STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING -- B. WING	05/29/2025

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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 03/31/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/29/25 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this PSR survey, The Woodlands was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 108 certified beds. At the time of the survey, the census was 76. Quality Review completed on 06/02/25	E 0000	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 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.	
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness	E 0037	E 037 – **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified to be affected by this deficient practice. **How other residents having the potential to be affected by the same alleged deficient practice**	06/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Spaugh	Administrator	06/15/2025

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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	training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 05/29/25 at 12:30 p.m., there was a sign-in-sheet of the annual EEP training dated 04/03/25, but there was no documentation to show what training was conducted and no documentation of demonstrated knowledge of the EPP for staff. Based on an interview at 12:30 p.m., the Maintenance Director stated the EPP training was conducted on 04/03/25 but could only find the sign-in-sheet. This finding was reviewed with the Maintenance Director during the exit conference at 1:15 p.m. This deficiency was cited on 03/31/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		**will be identified and what corrective action will be taken:** All residents have the potential to be affected by the deficient practice. The facility staff will be educated by the Executive Director/designee on the Emergency Preparedness Program (EPP) for current calendar year by compliance date below. Facility staff will complete a posttest following this education. ***It should be noted that this education was completed by the original compliance date. The surveyor was provided this information the morning following this re-visit. However, we only provided the signature page – education documents were uploaded the morning after the re-visit. (Refer to Exhibit A)*** **What measures will be into place of what systemic changes will be made to ensure that the deficient practice does not recur:** The facility staff will be educated by the Executive Director/designee on the Emergency Preparedness Program (EPP) for current calendar year with a posttest completed by facility staff by compliance date below. No facility staff will work past the date of compliance until the education and posttest have been completed. New employees will	

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			be educated during facility orientation on the EPP. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Executive Director/designee will conduct an audit weekly x 8 weeks, then monthly x 10 months to ensure all facility staff have been educated in the. The Executive Director will present a report on the findings at the monthly QAPI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 3/31/25 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 5/29/25 Facility Number: 000134 Provider Number: 155229	K 0000	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 alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such	

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	AIM Number: 100275430 At this PSR survey, The Woodlands was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, battery powered smoked detectors in all resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 108 and had a census of 76 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has three sheds and one pod providing storage which were not sprinklered. Quality Review completed on 06/02/25		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.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking area was maintained by disposing of cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff by the staff exit. Findings include: Based on observation with the Maintenance	K 0741	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified to be affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be**	06/20/2025

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	Director on 05/29/25 at 12:40 p.m., outside of the employee exit had over 20 cigarette butts disposed on the ground around the exit and a shed. Based on an interview at 12:40 p.m., the Maintenance Director agreed there were cigarette butts on the ground outside of the employee exit. This finding was reviewed with the Maintenance Director during the exit conference at 1:15 p.m. This deficiency was cited on 03/31/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**identified and what corrective action will be taken:** All residents have the potential to be affected by the deficient practice. Facility staff have been re-educated by the Executive Director/designee on facility smoking policies, and proper disposal of cigarette butts. An ashtray of noncombustible material and safe design has been provided at the facility for proper disposal of cigarette butts. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ***(DPOC) – The facility will ensure staff, residents and visitors adhere to established smoking policies and procedures. Smoking materials are discarded properly in areas where smoking is permitted and not permitted. Ongoing, the Administrator or designee will monitor smoking areas and non-smoking areas to ensure proper disposal of discarded smoking materials to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.*** The facility staff will be re-educated by the Executive Director/designee on the facility smoking policy. No facility staff	

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			will work past the date of compliance until the education has been completed. New employees will be educated during facility orientation on the facility smoking policy. The facility will take necessary disciplinary action if warranted, related to violations of facility smoking policy. New “No Smoking” signage has been added to the affected areas as well. An ashtray of noncombustible material and safe design has been provided at the facility for proper disposal of cigarette butts. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director/designee, will round and the property outdoors and complete an audit twice daily, M-F, x 8 weeks then weekly x 6 months to ensure cigarette butts are not accumulating on the property. The Executive Director/designee will round the outdoor property on a weekly basis and audit Maintenance Director monitoring. The Maintenance Director/designee will provide the Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAPI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is	

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			no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director on 05/29/25 at 12:38 p.m., the generator's annunciator panel at the main nurse's station showed a communication alarm on the panel. Based on an interview at 12:38 p.m., the Maintenance Director stated the generator was working but the generator's annunciator panel was not working and there is not another annunciator panel in the building. Also stated, the annunciator panel is currently being repaired and should be completed in the first week of June 2025. This finding was reviewed with the Maintenance Director during the exit conference at 1:15 p.m. This deficiency was cited on 03/31/25. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0916	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No residents were identified to be affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. It was explained to the surveyor on the date of survey that the Generator Panel was currently being serviced for the faulty alarm, and a part was ordered for the effective repair. The part was not yet available at time of survey. The facility has since had repairs made by the vendor to alleviate the faulty alarm. ***Please refer to attached Exhibit B – parts on order for repair*** **What measures will be put into**	06/20/2025

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	3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility Maintenance Director will be educated by the Executive Director/designee by the date of compliance on generator maintenance and what to do if generator is not working properly. Any faulty alarms identified during preventative maintenance will be reported to the Executive Director immediately and vendor will be notified immediately. ***(DPOC) – The facility will ensure a remote annunciator is hard-wired to the current working emergency generator to indicate alarm conditions of the emergency power source (generator) in a location readily observed by operating personnel. Ongoing, the Administrator or designee will monitor the remote annunciator to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.*** **How the corrective action will be monitored to ensure the deficient practice will not recur:** The facility Maintenance Director/designee will perform weekly monitoring tests on the facility Generator and will hold	

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			responsibility to ensure all functions are properly working, and report needed repairs immediately to the Executive Director and vendor for repairs. The Maintenance Director/designee will provide the Executive Director with the results of these audits. The Executive Director will present a report on the findings at the monthly QAPI meeting. Any negative trends will be addressed with an action plan. This criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criterion, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not recur and/or adapt audit schedules.	