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	12/21/2023

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

(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 Complaints IN00422734, IN00422875, and IN00424443. Complaint IN00422734 - No deficiencies related to the allegations are cited. Complaint IN00422875 - Federal/State deficiencies related to the allegations are cited at F580 and F622. Complaint IN00424443 - No deficiencies related to the allegations are cited. Survey dates: December 18, 19, 20, & 21, 2023. Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 3 Medicaid: 61 Other: 5 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/27/23.	F 0000		
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

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

Linda Lewis | Administrator | 01/08/2024

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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Bldg. 00	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the responsible party of a transfer to the Emergency Room for 1 of 3 residents reviewed for transfer and discharge. (Resident D) Findings include: On 12/18/23 at 10:18 A.M., the clinical record for Resident D was reviewed. Resident D was admitted to the facility on 5/22/22 with the most recent readmission date of 3/16/23. The resident's diagnoses included, but were not limited to, a history of stroke, gastrostomy (tube in the stomach for feeding), hemiplegia (partial paralysis), hemiparesis (partial weakness), aphasia (loss of ability to speak), and intracranial abscess (infected area in the brain). The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/23, indicated Resident D rarely or never understood others and rarely or never made himself understood. Resident D had severe cognitive impairment, was not ambulatory, was dependent on others for all activities of daily living, and required a feeding tube for all nutrition. Progress Notes, dated 11/26/23 at 3:16 P.M., indicated, "...[resident's nurse] was summoned to pts [patient's] room on assessment [resident's nurse] observed that the pts g tube was dislodged	F 0580	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective January 12, 2024 for the complaint survey completed December 21, 2023. Woodland Manor would like to respectfully request a desk review/paper compliance of this plan of correction. F 580 Notify of Changes It is the practice of this facility to ensure the family/responsible party are notified when a resident is transferred to the hospital with a change in condition. What corrective action will be accomplished for those residents found to be affected by the deficit practice: Resident D no longer resides in	01/12/2024

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	also note a small amount of bleeding and facial grimaces indicating some discomforts. [Resident's Nurse] was able to replace site...could also hear audible gurgling and wheezing. Lung assessment indicated some distress [patient's nurse] notified MD [medical doctor] and was given order to transfer out to [local hospital]...phoned [local ambulance] and pt was prepped for transfer..." An in-service training, dated from 11/27/23 to 12/01/23 and titled, "Transfers/Change of Condition/Notification", indicated nursing staff signed the training form specifying, "When there is a change of condition with a resident, nurses are to call MD, DON [Director of Nursing], and Family, Nurses MUST include in their note that they have call MD and Family and DON. Nurses are to call family if the resident is sent out to ER and note it in the nurses note..." During an interview on 12/20/23 at 10:45 A.M., LPN 2 indicated Resident D's sister called the facility and informed her the resident's responsible party notified her that the resident had been taken to the Emergency Room. LPN 2 indicated she explained why the resident was transferred to the ER at that time. LPN 2 indicated she had not notified Resident D's responsible party at the time the resident was transferred to the ER, and that nursing staff were responsible to notify the responsible party of transfers. During an interview with Resident D's responsible party on 12/20/23 at 1:00 P.M., she indicated she received a call from the ER on 11/26/23 around 5:30 P.M., notifying her the Resident was in the ER. The facility never notified her of the transfer nor a decline in the resident's condition. A policy titled, "Acute Condition		the facility. How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken: All residents who are transferred to the hospital with a change of condition have the potential to be affected by the alleged deficient practice. The charts of all residents who were transferred to the hospital since the incident occurred have been audited with chart documentation present that notification has been completed. What measures will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. The policy and procedure for Transfer or Discharge, facility-initiated was reviewed by the IDT. An in-service was provided to licensed nurses on the transfer policy including ensuring that family or responsible party have been notified of the transfer and it is documented in the medical record. A quality assurance audit tool has been developed to ensure family/resident representative notification has been completed and chart documentation is present on all residents that are transferred to the hospital with a change in condition. How the corrective action will be monitored to ensure the deficit	

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	Changes-Clinical Protocol," dated 3/18 was provided by the Administrator on 12/20/23 at 12:20 P.M., and indicated, "... A policy titled," Transfer or Discharge, Facility-Initiated," dated 10/2022, was provided as current by the Administrator on 12/20/23 at 12:20 P.M. The policy indicated, "...For an emergency transfer or discharge to a hospital or other acute care institution...When a resident is transferred or discharged from the facility, the following information is documented in the medical record...That an appropriated notice was provided to the...legal representative..." This citation relates to Complaint IN00422875. 3.1-5(a)(2)(4)		practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool will be completed by the Director of Nursing /Designee on all residents that are transferred to the hospital weekly for three weeks, then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable			

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	and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the			

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	resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on interview and record review, the facility failed to ensure the correct clinical information was provided to a receiving hospital that was necessary to meet a resident's needs and ongoing care, for 1 of 3 residents reviewed for transfer and discharge, (Resident D). Finding includes: On 12/18/23 at 10:18 A.M., the clinical record for Resident D was reviewed. Resident D was admitted to the facility on 5/22/22 with the most	F 0622	It is the practice of this facility to ensure the correct clinical information is provided to a receiving hospital to meet the residents needs and ongoing care. What corrective action will be accomplished for those residents found to be affected by the deficit practice: Resident D no longer resides in the facility. How other residents having the potential to be affected by the	01/12/2024

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	recent readmission date of 3/16/23. The resident's diagnoses included, but were not limited to, a history of stroke, gastrostomy (tube in the stomach for feeding), hemiplegia (partial paralysis), hemiparesis (partial weakness), aphasia (loss of ability to speak), and intracranial abscess (infected area in the brain). The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/23, indicated Resident D rarely or never understood others and rarely or never made himself understood. Resident D had severe cognitive impairment, was not ambulatory, was dependent on others for all activities of daily living, and required a feeding tube for all nutrition. Resident D's current Out of Hospital Do Not Resuscitate Declaration and Order (DNR), was dated 3/16/23. Resident D's current Physician's Orders included, DNR, nothing by mouth diet, and tube feeding for nutrition. Progress Notes, dated 11/26/23 at 3:16 P.M., indicated, "...[resident's nurse] was summoned to pts [patient's] room on assessment [resident's nurse] observed that the pts g tube was dislodged also note a small amount of bleeding and facial grimaces indicating some discomforts. [Resident's Nurse] was able to replace site...could also hear audible gurgling and wheezing. Lung assessment indicated some distress [patient's nurse] notified MD [medical doctor] and was given order to transfer out to [local hospital]...phoned [local ambulance] and pt was prepped for transfer..." The Transfer/Discharge Report, dated 11/26/23, Prehospital Care Report Summary, dated 11/26/23, Clinical Resident Profile, dated 11/26/23, and Order		same deficit practice will be identified and what corrective action will be taken: All residents who are transferred to the hospital have the potential to be affected by the alleged deficient practice. The charts of all residents who were transferred to the hospital since the incident occurred have been audited with chart documentation present that the correct clinical information has been sent. What measures will be put into place and what systematic changes will be made to ensure the deficit practice does not recur. The policy and procedure for Transfer or Discharge, facility-initiated was reviewed by the IDT. An in-service was provided to licensed nurses on the transfer policy including ensuring the correct paperwork is sent with the resident on hospital transfer and it is documented in the medical record. A quality assurance audit tool has been developed to ensure correct clinical information is provided to the receiving facility and chart documentation is present on all residents that are transferred to the hospital. How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place. The Quality Assurance Audit Tool	

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	Summary Report, dated 11/26/23, which were sent by the facility with the resident to the local ER, were provided by the local hospital's Medical Records Department on 12/19/23 at 9:30 A.M. The Transfer/Discharge Report indicated a different resident's (Resident F's), information was sent with Resident D to the ER, which included Resident F's name, date of birth, and medication list. The Transfer/Discharge Report indicated Resident F had a Full Code status, and that Resident F was diabetic. The Prehospital Care Report Summary, which was the summary of the service provided by the ambulance that transported Resident D to the ER, indicated Resident D's birthrate, social security number, and physical assessment, but Resident F's diagnoses. The report summary also included another Transfer/Discharge Report with all of Resident D's correct information. The Clinical Resident Profile was Resident D's current clinical information. The Order Summary Report was Resident D's current Physician's Order Summary. During an interview on 12/18/23 at 11:00 A.M., the Executive Director indicated that on 11/26/23, Resident D developed respiratory difficulty and was sent to a local ER for care. The facility had 2 residents with the same first and last names (Residents D & F) and some of Resident F's information was incorrectly sent the the ER along with some of Resident D's information. During an interview on 12/203 at 10:45 A.M., LPN 2 indicated when she attempted to printed out		will be completed by the Director of Nursing /Designee on all residents that are transferred to the hospital weekly for three weeks, then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	

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	Resident D's clinical paperwork to be transferred to the ER with the resident via the local Emergency Medical Technicians (EMT), the papers did not print out, so she attempted to print the information again. The second time she printed the information, it did print at the printer, but she believed she may have mistakenly printed Resident F's information first, and on the second attempt, she printed off Resident D's information, and both sets of information printed and Resident F's information was mistakenly sent to the local ER along with Resident D's information. A policy titled," Transfer or Discharge, Facility-Initiated," dated 10/2022, was provided by the Administrator on 12/20/23 at 12:20 P.M. as current. The policy indicated, "...For an emergency transfer or discharge to a hospital or other acute care institution...Prepare for medical record transfer...the following information is communicated to the receiving facility...Resident representative information, Advance directive information...All special instructions or precautions for ongoing care...diagnoses...medications...resident's discharge summary..." This citation relates to Complaint IN00422875. 3.1-12(a)(3)			