will be identified and what corrective The July 2023 MAR indicated the resident was action(s) will be taken: All administered, as needed, residents with orders for narcotic Hydrocodone/Acetaminophen 5/325 mg tablet on medications have the potential of the following dates and times: being affected by the deficient - 7/4 at 7:06 P.M. practice. CDR forms, when - 7/5 at 12:58 A.M., 9:30 A.M. and 3:59 P.M. completed, are to be turned in to - 7/6 at 2:54 A.M. and 8:00 P.M. the Director of Nursing to assign - 7/7 at 12:58 A.M. uploading into the medical record. - 7/8 at 12:23 P.M. and 9:58 P.M. An audit has been completed on - 7/9 at 7:03 A.M. all residents with orders for - 7/10 at 1:07 P.M. and 8:25 P.M. narcotic medication and - 7/11 at 2:11 A.M. and 7:30 P.M. medication error reports - 7/12 at 2:58 A.M. and 7:22 P.M. completed on those found with - 7/13 at 1:39 P.M. discrepancies in documentation. The order indicated a stop date of 7/13/23 Education on narcotic This equaled 17 tablets administered. documentation, process for medication errors and destruction There was no CDR form indicating the removal of of narcotics was provided to the the Hydrocodone/Acetaminophen 5/325 mg from licensed nurses/QMA's 7/4/23 through 7/13/23. responsible for the errors. What measures will be put into place During an interview, on 8/4/23 at 2:10 P.M., the and what systemic changes will Director of Nursing (DON) indicated she had be made to ensure that the provided all the CDRs for June and July. She deficient practice does not recur: indicated a new Controlled Drug Record would The policies on "Controlled have been started and would have had the Medication Destruction. signature, of the receiving nurse and the number Medication Administration General of tablets received. The DON did not know the Guidelines and the Long-Term amount of of tablets the facility received due to Care Abuse and Incident the next CDR form, starting on 7/4/23, was Reporting Policy" were reviewed missing. The DON indicated LPN 3 had destroyed by the IDT. An in-service was held with all nursing staff who pass all the remaining medications, on the dispensing

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

PRINTED: 09/08/2023 FORM APPROVED OMB NO. 0938-039

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086				(X3) DATE SURVEY COMPLETED 08/09/2023	
	.		343 S N	IAPPANEE ST		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
card and had anothed destruction. DON is in the medical record was never found. A typed Investigation indicated on 6/16/2 missing for Resider conducted with LPP "disposed of the resident the medication was [electronic medicated nurse in the buildin [Certified Nurse Aignored investigation indicated at the stock of the medication was at the medication was [electronic medicated investigation indicated at the came to the buildin box and the CDR was and the CDR was and the Administrated could not locate the During an interview and the Administrated indicated she was dose of the Norco, discontinued. So to made an error, she is of the remaining piece with her. She then water and disposed the shower room. So of had the CNA 7 se destruction of those might have been the the facility. She in	er nurse witness the indicated the CDR was placed rds box/folder by LPN 3, and son, dated 7/16-7/21/23, 3 a narcotic record (CDR) was at G. An interview was N 3. LPN 3 indicated she inedication with a witness as completed per the EMR iton record] she was the only g and had a CAN (sic) del witness this" The ited LPN 4 was concerned LPN on and did not destroy them, dicated she had seen the form in observed her to walking to the in left the building. The DON g to check the medical records was not in the box. The DON to researched everywhere but the form. We on 8/7/23 at 12:08 P.M., LPN destroyed Resident G's Norco taminophen) with CNA 7. LPN going to give Resident G a but realized the order had been ensure she nor anyone else thad CNA 7 witness the count llls, approximately 10 tablets, crushed them, put them in of them, down the drain, in the was aware she should not ign the count for the emedications, she thinks she ee only nurse on the unit and/or dicated she had taken the			performance improvement too been developed to monitor narcotic medication errors are documented and destroyed as policy, and disposition of CDR sheets to the Director of Nursi when completed. How the corrective action(s) will be monitored to ensure the deficie practice will not recur: A performance improvement too been initiated that randomly at five (5) residents to ensure narcotic medication destruction performed as per policy, CDR sheets are turned into the Director of Nursing when completed armedication errors are docume per policy. This Quality Assura Audit Tool will be completed be the Director of Nursing/Design weekly for three weeks; then monthly for three months, ther quarterly x three. In the event further concerns are identified issue will be immediately	ent I has udits n is octor ad inted ince y ee n any the	
	PROVIDER OR SUPPLIER AND MANOR SUMMARY (EACH DEFICIEN REGULATORY OF card and had anothed destruction. DON in in the medical recon was never found. A typed Investigative indicated on 6/16/2 missing for Resider conducted with LPI "disposed of the reference in the buildin [Certified Nurse Ai investigation indicated 3 took the medicative however LPN 4 ind LPN 3's hands and front office and the came to the buildin box and the CDR w and the Administrative could not locate the During an interview 3 indicated she had (Hydrocodone/Acet 3 indicated she was dose of the Norco, of discontinued. So to made an error, she is of the remaining pil with her. She then water and disposed the shower room. S of had the CNA 7 s destruction of those might have been the the facility. She in	OF CORRECTION IDENTIFICATION NUMBER 155086 PROVIDER OR SUPPLIER AND MANOR SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION card and had another nurse witness the destruction. DON indicated the CDR was placed in the medical records box/folder by LPN 3, and	PROVIDER OR SUPPLIER AND MANOR SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION card and had another nurse witness the destruction. DON indicated the CDR was placed in the medical records box/folder by LPN 3, and was never found. A typed Investigation, dated 7/16-7/21/23, indicated on 6/16/23 a narcotic record (CDR) was missing for Resident G. An interview was conducted with LPN 3. LPN 3 indicated she "disposed of the medication with a witness as the medication was completed per the EMR [electronic medication record] she was the only nurse in the building and had a CAN (sic) [Certified Nurse Aide] witness this" The investigation indicated LPN 4 was concerned LPN 3 took the medication and did not destroy them, however LPN 4 indicated she had seen the form in LPN 3's hands and observed her to walking to the front office and then left the building. The DON came to the building to check the medical records box and the CDR was not in the box. The DON and the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had destroyed Resident G's Norco (Hydrocodone/Acetaminophen) with CNA 7. LPN 3 indicated she had destroyed Resident G a dose of the Norco, but realized the order had been discontinued. So to ensure she nor anyone else made an error, she had CNA 7 witness the count of the remaining pills, approximately 10 tablets, with her. She then crushed them, put them in water and disposed of them, down the drain, in the shower room. She was aware she should not of had the CNA 7 sign the count for the destruction of those medications, she thinks she might have been the only nurse on the unit and/or the facility. She indicated she had taken the	AND MANOR SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG A typed Investigation, dated 7/16-7/21/23, indicated on 6/16/23 a narcotic record (CDR) was missing for Resident G. An interview was conducted with LPN 3. LPN 3 indicated she medication with a witness as the medication was completed per the EMR [electronic medication record] she was the only nurse in the building and had a CAN (sic) [Certified Nurse Aide] witness this" The investigation indicated LPN 4 was concerned LPN 3 took the medication and did not destroy them, however LPN 4 indicated she had seen the form in LPN 3's hands and observed her to walking to the front office and then left the building. The DON came to the building to check the medical records box and the CDR was not in the box. The DON and the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had destroyed Resident G's Norco (Hydrocodone/Acetaminophen) with CNA 7. LPN 3 indicated she was going to give Resident G a dose of the Norco, but realized the order had been discontinued. So to ensure she nor anyone else made an error, she had CNA 7 witness the count of the remaining pills, approximately 10 tablets, with her. She then crushed them, put them in water and disposed of them, down the drain, in the shower room. She was aware she should not of had the CNA 7 sign the count for the destruction of those medications, she thinks she might have been the only nurse on the unit and/or the facility. She indicated she had taken the	DENTIFICATION NUMBER 15086 ROVIDER OR SUPPLIER AND MANOR SUMMARY STATEMENT OF DEFICIENCIE (REACH DEFICIENCITY AUIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) card and had another nurse witness the destruction. DON indicated the CDR was placed in the medical records box/folder by LPN 3, and was never found. A typed Investigation, dated 7/16-7/21/23, indicated on 6/16/23 a narcotic record (CDR) was missing for Resident G. An interview was conducted with LPN 3. LPN 3 indicated she "disposed of the medication with a witness as the medication was completed per the FMR [electronic medication record] she was the only nurse in the building and had a CAN (sic) [Certified Nurse Aide] witness this" The investigation indicated LPN 4 was concerned LPN 3 took the medication and the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had destroyed Resident G a not of the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had destroyed Resident G a dose of the Norco, but realized the order had been discontinued. So to ensures he nor anyone else made an error, she had CNA 7 witness the count of the remaining pills, approximately 10 tablets, with her. She then crushed them, put them in water and disposed of them, down the drain, in the shower room. She was aware she should not of had the CAA 7 sign the count for the destruction of those medications, she thinks she might have been the only nurse on the unit and/or the facility. She indicated she had taken the	DEFORECTION DESTIFICATION NUMBER 155086 ROVIDER OR SUPPLIER AND MANOR SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION TAG PROCESS AND PROPRIET TAG PROPRIET TO COMPANY OR ISC IDENTIFYING INFORMATION TAG PROPRIET TAG PROPRIET TO COMPANY OR ISC IDENTIFYING INFORMATION TAG PROPRIET TAG TO PROPRIET TAG TAG PROPRIET TAG PROPRIET TAG PROPRIET TAG TAG PROPRIET TAG PROPRIET TAG TAG TAG PROPRIET TAG TAG TAG PROPRIET TAG TAG TAG TAG TAG TAG TAG TAG TAG TA

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 18 of 25

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/09/2023	
	PROVIDER OR SUPPLIEI	₹	3	343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	leaving the facility.						
	DON indicated the buster (deactivates/into a chemically in	v, on 8/7/23 at 3:24 P.M., the ir policy was to use a drug breaks down pharmaceuticals nactive form), which was cation room on unit 1.					
	record for Resident indicated the reside on 6/7/23. The reside were not limited to fracture of the of cl	O0 P.M., a review of the clinical F was conducted. The record ent was admitted to the facility dent's diagnoses included, but eleft tibia fracture, non-displace avicle, multiple fractures of the iver injuries, alcohol abuse and					
	Oxycodone/Acetan	ers, dated 6/7/23, indicated ninophen 7.5/325 mg. Give 1 ery 12 hours as needed for					
	administrated Oxy	cated the resident was codone/Acetaminophen on 12:00 P.M. and 6:25 P.M.					
		LPN 3 had removed a dose of etaminophen, on 7/16/23 at 3:00M.					
	3 indicated she had Resident F because pill around 6:00 A. give him another or stated "the man had pain so gave it to ha	•					
	On 8/9/23 at 11:18	A.M., the DON indicated there					

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 19 of 25

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/09/2023
	ROVIDER OR SUPPLIER		343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST IRT, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		error form or documentation eation error for Resident F,			
	record for Resident indicated the reside on 7/15/23. The res were not limited to:	60 A.M., a review of the clinical K was conducted. The record in the two admitted to the facility ident's diagnoses included, but fusion of spine-lumbar region udication and vertebrogenic			
	resident had an orde extended release(El pain. And another o	er, dated 7/15/23, indicated the er for Oxycotin 10 mg. R),by mouth, every 12 hours for order, dated 7/15/23, for every 4 hours as needed for			
	resident was adminion the following da - 7/15, LPN 3 documon of the following da - 7/16 at 8:00 P.M 7/16 at 8:00 A.M 7/18 at 8:00 A.M 7/19 at 8:00 A.M 7/20 at 8:00 A.M 7/21 at 8:00 A.M 7/22 at 8:00 A.M 7/23 at 8:00 A.M 7/24 LPN 4 and L the Oxycotin was not the following data.	ments, on the MAR, the s not available at 8:00 P.M. and 8:00 P.M.			
	MAR, the Oxycotin - 7/26 at 8:00 A.M. MAR, the Oxycotin	LPN 6 documents, on the was not available, at 8:00 P.M. LPN 6 documents, on the was not available, at 8:00 P.M. LPN 11 documents, on the			

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 20 of 25

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/09/2023
	PROVIDER OR SUPPLIEI AND MANOR	₹	343 S I	ADDRESS, CITY, STATE, ZIP CO NAPPANEE ST IRT, IN 46514	DD .
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	- 7/28 at 8:00 P.M., MAR, the Oxycotin A.M 7/29, LPN 4 & LI the Oxycotin was n 8:00 P.M 7/30 at 8:00 A.M. MAR, the Oxycotin This equaled 20 tab to the resident. A CDR, dated 7/15 indicated the facilit Oxycotin. The CDR indicated release tablet had b container/card on the resident of a sadministered by - 7/16 at 8:50 A.M 7/17 at 8:00 P.M 7/18 at 8:00 A.M 7/19 at 8:00 A.M 7/20 at 8:30 A.M 7/21 at 8:00 A.M 7/20 at 8:30 A.M 7/21 at 8:00 A.M 7/21 at 8:00 A.M 7/20 at 8:30	and 8:00 P.M. and 8:00 P.M. and 8:00 P.M. and 9:00 P.M. and 9:00 P.M. blets recorded as removed. Did t CDR as the next one received /23, signed by QMA 13, y had received 10 tablets of the Another CDR, undated and the facility received 30 more			

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet Page 21 of 25

PRINTED: 09/08/2023 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTII A. BUILDII B. WING		nstruction 00	(X3) DATE COMPI 08/09	LETED
	PROVIDER OR SUPPLIE	R	34	3 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	started using 1 or 2 the Oxycontin 10 in and Oxycotin wou extended release for 7/15 at 9:30 P.M. as administered by dose at 8:00 P.M. in 7/16 at 2:30 A.M. in 7/17 at 9:00 A.M. in 10 and documented Oxycotin at 8:00 in 7/17 at 7:15 P.M. in 7/18 at 8:09 A.M. in 7/18 at 8:09 A.M. in 7/20 at 3:50 P.M. in 7/22 at 9:10 P.M. in 7/23 at 8:00 A.M. in 7/24 at 7:30 P.M. in 7/25 at 8:00 A.M. in 7/25 at 8:00 A.M. in 7/26 at 19:26 P.M. in 7/27 at 8:00 A.M. in 7/28 at 8:00 A.M. in 7/28 at 8:30 A.M. in 7/28 at 8:30 A.M. in 7/28 at 8:30 P.M. in 7/30 at 8:00 A.M. in 7	2 of the Oxycodone to replace mg extended release. Oxycodone ld be the same except for the eature for the 10 mg dose). and was documented on MAR, r LPN 3. (She had removed a from the EDK also) and 4:15 P.M. and 3:00 P.M. removed by LPN don MAR as administering 1 A.M. and as administering 1 Oxycotin at a sadministering 1 oxycotin 10 mg as 3:00 P.M. and 3:00 P.M., LPN removed at each time, documents on a sing 1 dose of Oxycotin 10 mg as 3:00 A.M. and LPN 18 removed 1 Oxycodone on MAR as administering 1 A. and LPN 14 removed 1 Oxycodone on MAR as administering 1					

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

Oxycotin 10 mg - 7/31 at 7:00 P.M.

During an interview, on 8/4/23 at 2:10 P,.M. the

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 22 of 25

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086 AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING O B. WING				COMPLETED 08/09/2023		
	PROVIDER OR SUPPLIEF	8	343 S N	.ddress, city, state, zip cod APPANEE ST RT, 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)	ΓE	(X5) COMPLETION DATE
	removed from the I	codone 5 mg had been EDK for Resident K and it's locumented in the Progress				
	3 indicated the med Resident K was, sho mg tablet out of the	r, on 8/7/23 at 12:08 P.M., LPN ication error incident with e had taken an Oxycodone 5 EDK for him and then his om the pharmacy and she also otin 10 mg.				
	DON indicated faci getting he Oxycotin staff were using the	o, on 8/8/23 at 11: 05 A.M., the lity was having difficulty 10 mg ER from pharmacy and 5 mg-giving 2 at a time. She have documented the dosage es.				
	and there was no do nurse had administe	reviewed from 7/15-7/31/23 ocumentation indicating a cred 2 tablets of the instead of the Oxycotin 10 mg.				
	policy titled, "Disca Medications", dated the policy was the of facility. The policy be disposed of in ac and local regulation	a.M., the Administer provided a parding and Destroying d October 2014, and indicated one currently used by the indicated "Medications will ecordance with federal state as governing management of transceuticals, hazardous waste tances"				
	provided a policy ti Destruction", dated	A.M., the Administrator tled, "Controlled Medication 5/21/18 and reviewed on ted the policy was the one				

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 23 of 25

	OF CORRECTION	IDENTIFICATION NUMBER 155086	A. BUILDING B. WING	00	COMPL 08/09/	ETED
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
WOODLA	AND MANOR			RT, IN 46514		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Į	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
TAG		the facility. The policy	TAG			DATE
	1	director of nursing and the				
		ist are responsible for the				
	_	e with federal and state laws				
	and regulations in the	ne handling of controlled				
		authorized licensed nursing				
	and pharmacy perso					
		ons. 2. When a dose of a				
		on is removed from the istration but refused by the				
		n for any reason, it is not				
		container. It is destroyed in the				
	1 ~	ensed nurses, and the disposal				
	1 ~	ne accountability record				
	[Controlled Drug R	ecord] on the line representing				
	that dose. The same	process applies to the				
		partial tablets and unused				
	_	ose ampules and doses of				
	controlled substance	es wasted for any reason"				
		A.M., the Administrator				
	provided a policy ti					
		neral Guidelines, dated 5/21/18				
		23/23 and indicated the policy ly used by the facility. The				
		d Follow the six rights of				
	medication adminis					
	i. Right medica					
	ii. Right de					
	iii. Right pa	atient				
	iv. Right ro					
	v. Right ti					
	vi. Right de	ocumentation"				
	3.1-25(b)(3)					
	3.1-25(b)(9)					
	3.1-25(e)(2)(3)					
	3.1-25(o))\(5\\(\C\\(7\\(0\)\)				
	3.1-25(s)(1)(2)(3)(4	·)(5)(6)(7)(8)				

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

Event ID:

5XJE11

Facility ID: 000034

If continuation sheet

Page 24 of 25

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey .eted /2023
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 DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5XJE11 Facility ID: 000034 If continuation sheet Page 25 of 25