STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00456358. Complaint IN00456358 - Federal/state deficiencies related to the allegations are cited at F561 and F603. Survey date: April 1, 2025 Facility number: 000134 Provider number: 155229 AIM number: 100275430 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 50 Other: 19 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 4, 2025.	F 0000	This Plan of Correction is to serve as The Woodlands' credible allegation of compliance. By submitting the enclosed materials, The Woodlands nor it's management company are not admitting the truth or accuracy of any specific findings or allegations. The Woodlands reserves 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 the plan of correction be considered our allegation of compliance effective April 8, 2025 to the state findings of the Complaint Survey conducted on April 1, 2025. The Woodlands respectfully requests a desk review.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on observation, record review, and interview, the facility failed to allow residents to continue to gather around the nurses' station, as was their preference and common practice, for 4 of 4 residents reviewed for resident preferences. (Residents C, D, E, & F)	F 0561	F-561 ***The corrective action taken for those residents found to have been affected by the deficient practice is*** the care plans of Resident C,	04/08/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During an interview on 4/1/24 at 11:33 a.m., the Memory Care Activities Director indicated the Divisional Director of Clinical Services (DDCS) had insisted on moving furniture around and taking furniture away in the common areas of the secured unit. Specifically, a table that was in the dining room that was used during activities and meals by staff was removed. The residents enjoyed gathering around the nurses' station to talk with staff and each other. The DDCS indicated to staff they were to return the residents to their rooms following an activity or meals. On occasion, the residents had to be re-directed when they attempted to move a chair from the dining room or down the hall to the nurses' station area. The DDCS also removed tables and chairs from the activities room and the TV lounge. The TV lounge now had no seating and the activities area had only two chairs for residents to sit at a counter, facing the wall to do a puzzle or any other activity. The Memory Care Activities Director felt these changes had caused stress on the unit for the residents and staff and to provide a comfortable environment that they have been accustomed to in the past. There was a lot of confusion. During an interview on 4/1/25 at 11:53 a.m., CNA 3 indicated she felt the residents thought of the area around the nurses' station as a sort of living room area. They would gather there and talk, or rest when walking from the dining room to their rooms down the hallway. She felt the removal of the seating around the nurse's station had caused the residents stress and confusion, as they had nowhere to sit per their usual, and were confused as to what they should be doing and where to go.		Resident D, Resident E and Resident F were reviewed for preferences and all preferences are in place. Three benches were purchased and securely placed in front of the nurse's station for residents and visitors to sit. No resident was identified as being affected in this statement of deficiencies. ***The corrective action taken for the other residents that have the potential to be affected by the same deficient practice*** aan in house audit was completed by the Memory Care Director on preference care plans for residents. Any identified issues will be corrected immediately by date of compliance. Also, three benches were purchased and securely placed in front of the nurse's station for residents and visitors to sit. ***The measures that have been put into place to ensure that the deficient practices does not recur*** education will be provided to staff on self determination and resident preferences. No staff will work past date of compliance without this education completed. Education will be offered upon hire, at least annually and as needed. A recurring meeting was held and will continue to occur between direct staff and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The DDCS directed the staff to move the weight scales from the place in the dining room and to put them in the activities room positioned in front of the window. The staff had weighed the residents at the beginning of each month during an activity to be less disruptive to the residents and complete the task for all residents. With the scales being in the activity room, the task now was disruptive and the scales, in her opinion, were a fall hazard being in an already small room. During an interview on 4/1/25 at 1:47 p.m., CNA 4 indicated the staff had been instructed to move residents to their rooms from the dining room and discourage them from gathering at the nurses's station. The TV lounge was observed with CNA 4 during the interview. There were two chairs placed against the wall facing the TV. A resident was observed seated in one of the chairs watching TV. CNA 4 indicated the staff were aware that the chairs would need to be removed when the DDCS visited again to avoid her becoming upset. The CNA indicated she felt the falls had increased and the changes have contributed to this. 1. Resident C's clinical record was reviewed on 4/1/25 at 3:01 p.m. Diagnoses included schizophrenia, difficulty walking, convulsions, history of falling, and dementia. A current care plan, revised on 8/13/25, indicated the resident had impaired cognitive ability/impaired thought processes related to the diagnoses of dementia. Interventions included to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. An Event Note, dated 3/7/25 at 5:17 a.m., indicated the resident had a fall in her room. She indicated		management to ensure open communication is maintained of resident preferences, routines and changes needed to be made. ***The corrective action taken to monitor to ensure the deficient practice will not recur is that*** the Executive Director/designee will audit the environment for any changes weekly x 8 weeks, then monthly x 4 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. The facility respectfully requests review of the following to support our request for IDR IDR- THE WOODLANDS F tag citation 561 Did the facility fail to comply with CFR(s): 483.10 (f)(1)-(3) (8)—Self-Determination. The answer is NEGATIVE. In support of this IDR the facility submits the following and requests that the citation be removed in its entirety: <u>REGULATION</u>: The regulation reads: 483.10(f)(1)-(3)(8) Self Determination (See exhibit 1) The resident has the right to and the facility must promote and facilitate resident self-determination through support	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to staff she was getting up to go to the bathroom. The resident's call light was in reach but had not been activated. 2. Resident D's clinical record was reviewed on 4/1/25 at 3:08 p.m. Diagnoses included dementia, protein-calorie malnutrition, gastro-esophageal reflux disease (GERD), convulsions, and history of falls. A current care plan, revised on 5/2/23, indicated the resident had GERD. Interventions included, to avoid lying down for at least one hour after eating. Encourage resident to stand/sit upright after meals An Event Note, dated 3/8/25 at 7:00 a.m., indicated the resident had a fall in her room. She was observed in her room, sitting on her bottom with her back against the foot of the bed with her legs extended out. Resident was complaining about her head and the nurse observed a laceration and hematoma to the back of the resident's head. 3. Resident E's clinical record was reviewed on 4/1/25 at 3:11 p.m. Diagnoses included dementia, moderate protein-calorie malnutrition, muscle weakness, heart failure, and dysphagia. A current care plan, revised 1-8/15/24, indicated the resident had specific preferences. Interventions included, that most of the time, the resident chooses not to participate in group activities and prefers to eat her meals in her room. to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. An Event Note, dated 3/8/25 at 2:55 p.m., indicated the resident had a fall in her room and was		of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section: 483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. 483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident 483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility 483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. According to the 2567, *this requirement is not met as evidenced* by: the facility failed to allow residents to gather around the nurses' station as was their preference and common practice for 4 of 4 residents. Residents C, D, E & F.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed sitting on her bottom on the floor with her back against the bathroom door. Her walker was tipped over in front of her. 4. Resident F's clinical record was reviewed on 4/1/25 at 3:19 p.m. Diagnoses included Alzheimer's disease, muscle weakness, dysphagia, major depressive disorder, and history of falls. The resident admitted to the facility 5/15/24. A current care plan, created 5/17/24, indicated the resident was independent/dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. Interventions included, to introduce the resident to residents with similar background, interests and encourage/facilitate interaction. An Event Note, dated 3/8/25 at 11:45 p.m., indicated the resident had a fall in her room. She was found lying on the floor approximately five feet from her bed, lying on her back, arms bent at elbows with hands resting on upper abdomen. Her legs were bent at the knees with the soles of her shoes on the floor. Resident's walker was observed between resident's feet and the bathroom door. A review of the falls on the memory care unit for a Friday, Saturday or Sunday in January, February and March were as follows: In January 2025 there were two falls; in February 2025, there were seven falls on the weekends; and in March there were a total of eight weekend falls on or following 3/7/25, following the changes on the memory care unit. Anonymous interviews were completed during the survey. During an anonymous interview on 4/1/25 at 1:56		To support their argument, the 2567 states, 1 By way of suggestion from the Activity Director (4/1/24), that the removal of furniture, *specifically* a round table in the dining room of the secure unit caused stress on the unit for residents and staff and that the DDCS removed tables and chairs from the (common areas) activity room and the TV lounge. And the DDCS indicated to staff that they were to return the residents to their rooms following an activity or meals. The 2567 states that the 'Memory Care Activity Director' ***felt*** these changes had caused stress on the unit…' 2 During an interview with C N A -3, the statement was made that the DDCS directed them to move the weight scales from the place in the dining room and to put them in the activities room positioned in front of the window. The C N A further stated that 'the staff had weighed the residents at the beginning of each month *during an activity to be less disruptive to the residents*'. 3 During an interview with staff C N A-4, that staff member indicated they were told to move residents from the dining room to their rooms and discourage them from gathering at the nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., it was indicated the removal of the chairs around the nurses' station caused a lot of confusion for the residents. The DDCS had directed the staff to take the residents from the dining room following an activity or meal to their rooms to watch TV or into the TV lounge which now had no seating. The scale being placed in the small activities room was a trip hazard being in front of the windows. During a telephone interview on 4/1/25 at 2:36 p.m., the facility's previous DON who resigned recently due to the stress caused by the DDCS, indicated falls had increased on the memory care unit following the rapid changes. She knew of four falls that occurred the weekend following the removal of the seating around the nurses' station and the seating in the activities and TV lounges. The staff had verbalized concerns regarding the changes and the effect they would have on the residents. The DDCS ignored the staff concerns. The residents who fell over that weekend, were know to sit at the nurses' station when leaving the dining room before continuing to their rooms. She felt the residents routine and continuity had been affected by the multiple rapid changes. The residents were confused and upset. During an interview on 4/1/25 at 3:12 p.m., an anonymous resident representative indicated they visited routinely. They felt changes like the ones that had been made were difficult for memory care residents to manage. The residents loved sitting together around the nurses' station, and they were very surprised and dismayed that the facility removed the chairs. They asked the staff why the chairs had been removed and they responded that "corporate said they could not have them there anymore." There's a little room that they normally used to visit their relative, and it was nice because		station. C N A-4 also indicated that she '*felt*' that the falls had increased, and the changes have contributed to this. In response to the allegations the facility avers the following facts. 1 There are no dates in the statement of deficiencies (2567) which indicate when furniture was moved, removed or by whom. There is nothing to indicate that the surveyor was aware of any dates that furniture was moved, removed or by whom, and did not request information regarding replacement seating or other services to be provided on the dementia unit. a While the round table was to be removed from the activity room, the Activity Director did not provide the surveyor with any type of information or reasoning provided to him prior to its requested removal and replacement. In addition to the circular table in the TV room, there were counter height table/chairs which did not allow for proper seating for residents to be able to reach the table top, and the initial statement by the Activity Director was actually in regard to a 4-foot white folding table in the dining room, which was previously pushed up against the windows, between two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	they didn't have to squeeze into the resident's room and disturb their roommate. The TV room had seating and was mostly private for their visit. They came in for a visit, and suddenly all the furniture and seating was gone. They could not have visits in that room any longer unless they all stood, including their relative. They felt it was very inconvenient and uncaring to do this without any notice or explanation. During an interview on 4/1/25 at 3: 24 p.m., the Regional Director of Clinical Services (RDCS) indicated his goal had been to improve the memory care unit and get residents more involved with activities such as using the life stations (i.e.,baby station, work bench, games, puzzles, etc.) His thought was by removing the chairs around the nurses' station, and the table and chairs out of the TV room, it might encourage the residents to use the physical objects. He now felt that removing the table and chairs from the TV room was premature when considering the residents would need a place to sit to watch the television. He and the Divisional Director of Clinical Services (DDCS) were using this facility as a pilot for memory care units in the state and were trying new things to engage the residents. They planned to ask the staff at some point for suggestions, but wanted to try some things first. He had not followed up with the memory care staff since making the changes, to see if the changes had been positive or negative, or if the changes had been effective at engaging the residents at the life stations. During a telephone interview on 4/1/25 at 3:53 p.m., the DDCS indicated her goal was to improve the quality of the day-to-day activities for the residents. She felt these changes would enhance the memory care unit. She felt having chairs at the		dining tables. The Activity Director had previously said he did not use this table for any activities for the residents. As residents see square objects more clearly, it was decided there should be a square table in the TV room (where the life station dryer is). Having this type of table would allow residents to sit at it more comfortably and they would be able to reach the tabletop. It would also provide a folding area for the towels and washcloths which were purchased specifically for this life station area. The Activity Director did not advise the surveyor that changes were in the process of being made. In addition, the removal of a 'round' table from the dining room has no impact on the requirement cited as 'not met.' The removal of the table has nothing to do with allowing residents to gather around the nurses' station. b The Activity Director indicated that he was told the residents should be returned to their rooms after an activity or a meal. This concept allows the staff to provide toileting time and/or a nap if the resident is tired. It was not meant to be punitive but is a general standard of practice to toilet residents after a meal and/or after activities. It is also common practice to have residents nap during the day if they choose to or need to. Again,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurses' station was not something she wanted to see. The residents could fall when trying to sit down. She would expect the staff to toilet the residents and encourage a nap following group activities and meals. The tables were removed from the activities room due to them being circular, and people with dementia do not do well with circular tables. The table in the activity room was square, but taller than she felt was safe, and the corners could cause injury. She also felt it was a fall hazard. Her plan was to replace the tables and chairs in time. The plan was to starting with this facility and make unit a premier memory care unit. She had not reached out to the staff, the Administrator, nor the DON to obtain feedback on the current changes that had been made. She would have liked the staff to embrace these changes better. She felt she had included the staff and asked for suggestions, but none of the staff provided any feedback. A current facility policy, reviewed 11/19/24, titled, "Resident Rights," provided by the Administrator on 4/1/25 at 4:32 p.m., included the following: "...The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section...Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States." This citation relates to complaint IN00456358. 3.1-3(u)(3)		returning residents to their room for toileting or a nap following a meal has no impact on the requirement cited, as 'not met'. It has nothing to do with allowing residents to gather around the nurses' station. c The Activity Director for the unit ***"felt"*** that the changes caused stress on the unit. This 'feeling' is purely subjective. There is no proof that the changes caused any stress to residents at the facility. d The 2567 does not provide a 'date' that any furniture was removed or changed out. In fact, the facility, in the process of making the dementia unit a more comfortable homelike unit, had added seating benches for residents, allowing them to sit together as opposed to single chairs. The facility also added a life station to include baby furniture (a crib and a changing table), life like baby dolls, a clothes dryer, a clothes hamper and towels/washcloths. It is noted that the 2567 does not address the fact that changes were in the process of being made, to make the unit more homelike and amiable to residents with dementia. 2 While C N A-3 stated that the DDCS directed the staff to remove the weight scale from the dining room, the removal of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			weight scale from the dining room has no impact on the requirement in the regulation cited as 'not being met'. The weight scale has nothing to do with allowing residents to gather around the nurses' station. In addition, the facility was attempting to ensure a more comfortable dining experience by making the dining room more of a homelike atmosphere- during a meal. The weight scale does not add to the dining room ambiance and in fact would take away from it. It should be noted that the public, in general, does not keep a weight scale in their dining room so it was solid reasoning to remove it from the resident dining area. In addition, C N A -3 indicated that the residents were weighed monthly, during an activity to be less disruptive to the residents. This statement is not consistent with 'being less disruptive to residents'. The residents have a potential for being interrupted during an activity should the staff obtain weights during the activity. The placement of the weight scale would have no bearing on resident choices / preferences and does not support giving the facility a citation for failure to allow residents to gather around the nurses' station. C N A-3 is not a trained social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			worker or psychologist or psychiatrist. She does not hold an advanced degree which would lead one to rely on her 'opinion'. The 2567 states that 'C N A-3 ***'felt'*** the removal of the seating around the nursing station had caused the residents stress and confusion.' Her 'feelings' are purely subjective and not factual. Residents C, D, E & F have shown no changes in their respective behaviors, nor have they shown any signs of mental anguish or distress, as noted further in the IDR. In addition, C N A-3 only provided the surveyor with her 'feelings' which again are not facts. She did not provide the surveyor with information that changes were in the process of being made. 4 C N A-4 stated to the surveyor that "she ***felt*** the falls had increased and the changes contributed to this". The information provided by C N A-4 is purely opinion based. She has provided inaccurate information to the surveyor all based in assumption and again not based upon facts. C N A-4 has, and had, no intimate knowledge regarding resident falls and was not personally part of the IDT fall investigations or follow up. The falls listed as supporting evidence in the 2567 are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			inaccurately portrayed to tie the falls in with any changes made on the memory care unit. This portrayal is fundamentally unfair as all of the falls listed in the 2567 occurred in the resident rooms. There is no trend and nothing in the documentation of any fall to support that 'changes' on the unit contributed to the falls. As a matter of fact, each of these falls listed in the 2567 were before any changes were made to the memory care unit. On 3/19/25, a walking tour was completed with the DDCS, the RVP, the Administrator and RDCS for the region. In addition, other regional staff toured with this team. Recommendations for changes were not completed until after 3/19/25. Therefore, any attempt to tie the falls listed in with changes to the unit furniture was inaccurate and purely conjecture. a Resident C had a fall as indicated in the 2567 @ 0517 on 3/7/25. The fall occurred in her room while she was attempting to go to the bathroom. It had nothing to do with a change in furniture, in the dining room or on the unit and was not related to residents gathering at the nursing station. b Resident D had a fall in her room @ 0700 on 3/8/25. Resident D stated she was 'getting up out of bed and going to the dining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			room for breakfast and lost her balance.' This fall had nothing to do with a change in furniture, in the dining room or on the unit and was not related to residents gathering at the nursing station. c Resident E had a fall in her room @ 2:55PM. She stated she 'sat on the floor'. This fall had nothing to do with a change in furniture in the dining room or on the unit and was not related to residents gathering at the nursing station. d Resident F had a fall in her room @ 11:45PM. She stated she 'really did not know how she fell' but was able to state that she stood up out of bed, attempted to walk from the bed and fell. Her walker was between her feet and the bathroom. This fall had nothing to do with a change in furniture in the dining room or on the unit and was not related to residents gathering at the nursing station. 5 The anonymous interviewee indicated that a 1) the removal of chairs around the nurses' station caused a lot of confusion for the residents, b 2) the DDCS directed staff to take the residents from the dining room to their room or to the TV lounge which had no seating and c 3) the scale being placed in the activity room was a trip hazard being in front of the windows'.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Without additional information to identify the credentials of the person, the statements are incredulous at best. 1a) The anonymous interviewee stated 'the removal of chairs caused a lot of confusion for the residents. Where is the proof that the residents had increased confusion? What credentials does this person have to be able to state that there was increased confusion? Especially in light of the fact that the MD and nursing documentation reveal no increased confusion.. (See NN and MD notes below) 2a) As previously stated, it is common practice and a best practice to toilet residents following meals and/or activities and allow them to rest if they choose to do so and 3a) The scale being a trip hazard in the activity room is a matter of opinion. To wit: there have been no falls associated with the scale. 6 The anonymous resident representative interview indicated that the person ***felt*** that the changes were difficult for memory care residents to manage. As noted above, there is no additional information provided which indicates the credentials of the person or that the person has more than a nonprofessional opinion to offer. The statements made by this resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			representative are repeated words from disgruntled staff. Even minor changes to the work routine are difficult for some staff to manage. 7 The interview with the prior DON indicated that the 'falls had increased on the memory care unit following the rapid changes. She further stated that she "knew of 4 falls that had occurred over the weekend following the removal of the seating" however the 2567 does not state which weekend. The only dates the facility must go on are ones that are referenced as the annual survey dates and just before the dismissal of the prior DON. The prior DON was inaccurate in her portrayal of the falls. A review of the falls for all of March was completed and with tracking/trending completed there was no direct or indirect correlation between the falls and any changes made to furniture on the memory care unit. While there was an increase in the total number of falls, for the month, the tracking / trending revealed no common date, time or reason for the falls. Only one of these residents had more than 1 fall during March and it was directly related to a UTI and incontinent episode related to the UTI. None of the falls occurred near the nursing station and none occurred	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			due to the weight scale. The IDT reviews clearly indicate the reasons for the falls were other than a change in furniture placement as the cause of the falls for each resident. As a matter of fact, each of these falls listed in the 2567 were before any changes were made to the memory care unit. On 3/19/25, a walking tour was completed with the DDCS, the RVP, the Administrator and RDCS for the region. In addition, other regional staff toured with this team. Recommendations for changes were not completed until after 3/19/25. Therefore, any attempt to tie the falls listed in with changes to the unit furniture was purely inaccurate and conjecture. The prior DON's last day was 3/14/25 and the walking tour was not completed until 3/19/25 therefore, any attempt by the prior DON to tie the falls listed in with changes to the unit furniture was again inaccurate and purely conjecture. # 1 3/2/25 9:45 AM (Crump) Sitting on floor at exit door Positive for UTI 3/3 IDT root cause- increased confusion r/t UTI – sat herself on the floor (Exhibit # 2) # 2 3/3/25 7:35 AM	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			(Fern) Attempting to toilet herself, in room, Had an incontinent episode and fell 3/3/25 IDT incontinent episode related to diarrhea (Exhibit # 3) # 3 3/7/25 4:30 AM (Evans) Fell in room attempting to toilet 3/10/25 Place call bell within reach while she is in bed & Assist with toileting upon rising, before/after meals & @ HS (Exhibit # 4) # 4 3/8/25 7 AM (Johnson) Getting out of bed and lost her balance 3/10/25 Place call bell within reach while she is in bed (Exhibit # 5) Seen by NP on 3/14/25 r/t confusion/increased malaise & otitis media. Decreased ability to hear reported. Started on Cipro 0.3% otic drops in each ear 4 times daily for 5 days and referral to audiologist (See exhibit _5A__ Abode care Partners note 3/14/24) # 5 3/8/25 2:55 PM (Brown) Fell in room with walker tipped over IDT root cause note 3/10/25 determined to be related to weakness. Hospice collaboration to improve weakness / balance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			(See exhibit # 6) # 6 3/8/25 11 PM (Mills) Fell in room @ HS IDT discussed root cause of fall on 3/10/25 & determined it is weakness at hs/bedtime. Res walker is to be removed from her reach and w/c placed within reach to assure safe transfers during the night. See exhibit #7 # 7 3/16/25 3 PM (Hart) Fell in dining room during activity when she was attempting to stand up from a chair IDT note: 3/26 Stood up from a chair in the dining room and told staff she 'lost her balance" (See exhibit # 8) # 8 3/23/25 3:45 PM (Jackson) Noted on floor in dining room. Had just learned his wife had passed away. IDT note 3/24 IDT review –appears he sat himself on the floor after hearing the news (Exhibit # 9) # 9 3/27/25 12:30 AM (Crump) Sitting in room on floor in urine. Has a UTI, Self transferring to bathroom IDT note 3/27/25 Continued UTI –self transfer to toilet Exhibit # 10 # 10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			3/29/25 12 AM (Dragoo) Fell from bed 3/31/25 IDT review root cause: unwitnessed fall from bed. Bed to be in low position with mat beside bed Exhibit # 11 The prior DON's last day was 3/14/25. Any fall that occurred outside of a resident room occurred after her last day thus she would not have had knowledge of any falls that occurred in the dining or activity areas. As noted above, a resident fell in the dining room while attempting to stand up from a seated position in a chair, (with staff present) and a resident placed himself on the floor following upsetting news that his wife had passed. The prior DON attributed the increase in falls 'over the weekend' to the removal of the seating around the nurses' station. She further stated that the residents that fell 'that weekend' were known to sit at the nurses' station when leaving the dining room before continuing to their rooms. This statement was pure conjecture on her part as a review of each of the falls that occurred on weekends to include 3/7/25 & 3/8/25 revealed that each of the 4 residents fell in their rooms, not while walking back to their room and not near the nursing station.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			There was no trend related to the fall times. As a matter of fact, as stated above, each of these falls listed in the 2567 were before any changes were made to the memory care unit. As a matter of fact, each of these falls listed in the 2567 were before any changes were made to the memory care unit. On 3/19/25, a walking tour was completed with the DDCS, the RVP, the Administrator and RDCS for the region. In addition, other regional staff toured with this team. Recommendations for changes were not completed until after 3/19/25. Therefore, any attempt to tie the falls listed in with changes to the unit furniture was inaccurate and purely conjecture The prior DON also stated that she resigned due to the stress caused by the DDCS. It is obvious from the prior DON statements that she holds animosity towards the DDCS and is obviously projecting feelings of anger and resentment toward her. A review of the resident Activity attendance records as well as social services notes and GuideStar Psych Services notes or MD/NP notes have been reviewed for residents C, D, E & F. **Resident C:** A review of the social services notes, activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			participation notes and MD notes indicate that the resident has shown no increase in behaviors or confusion. She has ongoing behaviors related to multiple diagnoses. ***Social Services behavior notes: (See exhibit 12)*** 4/2/25 "IDT met at this time for behavior management. Resident exhibited 12 episodes of repetitive health concerns." There are no other care management notes related to behaviors and none that indicate this resident had increased behaviors or anxiety as a result of furniture being moved on the memory care unit. ***Activity Participation notes: (See exhibit 13)*** Activity participation notes show continued attendance at activities with active participation during entire month of March. There was no decrease in interest or participation ***Psych notes : 4/3/25:*** (See exhibit 14) "Chief Complaint / Nature of Presenting Problem: 85 year old female being seen for evaluation and treatment with GS psych services for dementia and depression. Pt has a history of schizophrenia diagnosis and also of taking olanzapine. Per SS she is not currently on psychotropics and *no behavioral notes per staff with the*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			exception of obsessive behaviors. Recent testing indicates that she has major depression and severe cognitive impairment. Per SS notes however she displays unimpaired memory. She is asleep at the time of our visit and did not wake when called. We will re-assess her at a future visit to try to discern memory impairment and depression grade. Schizophrenia evaluation will be ongoing as well". **Resident D:** A review of the social services notes, activity participation notes and MD notes indicate that the resident has shown no increase in behaviors or confusion. She has ongoing delusions, hallucinations and consistent behaviors related to cognitive decline related to dementia. There is no reason to suspect a decline in her overall condition, or that confusion increased or occurred as a result of furniture being moved in the memory care unit. **Social Services behavior notes**: (See exhibit 15-A,B,C,D) 11/20/24 " increased confusion and increased agitation. Resident believes her husband is still alive and adamant that she seen and spoke with him this morning. Ambulating around her room "stepping on all the bugs" Staff present at this time and floor is clear of insects and/or objects… Residents behavior improves	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			temporarily but reoccurring" 3/19/25 Late entry: "Resident exhibits episodes of delusions as evidence by, resident looking for husband, wanting to call husband and wandering…Residents behavior improves temporarily but reoccurring" 4/8/25 "Resident is exit seeking coming down the hall carrying jacket and blanket with no walker or w/c." 4/10/25 "Resident exhibiting increased confusion and hallucinations/delusions as evidence by, seeing her husband, seeing girls walking around. **Activity notes: (See exhibit 16)** Activity participation notes show continued attendance at activities with active participation during entire month of March. There was no decrease in interest or participation **PSYCH notes: (See exhibits 17)** 3/21/25: Pt referred for psychological evaluation and treatment to establish care for ongoing monitoring and management of mood and behaviors. Pt has a history of dementia and anxiety Session Summary: During session resident presented as neutral, with congruent affect. Resident described that she is doing okay. She reports she has no pain. She says she is eating	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and sleeping well. She reports no issues or complaints. She denies depression and anxiety. Pt is calm and appears in no distress. Pt reports that she has been at activities this morning and did her exercise. Staff report no change in pt's emotional or behavioral status at this time. Utilized supportive therapy, reorientation, redirection and neurocognitive stimulation to assess, explore and promote adaptive management of negative affect and anxiety. No SI/HI or AVH endorsed/evidenced during session. Will F/U. 4/10/25 : "4/10/2025 ___ is being seen today for f/u of psych services and also for possible GDR. She is discussed in IDT meeting. Nrsg do not voice any concerns or new behaviors. IDT agrees that the pt is due for a GDR of cymbalta. **Resident E:** A review of the social services notes, activity participation notes and MD notes indicate that the resident has shown no increase in behaviors or confusion. She has ongoing behaviors including agitation consistent with cognitive decline related to dementia. There is no reason to suspect a decline in her overall condition, or that confusion increased or occurred as a result of furniture being moved in the memory care unit. ***Social services (psychosocial)***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			notes; *(See exhibits 18-A,B,C,D,)* 3/14/25: “Resident continues to become agitated with others. At times, another resident will just be walking down hallway and resident will become irritated and stomp her walker. Most of the time, resident chooses to remain in her room. She talks on the phone to daughter, Kathy. Daughter reports to staff, resident exhibits verbal aggression towards family during phone calls and visits” 4/2/25: “IDT met at this time for Behavior Management. Resident exhibited 3 behaviors of increased agitation. Resident becomes irritated with peers and staff to continue to redirect, as needed. Resident has a dx of Unspecified Dementia, unspecified severity with other behavioral disturbance. Dx of Cognitive Communication Deficit. She receives no psychotropic medication. She resides in secure unit. Psych evaluation complete on 3/5/25 per family and hospice request r/t resident's mood” 4/3/25: “Resident's mood per her normal. Resident becomes irritable with peers. Resident returns from LOA with daughter, Kathy. Resident exhibits being argumentative and short-tempered with daughter. Psych evaluation complete with no new orders.” 4/4/25: “Resident's mood per her normal. Resident becomes easily irritated by others”	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Activity notes: (See exhibits 19) Activity participation notes show continued attendance at activities with active participation during entire month of March. There was no decrease in interest or participation. 4/4/25 note: "Resident was in dining room while bingo was being played. She does become irritable to peers" **Psych notes: (see exhibit 20)** 3/13/25 : "Chief Complaint / Nature of Presenting Problem: ____ is a 95-year-old woman with symptoms of dementia being seen and evaluated by Guidestar for depression. Her PHQ was negative patient spoke very complementary of the staff and the food. She told me multiple times she worked in a hospital so she knows how it can be and she is very grateful. She is in bed napping and appears comfortable. She denies any anxiety or depression. She is appropriately groomed. Her statements are repetitive. She cannot tell me how old she and remembers that the food is good but cannot tell me her favorite meal. She is mildly confused and unable to remember many things History Of Present Illness: Note 3/13/25 ____ is a 95 y/o with dementia who has been residing at the Woodlands Muncie for almost a year. She had COVID	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and then became paranoid. She was admitted for evaluation and care. She used to be an aid in a hospital. She had been living alone with help from her family until she became ill. ____ is a 95-year-old woman with symptoms of dementia being seen and evaluated for depression PHQ was negative patient spoke very complementary of the staff and the food. She told me multiple times she worked in a hospital so she knows how it can be and she is very grateful. She is in bed napping and appears comfortable. She denies any anxiety or depression. She is appropriately groomed. Her statements are repetitive. She cannot tell me how old she and remembers that the food is good but cannot tell me her favorite meal. **Resident F:** A review of the social services notes, activity participation notes and MD notes indicate that the resident has shown continued behaviors ongoing since admission. She can show pleasant confusion but then have aggression, wandering, hallucinations and show confusion. These ongoing behaviors are consistent with cognitive decline related to dementia. There is no reason to suspect a decline in her overall condition, or that confusion or anxiety increased or occurred as a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			result of furniture being moved in the memory care unit. **Social services /Care management note:** **(See exhibits 21- A, B)** 4/2/25: "IDT met on this day. Resident has reported behaviors of delusions x's3, verbal aggression x's 1, wandering x's 3, hallucinations x's 2 and increased confusion x's 3. Resident has had a total of 12 reported behaviors in the last 30 days... Resident continues on behavior management... Behavior monitoring in place. No new recommendations at this time." 3/17/25 (Late entry-behavior note) "Note Text: Resident exhibits episodes of increased confusion and wandering such as, looking for her mother, looking for her son ___ (who is deceased), looking for the teacher, looking for her car, and to call her father... Behavior improves temporarily when redirected by staff but reoccurring. MD notified. Psych notified. Family notified. Family is aware of reoccurring behavior and in agreement that this is resident's cognitive baseline. **Activity notes:** (See exhibit 22) Activity participation notes show continued attendance at activities with active participation during entire month of March. There was no decrease in interest or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			participation. **Psych services note**: (See exhibit: 23 A, B) 3/13/25 "___ is pleasantly confused when I see her. She smiles a lot and her thoughts and speech are a little disorganized. She is groomed and eating well. *Nursing denies any new concerns or behaviors.* 3/27/25 "___ is being followed for continuation of psych services today. She is seen at the table waiting for lunch. She smiles and nods but doesn't speak today. She is pleasantly confused. No acute changes since last visit." In closing, any person completing a 'reasonable man's test' would conclude that that the intent of the regulation is / was met. The residents have continued with activity programming without a decrease in participation, The recorded falls had nothing to do with a change to furniture placement as evidenced by the fall IDT notes. All falls had clear root cause analysis and did not occur near the nursing station. Social services & MD documentation clearly indicates that residents C, D, E & F behaviors were already present, are ongoing in nature and directly related to cognitive decline related to dementia. There is no documentation that the residents were having	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			increased anxiety, increased behaviors or issues related to the change in furniture placement at the time or anytime after. The comments made by staff, the prior DON and anonymous persons, were what they 'felt'. Feelings are not facts. Feelings are subjective. The 'feelings' of staff and others does not prove that any resident had increased confusion, had an increase in falls and resident behavior documentation does not support the 'feelings' of staff or others. MD notes do not indicate a change to resident demeanor or behaviors related to furniture placement. As a matter of fact, as stated above, each of these falls listed in the 2567 were before any changes were made to the memory care unit. The furniture that was moved was not moved until after the completion of a walking tour with the DDCS, the RVP, the Administrator and RDCS for the region, which included other regional staff. The prior DON last day was 3/14/25 and the walking tour was not completed until 3/19/25. Therefore, any attempt by the prior DON or C N A-4 to tie the falls listed in with changes to the unit furniture was purely inaccurate and conjecture. The facility did not fail to allow residents to gather around the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			nurses' station or any place else. The facility did not prevent residents from sitting together. The residents continue to gather and sit together now on new comfortable benches that had been ordered by the facility and obtained to replace individual chairs. The removal of old chairs did not interfere with the residents choosing to gather. The intent of the regulation as listed in the regulation has not been violated. The residents were not denied the right to choose or attend activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care The residents were allowed and not denied the right to make choices about aspects of his or her life in the facility that are significant to the residents. The residents were not denied the right to interact with members of the community and participate in community activities both inside and outside the facility The residents maintained the right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			At the end of the citation, a policy titled Residents Rights was quoted. "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section…Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States." At no time was the facility in violation of residents' rights for a dignified existence, self-determination, communication etc. The facility was in fact attempting to improve a more dignified existence for each resident on the unit. For the reasons stated with supporting documentation, the facility respectfully requests that the citation F 561 be reviewed and removed in its entirety.	
F 0603 SS=D Bldg. 00	483.12(a)(1) Free from Involuntary Seclusion Based on record review and interview, the facility failed to prevent a resident's involuntary seclusion by placing her in an activity room, alone and without explanation as to the reason for the deviation from her normal preferred activity and routine, for 1 of 1 residents reviewed for involuntary seclusion. (Resident B) Finding include:	F 0603	F-603 ***1 The corrective action taken for those residents found to have been affected by the deficient practice is*** Resident B was not found in the TV lounge. No resident was identified as being affected in this statement of deficiencies.	04/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/1/25 at 11:23 a.m., the Administrator indicated the Divisional Director of Clinical Services (DDCS) had been visiting the facility about once a month. She had been in the building Tuesday through Friday during the recent Annual Survey, which completed on 3/7/25. The facility's memory care unit was currently being focused on as a pilot unit for the corporation, so her main focus during her visits had been on the memory care unit. During an interview on 4/1/25 at 11:53 a.m., CNA 3 indicated Resident B enjoyed sitting outside the nurse's station. Resident B felt she was the Executive Director of the unit and liked to make sure "things were running smoothly." During a recent visit, the DDCS moved the resident from the nurse's station area and directed her into the activities room. She had the resident sit at the counter in the room and then turned and walked away, leaving the resident alone. CNA 3 indicated she went into the activities room as Resident B appeared confused. Resident B indicated to her, "What did I do wrong? Why have they put me in here by myself? Am I in trouble?" CNA 3 indicated it had been upsetting seeing the resident's distress and wondered why the DDCS moved Resident B to sit in a room by herself, when her normal routine was to "supervise" the nurse's station. During an interview on 4/1/25 at 1:47 p.m., CNA 4 indicated she overheard Resident B talking with CNA 3. The resident sounded sad and confused as to why she had to sit in that room and could not understand what she had done wrong. CNA 3 removed the resident from the activities room and assisted her to the dining room with other residents.		***The corrective action taken for the other residents that have the potential to be affected by the same deficient practice*** education was provided to facility staff on resident rights and dignity including involuntary seclusion. ***The measures that have been put into place to ensure that the deficient practices does not recur*** all residents have the potential to be affected. Education was provided to facility staff on resident rights and dignity including involuntary seclusion. ***The corrective action taken to monitor to ensure the deficient practice will not recur is that*** Executive Director/designee will visibly tour the unit to ensure no voluntary seclusion of any resident daily x 8 weeks, , then weekly x 4 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits The facility respectfully submits the following in support of our request for IDR: Did the facility fail to comply with CFR(s): 483.12 (a)(1) Free from Involuntary Seclusion. The answer is NEGATIVE. In support of this IDR the facility submits the following and requests that the citation F 603 be removed in its entirety.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an telephone interview on 4/1/25 at 3:53 p.m., the DDCS indicated having chairs around the nurses station was not something she personally wanted to see. The residents could fall when trying to sit down. She would have liked the staff to better embrace the changes being made. Resident B's clinical record was reviewed on 4/1/25 at 10:21 a.m. Diagnoses included Alzheimer's disease, severe protein-calorie malnutrition, and history of stroke. She admitted to the facility on 5/5/23. A significant change minimum data set (MDS) assessment, dated 3/19/25, indicated the resident had moderate cognitive impairment, used a walker for mobility, self transferred, and had no behaviors or rejection of care during the assessment period. A current care plan, revised on 9/16/24, indicated the resident had impaired cognitive ability and impaired thought processes related to the diagnoses of dementia. Interventions included to keep the resident's routine consistent. A current facility policy, reviewed 11/19/24, titled, "Area of Focus: Abuse & Neglect," provided by the Administrator on 4/1/25 at 4:32 p.m., included: "What....Each resident has the right to be free from abuse, neglect,...This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms." This citation relates to complaint IN00456358. 3.1-27(a)(4)		The statement of deficiencies (hereafter referred to the 2567) from the complaint survey dated 4/1/25 indicates/alleges that Resident B was placed in the activity room by the DDCS and left alone. The facility was cited under F 603—Free from Involuntary Seclusion. (Exhibit #1) Of utmost importance is the fact that the statement of deficiencies (2567) does not provide a definitive date, a time or a day that the alleged occurrence took place. Not withstanding that issue, is the fact that the DDCS does not make rounds alone without either the Regional Director of Clinical Services or the Administrator. Discussion with both of these persons revealed that the incident as reported by C N A-3 & C N A-4, did not occur as reported to the surveyor. (Exhibit #2 & Exhibit # 3) It is equally important to note that the interviews with C N A-3 and C N A-4 do not indicate a date, a time or a day that the alleged occurrence took place. (Exhibit #4) “The interview with the Administrator on 4/1/25 at 11:23 AM: indicated that the Divisional Director of Clinical Services (DDCS) had been visiting the facility about once a month. She had been in the building Tuesday through Friday during the recent Annual Survey, which completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			on 3/7/25. The facility's memory care unit was currently being focused on as a pilot unit for the corporation, so her main focus during her visits had been on the memory care unit. "During an interview on 4/1/25 at 11:53 a.m., C N A 3 indicated Resident B enjoyed sitting outside the nurse's station. Resident B felt she was the Executive Director of the unit and liked to make sure "things were running smoothly." During a *recent visit* the DDCS moved the resident from the nurses' station areas and directed her into the activities room. She had the resident sit at the counter in the room and then turned and walked away, leaving the resident alone. C N A-3 indicated she went into the activities room as Resident B appeared confused. Resident B indicated to her, "What did I do wrong" Why have they put me in here by myself? Am I in trouble? C N A 3 indicated it had been upsetting seeing the resident's distress and wondered why the DDCS moved Resident B to sit in a room by herself. When her normal routine was to "supervise" the nurse's station. C N A-3 removed the resident from the activities rooms and assisted her to the dining room with other residents. "During an interview on 4/1/25 at 1:47PM, C N A-4 indicated she	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			overheard Resident B talking with C N A-3. The resident sounded sad and confused as to why she had to sit in that room and could not understand what she had done wrong. The statements set forth by C N A-3 & C N A-4 are laden with innuendo as the following will show. (By definition, innuendo is an allusive or oblique remark or hint, typically a suggestive or disparaging one) If C N A-3 personally observed the DDCS take Resident B in the activity room and leave her there, then C N A-3 was present, and had to be present in order for her to observe the interaction or she would not have known Resident B was in the room. And it stands to reason, that if C N A-3 was present, Resident B was not left alone in the room therefore there could not be an incident of Involuntary Seclusion. In the alternative, if C N A-3 was not present during the alleged incident, then she would not have knowledge that Resident B was placed in the activity room without providing Resident B with an explanation as to why she was moved to the activity room. If C N A-4 overheard the conversation between Resident B	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and C N A-3 then the resident was not alone at that time either. C N A-4 did not state that she observed the DDCS take Resident B into the Activity room. She only stated that she heard the conversation between Resident B and C N A-3. It should be noted that the activity room referenced in the statement of deficiencies has an open doorway with ease of access and is directly across from the nurses' station. (See exhibit 5) The T V room is a separate room and further down the hall. Interview with the DDCS: (Exhibit #6) During a telephone interview on 4/1/25 at 3:53PM, the DDCS indicated having chairs around the nursing station was not something she personally wanted to see. The residents could fall when trying to sit down. She would have liked the staff to better embrace the changes being made". The surveyor interview with the DDCS on 4/1/25 never addresses Resident B being moved to the activity room, by her or anyone else. The interview only addresses the chairs at the nurse's station. The DDCS was only questioned about 'chairs' and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			was not afforded an opportunity to discuss or refute the statements made and the innuendo supplied by C N A-3 & C N A -4 which were used to cite the facility. Referring back to the interview with the Administrator, (Exhibit # 7) he stated that the DDCS had been visiting the facility about once a month and that she had been in the building Tuesday through Friday during the recent annual survey, which was completed on 3/7/25. During the Administrators interview, he was only questioned about when the DDCS is in the facility and the memory care unit focus as a pilot program. At no point during the interview, was there a reference to Resident B or a question about the alleged incident. It is fundamentally unfair to state that someone, in this case the DDCS, did something, which caused the facility to be cited at F 603 when the statements provided to the surveyor by C N A-3 & C N A-4 are not factual with dates/times and have their opinion interlaced. A review of the Resident B's care plan (See Exhibit 8) specifically under choice/preferences reveals that there is no reference to Resident B liking to sit at the nurses station OR her supervising	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the unit to make sure things are running smoothly." If this is / was the resident preference, C N A – 3 and C N A-4 have not shared that information with the IDT team. Thus other staff would not be aware that sitting at the nursing station is a preference or a routine. A review of Resident B's mobility status revealed that she is on restorative for ambulation and walks about 220' with the use of a walker. (Exhibit # 9) At any given time, she was free and able to move about the unit ad lib, to include leaving the activity room if she so desired. A review of the Behavior notes for the entire month of March 2025 revealed that there is no reference of a behavior… as indicated in the interviews for the C N A's. C N A-3 & C N A-4 indicated that the resident was confused and/or sad/distressed. If this was the case, on any day in March, the C N A's did not report such to the charge nurse or to Social Services for intervention. There were no behaviors (allegedly occurring) reported by staff to the SS designee or to the charge nurse or to the IDT team and none documented. A social services note dated 3/14/25 states "appears to be in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			good spirits. No signs or symptoms of distress noted" (See exhibit #10) Additionally, a review of the activity participation log (See exhibit #11) reveals that the resident had no decrease in activity participation at any time during the month. A care plan meeting/IDT review was completed on 3/25/25 as follows. 3/25/25 -- Care plan meeting/IDT review : (Exhibit # 12) Note Text: Care plan meeting held on this day. Resident does not attend. Son _____ in attendance via telephone. IDT in attendance. Resident is here for long-term care and wishes to remain at The Woodlands. She resides in secure unit r/t elopement risk. Followed by GuideStar psych services. Reviewed dx/medication with no concern. Reviewed weight/diet. Resident was last seen by Podiatry on 12/19/24, Optometry on 2/2/24, Dental on 10/7/24 and Audiology on 2/7/25. No concerns voiced in these areas. Regular Diet, Regular Texture, Thin Const. Advance Directives reviewed, and resident remains DNR. Family voices no concerns at this time. Care plan reviewed and revised, as needed 3/5/25 MD notes: Session Summary (Encounter note) Exhibit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			# 13 During session resident presented as neutral, with congruent affect. Resident described that she has no pain. She says that she eats well but has some difficulty with sleep at times. She is smiling, calm and pleasant throughout visit, appearing in no distress. She says that she tries to take care of herself as well as she can. She reports that she has no other issues or complaints. When asked about depression, she says that at times the weather can get her down. She denies anxiety. Staff report pt's moods and behaviors are mostly stable, pt can be overly directive with other pts at times, but staff state that this is pt's typical behavior. Utilized supportive therapy to assess, explore and promote adaptive management of negative affect and depression. No SI/HI or AVH endorsed/evidenced during session. In conclusion, there is no evidence to prove the facility failed to meet the regulation and nothing to support being cited at F 603 -Free from Involuntary Seclusion. There are no nursing or behavior notes to indicate that the alleged incident took place Resident B had no change to activity participation. Either C N A-3 was present to see Resident B being left alone,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			in which case Resident B was not alone, OR C N A-3 was not there and could not attest to Resident B not being given an explanation as to the 'deviation' from normal routine. The 'normal routine' as stated by the C N A's is not part of the plan of care under routines/preferences (See exhibit #8) The Mood care plan (See exhibit #14)reveals that the resident has a history of depression and exhibits episodes of sad mood and negative statements. During the PHQ-9 Resident B voiced feeling down, depressed, hopeless, feeling tired/little energy & trouble concentrating. Both C N A 3 & C N A-4 made it appear as if the episode of sadness, they reported to the surveyor as if this was something new when the care plan and psych documentation clearly states there is a history of the behavior. The DDCS did not make rounds alone and the people accompanying her on rounds, specifically the RDCS and the Administrator, have denied the event took place. Since there is only one C N A that alleged the event occurred and both the RDCS and Administrator indicated that the event never occurred, it stands to reason that there is nothing supporting the statement in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			2567 from C N A-3. (Refer to exhibits #2 & #3) F 603 appears to be a personal attack against the DDCS from staff that do not wish to make changes to “their normalcy.” For the reasons stated, the facility respectfully requests that citation F 603 be removed in its entirety. The citation was based on innuendo and supposition and is without merit as there are no facts to support the allegation and citation.	