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	02/28/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00453989, IN00452803, IN00448083 & IN00453447. Complaint IN00453989- Federal deficiencies related to the allegations are cited at F550 & F725. Complaint IN00452803- Federal deficiencies related to the allegations are cited at F600. Complaint IN00453447- Federal deficiencies related to the allegations are cited at F686 & F725. Complaint IN00448083- no deficiencies related to the allegations are cited. Unrelated deficiencies are cited Survey dates: February 27 & 28, 2025 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF: 2 NF: 66 Total: 68 Census Payor Type: Medicare: 2 Medicaid: 66 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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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F 0550 SS=D Bldg. 00	Quality Review completed on 3/6/2025 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview and record review, the facility failed to ensure a resident's call light was answered timely and care was provided to maintain her dignity for 1 of 4 residents who were reviewed for dignity. (Resident H) Finding includes: A record review was completed on 2/27/2025 at 10:40 A.M. for Resident H. Diagnoses included but were not limited to cerebral palsy, chronic obstructive pyelonephritis and morbid severe obesity. A Quarterly Minimum Data Set (MDS) assessment, dated 1/14/2025, indicated Resident H's cognitively intact, required substantial/maximal assistance for bed mobility and toileting, was dependent for transfers with a mechanical lift, and was always incontinent of her bowel and bladder. A current Care Plan, revised on 7/12/2019, indicated Resident H had an activity of daily living (ADL) self performance deficit and required extensive assistance of two staff members for personal hygiene, bed mobility and transfers. A grievance document, filed on 1/29/2024 by Resident H indicated she had filed a grievance due to having to wait an extended period of time before receiving care. The form indicated it had been confirmed that the resident had to wait 4 hours to be changed and had called the nurses station on her cell phone repeatedly attempting to	F 0550	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · DON/designee to provide education on the requirement to answer call-lights in a timely manner so care can be provided without negatively affecting a resident's dignity. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? · Other residents who utilize call-lights have the potential to be affected · DON/designee to provide education to associates in all disciplines on the requirement to answer call-lights in a timely manner so care can be provided without negatively affecting a resident's dignity, that associates in all departments are to assist with answering call lights, and if unable to immediately address request they are to report to the assigned nursing associate and/or facility manager What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	03/21/2025

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	get help. The Corrective action documented on the form indicated more staff had been hired and staff had been re- educated. Review of a second grievance document, filed by Resident H on 2/19/2025, indicated she had filed a grievance due to not receiving care within 20 minutes of being told by the nurse that Resident H needed assistance. The investigation on the grievance indicated the concern was not verified. During an interview on 2/27/2025 at 11:43 A.M., Resident H recalled the event that had occurred on 2/19/2025 at about 1:00 A.M. She did not have her call light in reach and so she had called the facility on her cell phone to ask someone to retrieve her call light and to inform staff she had had a bowel movement and needed care. The resident indicated she called at least one more time requesting help but no one came until around 3:00 A.M., two hours later, to provide care. She indicated her bottom was sore and irritated after she had laid in bowel movement and cream was applied to her bottom. The resident indicated she felt embarrassed and gross to have to lay in that mess for that long. She indicated bowel movement was all over her legs and her bed sheet. She indicated she had filed a grievance with the social worker later that same day but had not received any resolution or response regarding the grievance. The resident indicated she has had to remember to make sure she has her call light in reach after care as staff often forgot to ensure it was within her reach. Resident H indicated there had been many times she had waited longer than 30 minutes for help. Resident H indicated on 2/27/2025 she had turned on her call light at 10:25 A.M. was told the aides were busy and would be in soon. She turned it on		· DON/designee to provide education to associates in all disciplines on the requirement to answer call-lights in a timely manner so care can be provided without negatively affecting a resident's dignity, and that associates in all departments are to assist with answering call lights, and if unable to immediately address request they are to report to the assigned nursing associate and/or facility manager. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · DON/designee will complete random call-light response times to ensure that call-lights are being answered in a timely manner in order to provide care for the resident without negatively affecting his/her dignity. Auditing to occur: 4 call lights 3 x's wkly (total of 12/wk. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education and/or disciplinary action, increased frequency and/or duration of reviews will be	

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	again at 10:55 A.M., and the nurse came in and told her the aides were still with another resident. The resident indicated she waited more than 45 minutes before she received assistance to get out of bed. During an interview on 2/28/2025 at 7:31 A.M., the Director of Quality Assurance indicated according to the grievance filed by the resident on 1/29/2025, it was confirmed that Resident H had waited 4 hours for care. The Director of Quality Assurance indicated the facility was short staffed that day but since then the facility had hired more CNAs. During an interview on 2/28/2025 at 8:42 A.M., LPN 6 indicated she was the charge nurse on 2/19/2025 when Resident H had called into the facility asking for her call light. The LPN indicated she gave the resident her call light. About 15 minutes later, the resident called on the phone again to inform the LPN she had had a very large bowel movement and would need a complete bed change. The LPN informed the CNAs but she could not be sure how long the resident waited as she was too busy with her own tasks to provide care to Resident H or ensure the aides provided care to Resident H in a timely fashion. On 2/28/2025 at 9:05 A.M. a current policy titled, "Activities of Daily Living (ADLs), Supporting" dated March 2018, was provided by the Director of Quality Assurance. The policy indicated, "...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate assistance with: a. hygiene...." This citation relates to complaint IN00453989.		increased as needed, if areas of noncompliance are identified through the auditing process.	

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	3.1-3(a)(t)			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, record review and interview, the facility failed to ensure a resident was not neglected (Resident T) and the facility failed to complete interventions in place to prevent neglect and abuse (Resident P and Q) for 3 of 4 residents reviewed for abuse. (Residents T, P & Q) . This deficient practice resulted in Resident T observed to be extensively incontinent of urine and bowel movement (BM), including his clothing, bed pad, sheet, and blanket and had not received incontinent care for an undetermined amount of time. In addition, using the reasonable person concept, resident T and Q could have had feelings of embarrassment, fear of neglect, hopelessness, or depression related to the lack of superivision. (Resident P and Q) Findings include: 1. During an initial tour on 2/27/25 at 9:44 A.M.., a strong urine and BM odor was noted in the hallway outside Resident T's room. From the door of the room, the resident was observed laying on his right side in a low bed with an quarter side rail in the raised position. He was wearing plaid pajama pants and no shirt and had a blanket partially covering him. Upon permission from the resident, the room was entered and the odor was stronger closer to the resident. The resident was observed with soiled and wet pajamas bottoms, with wetness and soilage noted partially down his bottom and a saturated incontinent brief soiled with urine and dark brown/black BM. The BM on his lower back was in various stages from wet to	F 0600	*F 600 Free from Abuse and Neglect* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Licensed nursing staff completed a head-to-toe skin assessment on 2/27/25 on Resident T and notified the physician and responsible parties of the new skin concern on (should have been 2/27 when). New tx orders were obtained. RP notified of new order. DON/designee updated Resident P and Resident Qs physicians and responsible parties as to the outcome of reportable investigation. A Velcro stop signs that fits across the length of the door was ordered and placed for Resident P's door to redirect Resident Q from entering his room. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other incont residents have the potential to be affected. DON/designee will identify thru	03/21/2025

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	drying. The bed pad was soiled with urine and BM and had drying stains in various stages of drying. The blanket, which had been partially covering the resident, was also wet and soiled with urine and BM, in various stages of drying, The facility was alerted of the situation and help was summoned at 9:50 A.M. During an interview with the resident at 9:54 A.M.,. he indicated he had not been changed since "yesterday." LPN 14 arrived at 9:56 A.M.. and indicated at that time, the resident needed care. He then summoned CNA 12 to the room to provide care to the resident. At that time, CNA 12 indicated she was not assigned to this hall but came to assist LPN 14. Both LPN 14 and CNA 12 began providing care for the resident using wipes. They pulled down his pajamas and attempted to remove the incontinent brief and identified wipes would not provide the care he needed. The LPN exited the room to get more supplies. CNA 12 continued to provide care to Resident T. As the incontinent brief was pulled down and the resident rolled onto his back, it was observed his bottom and back were noted to be saturated with urine and BM in the front and back of his peri area and there was an area of scant bleeding coming from his scrotum. The CNA patted the blood off the scrotum with a cloth and a pinpoint open area was observed. The resident indicated he had to urinate. There was no urinal in the room, so the CNA placed a pad over him, and he was able to urinate. The sheet under the resident was observed to have a large area of brown/black BM, in various stages from wet to drying. There was also dried brown rings on the sheet. At 10:06 A.M., LPN 14 arrived back to the room with more linens for care and at 10:09 A.M., CNA 11 arrived to assist. At 10:10 A.M.. the Director of Nursing was summoned to the room to observe the condition of the resident. However, at 10:14 A.M.., the RN Consultant arrived and		medical record review and will ensure their plan of care is updated to reflect incont care needs. Other cognitively impaired residents who have known inappropriate sexual behaviors have the potential to be affected. SSD/designee to identify thru med rec review to ensure appropriate safety interventions are in place. The DON/designee will review the electronic medical record to identify these residents and will ensure appropriate safety measures are in place per the plan of care. The plan of care will be updated to reflect each resident's needs. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee to provide education to staff on the requirement to ensure incont care is provided timely to meet resident needs. The DON/designee will provide education to staff in all disciplines of the requirement to immediately report sexual contact between residents to the Administrator, immediate reporting of inappropriate sexual behaviors, as well as ensuring interventions are in place as indicated. DON/designee will complete daily auditing 5 days/wk on the	

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	during an interview at that time, indicated the DON was out sick. She observed and verified the condition of the resident. She left the room, and CNA 12 continued to attempt to provide care to the resident. CNA 12 indicated the resident would need a shower and the resident agreed. The stand-up lift was brought into the room at 10:20 A.M.. As the CNA's attempted to use (the lift), the battery was dead. CNA 11 left the room to retrieve a new battery at 10:24 A.M. and returned at 10:26 A.M.., and discovered another dead battery. CNA 11 again left the room to retrieve a new battery. She arrived back in the room at 10:30 A.M. with 2 batteries, one of which worked. The resident was then transferred into the shower chair and taken for a shower by CNA 12. At 10:52 A.M., CNA 12 returned the resident to his room and CNA 11 assisted to get him dressed and up in his wheelchair. CNA 12 began providing care to Resident T at 9:56 A.M..and was continuously with the resident until 11:00 A.M.. CNA 11 was providing continuous care for Resident T from 10:09 A.M. to 10:35 A.M During an interview with CNA 11 at 10:45 A.M., she indicated she was assigned to the front hall and there were only two CNA's working on the unit. She indicated she was the CNA assigned to Resident T for the day. She indicated had arrived to work in the morning and found the night CNA watching movies on his phone. She indicated started getting residents up for breakfast after she had arrived. She indicated had had not been able to check or change Resident T. She stated Resident T "looked like he had not been toileted all night." The record review for Resident T was completed on 2/27/25 at 1:24 p.m. Diagnoses include, but were not limited, to vascular dementia, mild and		memory care unit to ensure safety interventions are in place for inappropriate sexual behaviors and/or contact between residents. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee to complete auditing to ensure that incont care is being provided timely to meet resident needs.. Auditing to occur: 4 incont checks audits 3 x's wkly x's 30 days, then 4 incont checks wkly x's 30 days, then 4 incont checks monthly x's 4 months for a total of 6 months of monitoring. Incont checks to include all shifts. DON/designee will complete routine auditing on the memory care unit to ensure safety interventions are in place for inappropriate sexual behaviors and/or sexual contact between residents. Auditing to occur: 5 days/wk x's 30 days, then 3 x's wkly x's 30 days, then wkly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring.	

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	chronic kidney failure. A physician order, dated 2/24/25, indicated the resident was to be offered toileting at 12 A.M., 5 A.M., 8 A.M., 12 P.M., 3 P.M., 5: 30 P.M., and at bedtime. A Quarterly Minimum Data Set (MDS) Assessment, dated 1/15/25, indicated the resident had severe cognitive impairment, had feelings of being down, depressed, or hopeless several days, was frequently incontinent of bladder and bowel and required partial to moderate assistance with toileting and transfers. Care Plans revised on 12/6 24, indicated the resident had a self-care deficit in incontinence care and required up to 2 staff for participation in toileting and to provide assistance as needed. The resident was also at risk for skin breakdown related to incontinence and the resident's skin was to be kept clean and dry and staff were to offer toileting at 12 A.M., 5 A.M., 8 A.M., 12 P.M., 3 P.M., 5: 30 P.M., and at bedtime. An Activities of Daily Living task sheet reviewed on 2/27/25 at 2 p.m., indicated the resident last received incontinent care on 2/26/25 at 6:30 P.M. 2. During an observation, on 2/27/2025 at 10:00 A.M., a stop sign was not observed across Resident P's doorway. Resident P was in bed with his eyes closed. During an observation, on 2/27/2025 at 1:38 P.M., a stop sign was not observed across Resident P's doorway. Resident P was in bed with his eyes closed. A record review for Resident P was completed on 2/27/2025 at 11:03 A.M. Diagnoses included, but		Re-education and/or disciplinary action, increased frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	

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	were not limited to: Alzheimer's disease, bipolar disorder, anxiety disorder and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 11/7/2024, indicated Resident P had moderate cognitive impairment and had verbal behavioral symptoms directed towards others. A Progress Note, on 1/31/2025 at 8:19 A.M., indicated Resident P was found in his bed with resident Q partially clothed. Resident P was placed on one-on-one checks. An Interdisciplinary Team (IDT) Note, on 1/31/2025 at 11:12 A.M., indicated the team met and Resident P would have a stop sign placed in his doorway to prevent another resident from wandering into his room. An Interdisciplinary Team Note, on 2/3/2025 3:48 P.M., indicated one-on-one supervision was discontinued and 15-minute checks were to be continued for 72 hours. A Care Plan, initiated 2/3/2025, indicated Resident P demonstrated inappropriate sexual behaviors at times related to unspecified dementia, bipolar disorder with severe psychotic features. These diagnoses resulted in poor impulse control. The goal indicated Resident P would not touch any confused or non-consenting resident in a sexual or inappropriate manner. Interventions included, but were not limited to: Resident P was placed on one-on-one checks following the reported incident. A Care Plan, initiated on 1/31/2025, indicated Resident P was at risk for emotional distress related to another resident had entered his room.			

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	The goal indicated Resident P would not show any signs of emotional distress. Interventions included, but were not limited to: 15-minute checks initiated for 72 hours after the one-on-one staff supervision concluded. A document titled, "Resident Specific Problem or Behavior Tracking Sheet", was provided by the Quality Assurance Administrator. The document was dated 1/30/25-1/31/25. The tracking began at 4:00 P.M. on 1/30/2025 and ended on 1/31/2025 at 11:45 A.M. There was empty tracking during the times of 1/31/2024 6:45 A.M. through 8:45 A.M. and 10:30 A.M. through 11:45 A.M. During an interview, on 2/28/2025 at 11:49 A.M., the Quality Assurance Administrator indicated the documents provided were the only documents that she could find in the facility. On 2/27/2025 at 2:14 P.M., CNA 5 documented a safety device for a stop across the door was in place. During an interview, on 2/27/2025 at 2:28 P.M., CNA 5 indicated the documentation of the stop sign across the doorway was incorrect. She indicated she had never seen a stop sign across Resident P's doorway, but she would obtain a stop sign for the doorway. During an observation, on 2/28/2025 at 4:07 A.M., 5:38 A.M., 6:22 A.M. and 715 A.M., a stop sign was not observed across Resident P's doorway. During an interview, on 2/28/2025 at 4:19 A.M., CNA 15 indicated he had not seen a stop sign across Resident P's door since the reported incident between Residents P and Q.			

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	During an interview, on 2/28/2025 at 4:29 A.M., LPN 6 CNA 4 had informed her there were two residents in bed together. CNA 4 informed LPN 6 Resident P was fully dressed and had gotten up and went to the bathroom and Resident Q was noted to have her top off. During an interview, on 2/28/2025 at 4:40 A.M., QMA 3 indicated she oversaw the medication cart on the dementia unit the night of 1/29/2025. She had worked alongside CNA 2 and CNA 15. She indicated CNA 15 informed her that Resident P and Resident Q were in Resident P's room together, but CNA 15 had not indicated what had happened. She indicated she ihad nformed LPN 6 that Resident Q had exited Resident P's room. During an interview, on 2/28/2025 at 10:15 A.M., the Quality Assurance Administrator indicated she was not sure if the facility had a door stop sign for Resident P's room. 3. During an observation, on 2/27/2025 at 10:28 A.M., Resident Q was observed in the hallway for 30 minutes. During an observation, on 2/27/2025 at 2:21 P.M., Resident Q was observed wandering on the dementia unit hallway. During an observation, on 2/28/2025 at 1:34 P.M., Resident Q was observed roaming the dementia unit hallway with another male resident. A record review for Resident Q was completed on 2/27/2025 at 1:36 P.M. Diagnoses included, but were not limited to: dementia and schizophrenia. A Quarterly MDS assessment, dated 1/20/2025 indicated Resident Q had severe cognitive			

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

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	impairment and had no behaviors documented during the assessment period. A Nursing Progress Note, dated 1/30/2025 at 3:30 P.M., indicated Resident Q was partially dressed and found in Resident P's room. A Nursing Progress Note, on 1/31/2025 at 11:02 A.M., indicated the IDT team met and discussed Resident Q having been found in Resident P's room. Resident Q was placed on 30-minute checks and was to be encouraged to participate in activities. A Care Plan, initiated on 1/31/2025, indicated Resident Q was at risk for emotional distress related to being partially clothed in another resident's room. The goal indicated Resident Q would not show any signs of emotional distress. Interventions included, but were not limited to: one-on-one supervision until the IDT team had discussed and determined Resident Q was no longer an acute risk of repeating the behavior and 30-minute checks were put into place. Documents titled, "Resident Specific Problem or Behavior Tracking Sheet", were provided by the Quality Assurance Administrator. The documents had the following dates with missing documented checks: - 1/31/2025 started documentation at 10:45 A.M. Documentation into 2/1/2025 at 6:45 A.M. through 2:15 P.M was missing. - 2/1/2025 documentation from 3:30 P.M. through 5:30 P.M. was missing. - There was no documentation for 2/2/2025. - A document titled, "Frequent Monitoring check sheet", dated 2/3/2025 had documentation from 12:00 P.M. through 8:30 P.M. and no other documentation was present.			

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	- 2/4/2025 documentation was recorded from 6:30 A.M. through 6:30 A.M. on 2/5/2025. No further documentation of 30-minutes checks were available after this documented time and date. A Facility Report Incident was reported to the Indiana Department of Health, on 1/30/2025. The report indicated the incident between Resident P and Q occurred on 1/29/2025 at 8:01 P.M. The investigation notes revealed: - A typed statement, signed by the Director of Nursing (DON) and the Executive Director (ED), indicated CNA 2 was interviewed on 1/30/2025. She indicated she was working on the dementia unit on 1/29/2025 from 2:30 P.M. through 10:30 P.M. CNA 15 requested her to go to Resident P's room. She indicated when she walked into the room, Resident Q was seated on Resident P's bed with her shirt off and her shirt was on Resident P's bed. - A typed statement by the ED, dated 1/30/2025, indicated the DON and herself were advised, at 4:00 P.M. on 1/30/2025, of Resident Q was in Resident P's bed without a shirt and Resident P was without his pants in the bed. The ED placed Resident P on one-to-one supervision for the evening. - A typed statement by the ED, indicated QMA 3 was working on 1/29/2025. QMA 3 indicated CNA 15 requested her to come to Resident P's room. She observed Resident P walking to the bathroom and Resident Q exiting Resident P's room. QMA 3 informed LPN 6 of her observations. CNA 15 did not inform QMA 3 or LPN 6 of his observations. During an interview, on 2/28/2025 at 11:49 A.M., the Quality Assurance Administrator indicated the documents provided were the only documents she d in the found in the facility.			

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	A policy was provided by the Quality Assurance Administrator, on 2/28/2025 at 12:03 P.M. The document titled, "Abuse Policy", indicated, " ...The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to the resident's medical symptoms ...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers ...The facility shall have a process in place to include screening, training, prevention, identification, protection, investigation, reporting and response to allegations of potential actual abuse and neglect ... Sexual Abuse is defined as non-consensual sexual contact of any type with a resident ...." The Abuse policy dated as reviewed 1/2020 was provided by the Quality Assurance Director on 2/28/25 at 12:03 p.m. The policy indicated "The resident has the right to be free from abuse, neglect...Neglect is defined as the 'failure of the facility, its employees or services providers to provide goods and services to a resident that is necessary to avoid physical harm, pain, mental anguish or emotional distress...." This citation relates to complaint IN00452803. 3.1-27(a)(1) 3.1-27(a)(3)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to prevent and identify pressure injuries for	F 0686	*F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer*	03/21/2025

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	2 of 3 residents reviewed for pressure injuries (Residents E & F). The deficient practice resulted in wounds developed to a Stage 3 pressure ulcer for Resident E and an unstageable wound for Resident F. Findings include: 1. A record review was completed for Resident E on 2/27/2025 at 10:18 A.M. Resident E was admitted to the facility on 9/18/2024. Diagnoses included, but were not limited to: type 2 diabetes, moderate protein calorie malnutrition and iron deficiency anemia. A Nursing Admission Evaluation, dated 9/18/2024, indicated Resident E was at mild risk for pressure ulcers. Care plans, initiated on 9/19/2024 and reviewed as current through 12/25/2024 included a plan to address the resident's potential for impaired skin integrity related to incontinence and limited mobility. Interventions, included but were not limited to: educate resident/family/caregivers on causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, keep skin clean and dry, use lotion on dry skin. Do not apply to open areas, treatments as ordered by MD. A care plan to address the resident's ADL (activities of daily living needs, included an intervention for staff to provide extensive assistance for toileting, transfers and bathing needs. A Weekly Skin Review, dated 10/27/2024, indicated Resident E's skin was dry, intact and without any skin alterations. A Weekly Skin Review, dated 11/13/2024, lacked		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** DON/designee completed and documented a head-to-toe assessment on Resident E on 2/17/25 and Resident F on 2/20/25. The physicians and responsible parties for both residents were notified of their skin concerns. Appropriate tx's have been obtained. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who are at risk for and have actual skin breakdown have the potential to be affected. DON/designee to complete routine auditing to ensure weekly skin assessments are being completed to identify new skin concerns. DON/designee to ensure residents have updated Braden assessments and have appropriate measures in place to prevent skin breakdown. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee to provide education to nursing associates	

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	documentation of any abnormal skin issues for Resident E. Review of a quarterly Minimum Data Set (MDS) assessment, completed on 11/17/2024 indicated Resident E was severely cognitively impaired, required moderate assistance for hygiene and transfer needs, had an indwelling urinary catheter, was frequently incontinent of bowels and required extensive staff assistance for toileting and bathing needs. A Physician's Order, initiated on 12/7/2024 and discontinued on 12/13/2024, indicated to cleanse area to sacrum with normal saline and apply mepilex every day and as needed. Resident E's December Medication Administration Record (MAR) indicated on 12/7/2024, 12/8/2024, 12/10/2024 and 12/11/2024 there was no indication the treatment of normal saline and mepilex to the sacrum had been completed. A Physician's Wound note, dated 12/11/2024, indicated Resident E had a stage three pressure wound to his sacrum of full thickness. Documentation indicated the wound had been present for greater than 14 days. Wound measurements were documented at 2.4 cm x 1.0 cm and depth was immeasurable due to the presence of nonviable tissue and necrosis (dead tissue). No further nursing skin evaluations were completed until 12/11/2024 after the Physician's Wound note. The 12/11/2024 skin evaluation indicated Resident E had a stage three pressure ulcer to his sacrum. A Weekly Pressure Ulcer Injury Evaluation, dated 12/11/2024, indicated Resident E had an in-house		on the requirement to accurately complete weekly skin reviews, physician notification of new skin concerns, obtain and complete wound tx's as ordered, weekly wound measurements until resolved, and appropriate measures to prevent breakdown and promote healing of existing wounds. The plan of care will be updated to reflect resident needs. DON/designee will complete routine auditing to ensure the completion of accurately complete weekly skin reviews, physician notification of new skin concerns, obtain and complete wound tx's as ordered, weekly wound measurements until resolved, and appropriate measures to prevent breakdown and promote healing of existing wounds. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete routine auditing as noted above on 4 residents 4 x's/wk x's 30 days, then 4 residents wkly x's 30 days, then 4 residents monthly x's 4 months for a total of 6 months of monitoring The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for	

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	acquired stage three pressure injury to his sacrum, with an onset date of 12/11/2024. The resident's wound measurements were documented at 2.4 centimeters (cm) x 1 cm. A Care Plan, revised on 12/12/2024, indicated Resident E had a stage three pressure ulcer to his sacrum. Interventions included, but were not limited to: Administer treatments as ordered and observe for effectiveness A Physician's Order, initiated on 12/14/2024 and discontinued on 2/25/2024, indicated to cleanse area to sacrum with normal saline and apply calcium alginate and cover with island border gauze one time a day for wound management. A Significant Change Minimum Data Set (MDS) assessment, dated 12/15/2024, indicated Resident E had significant cognitive impairment, was dependent on staff for bed mobility and transfer needs and had impaired range of motion to both lower extremities Resident E's December MAR indicated from 12/15/2024 through 12/24/2024 and on 12/27/2024, 12/29/2024 and 12/31/2024 there was no indication the treatment of calcium alginate to the sacrum had been completed. A Physician's Wound note, dated 2/24/2025, indicated the wound had been present for greater than 89 days. Wound measurements were documented at 3 cm x 1.2 cm x 0.4 cm. A treatment plan indicated to apply a hydrocolloid sheet three times per week and as needed for 16 days. A Current Physician's Order, dated 2/27/2025, indicated to cleanse the sacrum, pat dry, apply hydrocolloid sheet, cover with border gauze three		three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education and/or disciplinary action, increased frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Woodland Manor respectfully requests an informal dispute resolution (IDR) for F-tag 686 cited on CMS-Form 2567 for complaint survey conducted 28 February 2025. Woodland Manor is requesting F686 citations be reconsidered. The outcome of this incident is obviously agonizing, but this should not translate into penalty. The issues identified in the 2567 were the facility failed to prevent and identify pressure ulcer injuries for Residents E and Resident F. First, the facility conducted its own skin sweep and identification of specified wounds prior to the complaint visit of 28 February 2025. This action precludes the corollary of the citation “failing to identify ulcer injuries.” The facility in fact acted on the wounds found during its ***pre-complaint visit skin sweep***. Resident E was seen by wound	

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	times per week every Monday, Thursday, and Saturday. During an interview on 2/27/2025 at 2:49 P.M., LPN 9 indicated residents usually had their skin assessments completed weekly. He indicated CNA's were required to notify the nurse if an abnormal skin issue was identified. The nurse was to have performed an assessment and document the findings under a new skin evaluation. During an interview on 2/27/2025 at 2:58 P.M., the Quality Assurance Director indicated CNA's did not use shower sheets and CNA's were to complete skin observations during showering and when providing incontinence care. The observations should be documented in the computer. The CNA's documentation of Resident E's skin observations for the month of December lacked documentation of an open area on the resident's sacrum. The skin observations documented on 12/10/2024 and from 12/12/2024 through 12/31/2024 indicated Resident E had no new skin abnormalities. During an interview on 2/28/2025 at 8:26 A.M., CNA 10 indicated Resident E was able to roll from side to side in bed if requested. She indicated the resident was unable to scoot himself up in bed and was unable to help staff scoot him up in the bed. During an interview on 2/28/2025 at 9:17 A.M., the Regional Director of Care Services indicated she was unsure how the resident had developed a stage three pressure injury. She indicated the aides did a skin observation every shift and any new skin findings should have been documented		care consultant Vohra on 11/15/24, 11/21/24, 11/27/24, 12/11/24. The sacrum was identified as a state 3 wound and clinically addressed. Identified skin conditions were outlined in consultant reports. On 12/9/24 a reddened open area was identified on the CNA observation task at 0658. The physician was notified, and treatment ordered. Patient was receiving Mighty Shake TID at med pass. Dietary note on 12/6/24 determined resident remained at nutritional risk due to chronic conditions-diabetes, iron deficiency, and elderly age. BMI was 20.8. All these chronic conditions impede wound healing. A pressure reducing mattress was utilized. A low pre-albumin of 6.2 was identified on 11/9/24. Preventative skin care was provided at least daily by aides. Resident F was seen by wound care consultant Vohra on 2/10/25, 2/17/25, and 2/24/25. Left Foot pressure injuries on the left foot identified 2/17/25. Preventative skin care was provided at least daily by aides. A pressure reducing device was utilized on the bed. Care plan notes indicate refuses showers frequently despite encouragement making wound identification more difficult. Dietary note on 1/15/25 states resident at nutritional risk due to being underweight. BMI 20.1. Total protein 6.2. Albumin 3.3.	

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	in the computer. During an interview on 2/28/2025 at 10:38 A.M., the Regional Director of Care Services indicated she was unable to find anything in the resident's electronic record indicating the resident had a skin abnormality prior to 12/11/2024. 2. A record review was completed for Resident F on 2/27/2025 at 9:24 A.M. The resident was re-admitted to the facility on 11/1272024. Diagnoses included, but were not limited to: malnutrition, polyosteoarthritis and muscle weakness. An Admission Minimum Data Set (MDS) assessment, dated 12/2/2024, indicated Resident F was cognitively intact, required supervision or touch assistance with bed mobility and had no current pressure areas, but was at risk for pressure injuries. A Weekly Skin Review, dated 12/15/2024, indicated Resident F had no pressure abnormalities to his skin. A Weekly Skin Review, dated 12/23/2024, indicated Resident F's skin was intact with no skin alterations. Resident F's record lacked documentation that any weekly skin review assessments had been completed since 12/23/2024. A Braden Scale assessment (assessment for predicting pressure sore risk), dated 1/20/2025, indicated Resident F was at mild risk for pressure injury development. A Nursing Progress Note, dated 1/22/2025,		*The documentation speaks loudly.* The facility identified resident E and resident F wounds weeks ago and was providing consistent treatments. Wounds do increase in scope, not necessarily though neglect, but as consequence of changing declining medical conditions. The facts stated above support the conclusion these incidents did not occur due to lack of identification or treatment. Respectfully Submitted, Chris Chalman, Administrator	

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	indicated Resident F complained of severe pain to both feet. Upon assessment, the nurse had observed both great toes to be red and painful when touched. Resident F also complained of pain when repositioning his feet and in both heels. The Physician was notified. There was no further documentation regarding any skin abnormality until 2/10/2025 and no physician response in regards to the notification of red/painful toes and painful feet and heels noted on 1/22/2025. A Weekly Non-Pressure Injury Review, dated 2/10/2025, indicated Resident F's only skin abnormality was a skin tear to his right upper arm. No pressure abnormalities were documented. A Physicians Wound Note, dated 2/10/2025, indicated Resident F had a non-pressure wound of the right upper arm. No other pressure related skin abnormalities were documented. However, a Physician's Wound Note, dated 2/17/2025, indicated Resident F had wounds to his right upper arm, left heel and left plantar foot. The note indicated the resident had an unstageable pressure wound to his left heel of full thickness. Wound measurements were documented at 1 cm x 0.8 cm x immeasurable depth. Wound duration was documented at greater than 7 days. Resident F also had an unstageable pressure wound to his left plantar foot of full thickness. Wound measurements were documented at 1 cm x 1.8 cm x immeasurable depth. Depth was immeasurable for both pressure injuries due to the presence of nonviable tissue and necrosis. A Nursing Progress Note, dated 2/19/2025, indicated Resident F's skin was assessed and			

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	noted a small necrotic area on the tip of the resident's left great toe measuring 0.5 cm x 0.5 cm. A Weekly Non-Pressure Injury Review, dated 2/19/2025, indicated Resident F's non-pressure injury was facility acquired and was located on the left great toe. A Physician's Progress Note, dated 2/19/2025, indicated the resident was to be evaluated by the podiatrist and a wound physician. A Physician's Order, dated 2/20/2025, indicated betadine external solution to be applied to resident's left heel and left plantar foot topically one time a day for 30 days for wound management. A Care Plan, initiated on 2/21/2025, indicated Resident F had an unstageable pressure injury to the left heel. Interventions included, but were not limited to: elevate foot while in bed and treatment to area as ordered. During an interview on 2/28/2025 at 1:57 P.M., the Regional Director of Care Services indicated weekly skin assessments should have been completed on Resident E and Resident F. She indicated Resident E's stage three pressure injury and Resident F's unstageable pressure injuries should have been prevented and identified. She indicated the residents should have had Braden Assessments completed every week for four weeks post admission. She indicated Resident E's treatments should have been completed on the days where there were no documented treatments. Resident E and F's pressure areas were unable to be observed due to hospitalization at this time for both residents.			

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	On 2/28/2025 at 1:38 P.M., the Quality Assurance Director provided a policy titled, "Skin and Wound Management System," dated 4/2017, and indicated it was the policy currently being used by the facility. The policy indicated " ...Policy: It is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes ... 3. Ongoing weekly evaluations of resident's skin will be completed and documented in PCC on the "Weekly Skin Evaluation" form ...." A policy regarding the prevention of pressure injuries was requested but one was not provided prior to the survey exit. This citation relates to complaint IN00453447. 3.1-40(a)(1)			
F 0725 SS=G Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview and record review, the facility failed to ensure there were staff available to provide care in a timely manner to residents who required assistance(Resident T and H) and failed to ensure staff did not work greater than 20 hours in a day. (QMA 3 and LPN 6) Using the reasonable person concept, resident T could have feelings of embarrassment, fear of neglect, hopelessness, or depression. Findings include	F 0725	*F 725 Sufficient Nursing Staff* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident T was provided with incontinence care on 2/27/25, when deficiency identified and has had no further concerns Resident H's call-light was	03/21/2025

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	1. Resident T was observed on 2/27/25 at 9:44 a.m., to be visibly soiled urine and bowel movement (BM), that saturated his pull-up, bed pad, bed linens, and blanket. The resident was to be on a toileting schedule, and documentation indicated he had not been toileted as schedule. Cross Reference: F600 2. Resident H did not have her call light answered timely in order to have to have her care needs met. Cross Reference F 550 3. The posted staffing for 2/27/25 indicated there were 2 CNA's for Unit 1 and Unit 2. There were 39 residents residing on Unit 1 and Unit 2. During an interview, on 2/27/2025 at 3:09 p.m., CNA 12 indicated if there are three aides on Unit 1 and 2, then the showers could get done. If there were just two aides, then not all of them (showers) were completed. There were 10 showers on the day shift, and staff were too busy getting residents up, assisting with meals, and laying the residents down to complete showers. During an interview, on 2/27/2025 at 3:10 p.m., CNA 11 indicated if there were three aides assigned, showers were provided, but any less than three aides, the assigned work could not be completed and this occurred "all the time." During an interview, on 2/28/25 at 10:42 a.m. the Quality Assurance Director (QAD) indicated the facility usually did not have a lot of staff call-offs and they tried to replace them. The DON, Administrator, and scheduler had been out sick, and the scheduler had just returned back to work		answered, and needs were met on 2/27/25, when deficiency identified and has had no further concerns. QMA 3 and LPN 6 have not worked greater than 16 hours since date deficiency identified. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents requiring assistance with care have the potential to be affected DON/designee to provide education to staff in all disciplines on the requirement to answer call-lights, and if unable to assist, notify appropriate nursing associates, facility manager. DON/designee to provide education to licensed and certified nursing staff on the requirement to assist with toileting/complete bed checks per their individual need as per plan of care. Facility will update the facility assessment to ensure appropriate staffing levels to meet resident needs and will not work greater than 16 hrs/day. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee to provide education to staff in all disciplines on the requirement to answer call-lights, and if unable to assist,	

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	155086	A. BUILDING 00 B. WING	02/28/2025

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	today. There had been staff call -offs for today and the scheduler was working to have staff come in to cover. There was an LPN and QMA that were still working from the prior shift ,which had started at 6:30 P.M. on 2/27/25. The QAD indicated if the facility could not find replacements for the staff who had been working greater than 16 hours already, then the corporate nurse would have to work on a medication cart. The Corporate nurse was not seen working any unit. The QAD indicated bonuses were offered to staff if they picked up shifts During an interview, on 2/28/25 at 12:18 P.M., QMA 3 indicated she was staying over to cover a call off for day shift and there had been no communication about a replacement from anyone. She indicated she was not offered a bonus. On 2/28/2025 at 3:35 P.M., before the survey exit, QMA 3 and LPN 6 were still observed working on the floor, over 20 hours straight. The Facility Assessment was received from the RN consultant on 2/27/25 at 11:59 A.M. The assessment was dated 12/9/24 and had been reviewed by the Quality Assurance team on 12/20/24. The assessment indicated it would be used to: "...Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs identified through resident assessments and plans of care; Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on the changes to its resident population;....average daily census (ADC) 56-72...Resident Acuity Affecting Nurse Aides (including facility specific		notify appropriate nursing associates, facility manager. DON/designee to provide education to licensed and certified nursing staff on the requirement to assist with toileting/complete bed checks per their individual need as per plan of care. Facility will update the facility assessment to ensure appropriate staffing levels to meet resident needs and no staff to work greater than 16 hrs/day. Routine auditing to be completed as noted below to ensure call-lights are being answered in a timely manner to meet resident needs, staffing levels meet resident needs and no staff to work greater than 16 hrs/day. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete random call-light response times to ensure that call-lights are being answered in a timely manner in order to provide care for the resident without negatively affecting his/her dignity. Auditing to occur: 4 call light audits 3 x's wkly x's 30 days, then 4 call light audits wkly x's 30 days, then 4 call light audits monthly x's 4 months for a total of 6 months of monitoring.	

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	not already listed) Assistance Provided with Dressing 35 Assistance Provided with Bathing 58 Assistance Provided with Transfers 27 Assistance Provided with Eating 5 Assistance Provided with Toileting 35 Assistance Provided with Mobility 29 Assistance Provided with Splint braces 2 Assistance Provided with Behavior symptoms 35... SERVICES AND CARE WE OFFER BASED ON OUR RESIDENT'S NEEDS Activities of Daily Living Dressing, oral care, toileting, eating, bathing, bed mobility, transfers, ambulation... Bowel and Bladder Three day void to assess incontinence and determine if a scheduled toileting program is required. Residents who meet the requirement are then place on a written toileting program including care planning. Information about our staff... INFORMATION ABOUT OUR STAFFING PATTERNS Average Nurse Aide/Resident Ratio (Direct Care Staff) 1 to 6... Administration Staffing as described above is adequate as evidence by: All care requirements are met daily and by shift...." Although the facility assessment indicated the direct care staffing ration was to be at a 1 staff to 6 resident ration, the ratio observed on 2/27/2025 on the 100 and 200 units, during the day shift was at a 1 staff to 13 resident ratio. (2 CNAs and 1 nurse for 39 residents)		DON/designee to complete auditing to ensure that incont care is being provided timely to meet resident needs.. Auditing to occur: 4 incont checks audits 3 x's wkly x's 30 days, then 4 incont checks wkly x's 30 days, then 4 incont checks monthly x's 4 months for a total of 6 months of monitoring. Incont checks to include all shifts. Administrator/designee will review daily staffing sheets daily to ensure appropriate levels to meet resident needs as per the updated facility assessment. The Administrator will be notified of any staffing issues that do not meet facility assessment/staffing needs and will ensure no associate works greater than 16 hrs/day. Facility assessment be followed. Administrator will also ensure that a nurse manager or agency associate is on duty to replace staffing issues that would not meet resident needs as per facility assessment. Reviews to be completed daily x's 30 days, wkly x's 30 days, then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance	

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	This citation relates to complaint IN00453989 and complaint IN00453447.		has been achieved for a total of 6 months of monitoring. Re-education and/or disciplinary action, increased frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Woodland Manor respectfully requests an informal dispute resolution (IDR) for F-tag 725 cited on CMS-Form 2567 for complaint survey conducted 28 June 2025. The issues identified in the 2567 were the facility failed to ensure they met the state staffing requirements on 2/27/25. This tag cross references F600. The facility is submitting an IDR for that tag. Cross reference F 550 provides no specific time for allegation of untimely call bell answering. Without data the facility cannot adequately dispute. The facility did in fact have 2 aide callouts, 16 hours on first shift. The Administrator, Nursing Director-due to illness, and scheduler-due to illness, were all out. Regardless, the Administrator and Nursing Director communicated to the facility	

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			throughout the day. The facility made attempts to fill open positions. Ultimately some staff worked long hours during this emergency. The QAD incorrectly indicated that the corporate staff nurse fills in for open positions. Regional staff are not facility staff; they are consultants on completely different payroll. Shift bonus payments were and are frequently offered to entice staff to cover shifts. They are not always effective. Shift bonus payments are at the discretion of the Administrator and Nursing Director. Surveyor documentation cites multiple statements of aides alleging “the assigned work could not be completed, and this occurred all the time.” The aides do not determine the facility staffing pattern. This facility routinely meets Indiana staffing requirements; at times over 3.0PPD. There are of course acts of God we cannot control, and callouts is one such event. The surveyor mentions the facility failed to follow its own facility staffing assessment. This assessment was revised by the current interim administrator incorrectly. This mistake is acknowledged and was corrected. The facts state above support the conclusion that this incident did not occur due to facility	

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			negligence, or lack of trying to organize a staffing response. We request amendment to the citation. Respectfully submitted, Chris Chalman, Administrator	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility staff failed to follow infection control procedures for a resident on Enhanced Barrier Precautions (EBP) for 1 of 1 resident reviewed for infection control. (Resident M) Finding includes: During an observation on 2/28/2025 at 5:20 A.M., CNA 7 and QMA 8 provided peri-care for Resident M, who had an indwelling urinary catheter. Both the CNA and the QMA entered the room and donned gloves but did not don gowns. There was a sign on the wall next to the door in the hallway for Resident M's room that indicated the resident was on Enhanced Barrier Precautions. During an interview on 2/28/2025 at 5:22 A.M., QMA 8 indicated staff never wore gowns for Resident M and she did not know the resident was on EBP even though he had a urinary catheter and a sign was present in the hall. CNA 7 also indicated, at the same time, she did not know the resident was on EBP isolation. A record review was completed on 2/28/2025 at	F 0880	F 880 Infection Prevention and Control What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident M did not experience a negative outcome r/t staff not wearing a gown during care · IP/designee to provide education to licensed and certified nursing staff on conditions that require EBP, signage and on what PPE should be donned before starting high resident care activities high resident care activities. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? · Other residents receiving high resident care activities who meet criteria for EBP have the potential to be affected. These residents will be identified thru med rec review.	03/21/2025

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	5:54 A.M. for Resident M. Diagnoses included, but were not limited to, hemiparesis and hemiplegia to right side, hydronephrosis with ureteral stricture, chronic obstructive uropathy and vascular dementia. An Annual Minimum Data Set (MDS) assessment, dated 2/5/2025, indicated Resident M's cognition was severely impaired, he was dependent for toileting, had an indwelling urinary catheter and needed substantial/maximal assist with bed mobility. Physician Orders included, but were not limited to: -12/3/2024 Enhanced Barrier Precautions - gown and gloves must be worn for the following care: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care or any skin opening requiring a dressing. A current Care Plan, initiated on 7/10/2024, indicated the resident was on EBP for an indwelling urinary catheter and staff should wear gown and gloves for personal hygiene, changing briefs or providing care for a urinary catheter. During an interview on 2/28/2025 at 6:05 A.M., the Director of Quality Assurance indicated staff should have known the resident was on EBP and should have been wearing gowns. On 2/28/2025 at 7:00 A.M., the Director of Quality Assurance provided evidence CNA 7 had received education on EBP on 2/11/2025 and QMA 8 had attended an inservice that included education on EBP on 12/19/2024.		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · IP/designee will provide education on conditions that require EBP, signage and on what PPE should be donned before starting high resident care activities high resident care activities. · IP/designee will complete routine auditing to ensure EBP requirements are being followed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · DON/designee will complete routine auditing during high resident care activities to ensure EBP are being followed Auditing to occur: 4 residents 4 x's/wk x's 30 days, then 4 residents wkly x's 30 days, then 4 residents monthly x's 4 months for a total of 6 months of monitoring The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education and/or disciplinary action, increased frequency and/or duration of reviews will be	

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	On 2/28/2025 at 9:05 A.M., a current policy titled, "Enhanced Barrier Precautions," and dated August 2022, was provided by the Director of Quality Assurance. The policy indicated, "...EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply...." 3.1-18(a)(2)		increased as needed, if areas of noncompliance are identified through the auditing process	