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	04/11/2025

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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00453447, IN00453989 and IN00452803 completed on 2/28/2025. Complaint IN00453447 - Not corrected. Complaint IN00453989 - Corrected. Complaint IN00452803 - Corrected. Unrelated deficiencies are cited. Survey dates: April 10 & 11, 2025 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 2 Medicaid: 63 Other: 1 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 4/21/2025	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	QAA	04/25/2025

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

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	Based on observation, record review and interview, the facility failed to ensure a resident at mild risk for pressure ulcers did not develop an unstageable pressure ulcer for 1 of 2 residents reviewed for pressure injuries (Resident W). Finding includes: A record review was completed for Resident W on 4/10/2025, at 10:46 A.M. Diagnoses included, but were not limited to: hemiplegia/hemiparesis and hyperlipidemia. Resident W was admitted to the facility on 3/26/2025. A Nursing Admission evaluation, dated 3/26/2025 indicated Resident W was at mild risk of developing pressure injuries. In addition, the assessment indicated Resident W had redness to his bilateral buttocks and sacrum but had no open areas. A Nutrition Risk assessment, dated 3/31/2025, indicated Resident W's skin was intact. A Care Plan, revised on 3/31/2025, indicated the resident was at risk for skin breakdown related to impaired mobility. Interventions included, but were not limited to: Assess for changes in skin condition each shift. An Admission Minimum Data Set (MDS) assessment, dated 4/2/2025, indicated the resident's cognition was moderately impaired, he had lower extremity and upper extremity impairment on one side and used a wheelchair for mobility. The MDS indicated the resident was admitted to the facility without any pressure ulcers, was at risk for developing pressure injuries and utilized a pressure reducing device for his	F 0686	*Requesting a Desk Review for these 2 citations* *F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident W's wounds have resolved and no longer has skin impairment DON/designee updated Resident W's Braden Risk Assessment and the plan of care to reflect interventions in place to prevent further unavoidable skin breakdown. **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 skin breakdown have the potential to be affected. DON/designee to ensure current residents have updated Braden assessments and that appropriate interventions are in place to prevent unavoidable pressure wounds for those identified to be at risk. **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	04/28/2025

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	bed. A Weekly Skin Review, dated 4/2/2025, indicated the resident had redness to his right and left buttock and the resident's skin was intact. A Physician's Order, initiated on 4/6/2025 and discontinued the same day, indicated to apply antibiotic ointment to the reddened areas on the buttocks and sacrum then cover the areas with a hydrocolloid dressing (a wound dressing that uses a special gel-forming substance, a hydrocolloid, to create a moist and insulating environment that promotes wound healing and protects the wound from bacteria and other foreign matter) once per day and as needed when soiled. A Braden assessment, dated 4/7/2025, indicated Resident W was not at risk of developing pressure injuries. A Weekly Skin Review, dated 4/7/2025, indicated the following areas: a 1 cm by 1 cm (centimeter) skin sore newly broken open on the resident's left buttock and a 2 cm by 2 cm sore newly broken open on the right buttock and a 1 cm by 1 cm sore newly broken open on the coccyx. A Care Plan, revised on 4/7/2025, indicated the resident had open areas to the right and left buttock. Interventions included, but were not limited to: encourage the resident not to rock back and forth when preparing to standup but to ask for assistance from staff and treatment as ordered The record lacked documentation to show a treatment and preventative interventions were put into place on admission when the resident was admitted with reddened areas to his bilateral		education to nursing associates on the requirement to ensure appropriate interventions are in place to prevent unavoidable pressure wounds for residents identified as being at risk. The plan of care will be updated to reflect those interventions. DON/designee will complete routine auditing of newly admitted residents to ensure that residents identified as being at risk for unavoidable pressure wounds per the Braden risk assessment have appropriate interventions in place and that the plan of care reflect those interventions. **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 of newly admitted residents Braden risk assessment and will ensure that appropriate interventions have been care planned to prevent unavoidable pressure wounds. New admission auditing to occur: 4 newly admitted residents if they exist 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	

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	buttocks and coccyx. A treatment was not started until 4/6/2025. A Weekly Pressure Injury evaluation, dated 4/8/2025, indicated the resident had an unstageable deep tissue injury to his left buttock measuring 0.4 cm by 0.3 cm by UTD (undetermined depth). The resident also had an unstageable deep tissue injury to his right buttock measuring 0.7 cm by 1.9 cm by UTD. The date of onset was documented as 3/26/2025. Additional comments indicated the resident accepted a low air loss mattress but then wanted his original pressure relieving mattress back on the bed. A Wound Care Note, dated 4/8/2025, indicated the resident was being evaluated for an initial consultation for wound care services. The note indicated the resident had areas of redness on his right and left buttock on admission, however the areas opened over the last few days. Wound #1 was documented as an unstageable pressure ulcer to the residents left buttock at full thickness and present on admission. The wound measured 0.4 cm by 0.3 cm by UTD and was 100% scabbed over and crusted. Wound #2 was documented as an unstageable pressure ulcer to the residents right buttock at full thickness and present on admission. The wound measured 0.7 cm by 1.9 cm by UTD and was 70% scabbed and crusted and had 30% hypergranulation. Treatment orders indicated to cleanse with wound cleanser, apply triad paste (a paste that helps maintain a moist wound healing environment to facilitate autolytic debridement) and a clean dressing daily and as needed. Additional comments indicated the treatments were chosen for autolytic debridement and for barrier protection. A Care Plan, revised on 4/8/2025, indicated the		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 increased as needed, if areas of noncompliance are identified through the auditing process.	

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	resident had potential/actual impairment to skin integrity. Interventions included, but were not limited to: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physician. A Physician's Order, initiated on 4/9/2025, indicated to apply triad paste and a clean dry dressing daily and as needed to the right and left buttock wounds. During an interview, on 4/10/2025, at 11:47 A.M. the ADON indicated he only staged the wounds as unstageable because that was what the wound doctor had assessed and staged the wounds as being. He indicated he was not sure why the documentation in the wound note said the unstageable pressure ulcers were present on admission and indicated the resident was admitted with redness to his right and left buttocks but not unstageable pressure ulcers. On 4/10/2025 at 2:05 P.M., Resident W's wounds were observed with the ADON. Resident W's pressure injury to his left buttock was dark in color, was hard and crusted and was approximately the size of a pea. The pressure injury to the resident's right buttock was also dark in color, hard and crusted over and approximately 3/4 of an inch in length and 1/4 of an inch in width. The ADON indicated the wound Nurse Practitioner was going to add an addendum to her wound visit completed on 4/8/2025 that indicated she believed the areas were no longer unstageable pressure ulcers, but instead were wounds caused by trauma from the resident's wheelchair. During an interview, on 4/11/2025, at 9:46 A.M., the wound Nurse Practitioner indicated she first			

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	saw the resident on 4/8/2025. She indicated she staged his pressure injuries as unstageable because she was unable to visualize the wound bed. She indicated she added the addendum to the resident's initial visit on 4/10/2025, but she did not physically come in and assess the resident's wounds on 4/10/2025. On 4/11/2025 at 9:10 A.M., the Administrator provided a policy titled, "Skin and Wound Management System," dated 9/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...4. Preventative intervention will be implemented for residents identified as risk appropriate, for example beds, wheelchair cushions, nutrition, incontinence, therapy etc. These interventions are documented in the medical record based on overall score. Deep tissue pressure injury: Obscured full thickness tissue loss. Full thickness tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough is removed, a stage 3 or stage 4 pressure injury will be revealed...." This deficiency was cited on 2/28/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to complaint IN00453447 3.1-40(a)(1)			
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 failed to ensure staff followed infection control guidelines when completing peri	F 0880	*Requesting desk review for these 2 citations* *F 880 Infection Prevention and*	04/28/2025

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	care for 1 of 1 resident reviewed for incontinence care. (Resident T) Finding includes: During an observation, on 4/10/2025 at 10:26 A.M., Resident T was observed laying on his right side. Resident T indicated the staff had changed his brief earlier in the morning when they had gotten him up for the day. He indicated he did not go to the bathroom to void. The record for Resident T was reviewed on 4/9/2025 at 10:48 A.M. Diagnoses included but were not limited to chronic kidney disease stage, diabetes and mild vascular dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated Resident T had severe cognitive impairment, was frequently incontinent of bladder and always incontinent of bowels and required substantial to maximum assist for transfers and was dependent for toileting needs. During an observation, on 4/10/2025 at 1:52 P.M., CNA 4 entered Resident T's room and explained to him she was going to check him for wetness. CNA 4 applied gloves and untaped the brief. She removed the resident's brief and an incontinence pad that had been inserted in the brief. Both the brief and the pad were soaked with yellow urine. CNA 4 indicated, "I changed him after lunch." Resident T's shirt, along the bottom edge, and the waist band of his pants were also visibly wet with urine. CNA 4 placed a new brief under the residents' buttocks and taped the sides. She removed her gloves and placed them in the trash can.		*Control* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident T was provided with peri-care on 4/10/2025 by nursing staff Licensed nursing staff completed a skin assessment on Resident T on 4/10/2025 with no findings of skin impairment. CNA 4 was provided with education by the DON/designee on providing peri care using appropriate infection control measures and will successfully pass a return demonstration. **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 require assistance with incontinence care have the potential to be affected. IP/designee will provide education to licensed and certified nursing staff on the requirement to provide peri care after incontinent episodes using appropriate infection control measures. **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 to licensed and certified	

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	During an interview, on 4/10/2025 at 2:01 P.M., CNA 4 was asked if when she completed incontinence care, she provide any peri care such as cleaning the resident's skin with soap and water prior to applying a clean brief. CNA 4 indicated she should have washed the residents' peri area. On 4/11/2025 at 9:13 A.M., the Administrator provided the policy titled, "Perineal Care", with a revised date of February 2018, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition... The following equipment and supplies will be necessary when performing this procedure: 1. Wash basin; 2. Towels; 3. Washcloth; 4. Soap (or other authorized cleansing agent); and 5. Personal protective equipment...." This deficiency was cited on 2/28/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(a)		nursing staff on the requirement to provide peri care after incontinent episodes using appropriate infection control measures. IP/designee will complete random skills validations with nursing associates on all shifts who provide peri-care to ensure infection control measures 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 random associate skills validations on all shifts to ensure appropriate infection control measures are being followed when providing peri care. Validations to occur: 3 random associates on all shifts 3 x's/wk x's 30 days, then 3 random associates on all shifts wkly x's 30 days, then 3 random associates on all shifts 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	

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			duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process.	