DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 09			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			

MPLETED 155086 B. WING 06/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 343 S NAPPANEE ST WOODLAND MANOR ELKHART, IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 By submitting the enclosed conducted by the Indiana Department of Health in materials, we are not admitting the accordance with 42 CFR 483.73. truth or accuracy of any specific findings or allegations. We reserve Survey Date: 06/11/24 the right to contest the findings or allegations as part of any Facility Number: 000034 proceedings and submit these Provider Number: 155086 responses pursuant to our AIM Number: 100274880 regulatory obligations. The facility requests that the plan of At this Emergency Preparedness survey, correction be considered our Woodland Manor was found not in compliance allegation of compliance effective with Emergency Preparedness Requirements for July 4th, 2024 to the life safety Medicare and Medicaid Participating Providers survey completed on June 11th, and Suppliers, 42 CFR 483.73 2024. We respectfully request a paper review and will provide any The facility has 80 certified beds. At the time of additional information requested. the survey, the census was 67. Quality Review completed on 06/18/24 E 0018 403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) SS=F and (v), 441.184(b)(2), 482.15(b)(2), Bldg. --483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6) (ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b) (1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(a) of this section, risk assessment at

TITLE (X6) DATE

Katherine Wright Administrator 07/04/2024

Any defiency statement 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 disclodays 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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		JILDING	NSTRUCTION	(X3) DATE COMPI 06/11	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	communication pla section. The polici reviewed and upd [annually for LTC	of this section, and the can at paragraph (c) of this es and procedures must be cated at least every 2 years facilities]. At a minimum, cocedures must address						
	on-duty staff and s [facility's] care dur on-duty staff and s relocated during th must document th	m to track the location of sheltered patients in the ing an emergency. If sheltered patients are ne emergency, the [facility] e specific name and eiving facility or other						
	§483.73(b), ICF/III §460.84(b):] Polici system to track the and sheltered resi ICF/IID or PACE] emergency. If on- residents are reloce emergency, the [F PACE] must docu	41.184(b), LTC at Ds at §483.475(b), PACE at les and procedures. (2) A le location of on-duty staff dents in the [PRTF's, LTC, care during and after an led duty staff and sheltered leated during the leated during the leater an leater an leater an leater an leater an leater an leater and leater an leater an leater an leater an leater an leater and leater an leater and						
	Policies and proce (ii) Safe evacuation includes consideraneeds of evacuee transportation; ide location(s) and pring of communication assistance.	spice at §418.113(b)(6):] edures. In from the hospice, which ation of care and treatment s; staff responsibilities; intification of evacuation mary and alternate means with external sources of ack the location of hospice						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
the hospice's care the on-duty emplo are relocated duri hospice must doc and location of the location. *[For CMHCs at § procedures. (2) So CMHC, which incl and treatment nee responsibilities; tra of evacuation loca	ty and sheltered patients in a during an emergency. If eyees or sheltered patients ing the emergency, the ument the specific name is receiving facility or other. 485.920(b):] Policies and afe evacuation from the udes consideration of care add of evacuees; staff ansportation; identification attion(s); and primary and of communication with					
*[For OPOs at § 4 procedures. (2) A documentation the actual donor information, and separated availability of procedures. (2) Separated availability of reconstruction of the residents are relocated and procedures. (2) Separated and procedures and procedures and procedures included to ensure employed and procedures are relocated to ensure employed and procedures	86.360(b):] Policies and system of medical at preserves potential and mation, protects otential and actual donor ecures and maintains the rds. 94.62(b):] Policies and afe evacuation from the	E 0018	What corrective action(s) will accomplished for those residents found to have been affected by the alleged deficipractice: No residents were found to habeen affected by the alleged deficient practice. How other residents have the potential to be affected by the	n ient ve		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION TO SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIEF AND MANOR	A.	343 S N	NAPPANEE ST RT, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) identified and what corrective	5.112
	06/11/24 at 12:10 p that include a syster on-duty staff and sh facility's care during available for review policy stated the Ac tracking residents b tracking log was av the time of record r "no actual log" for the The finding was rev and the Maintenanc conference.	view with the Administrator on .m., no policies and procedures in to track the location of heltered residents in the LTC g and after an emergency was v. Based on record review the diministrator is responsible for ut no policy, procedure or ailable. Based on interview at eview, the Administrator stated tracking was available. Viewed with the Administrator he Director during the exit		action(s) will be taken: All residents and staff have the potential to be affected by the alleged deficient practice. What measures will be put in place and what systemic changes will be made to ensithat the alleged deficient practice does not recur: The Administrator/Designee hereated a tracking log to track location of on-duty staff and sheltered residents in the LTC facility's care during and after emergency. How the corrective action(s) be monitored to ensure the alleged deficient practice with not recur, i.e., what quality assurance program will be pinto place: The Administrator/Designee wereview the tracking log and an negative findings will be immediately remedied. The reof the review will be addressed the Quality Assurance Process Improvement committee mont in the Quality Assurance Meet The date the systemic change will be completed: July 4th, 2024	e nto ure as the an will ut vill y sults d by shly ing.
E 0032 SS=F Bldg	441.184(c)(3), 482 483.73(c)(3), 484	6.54(c)(3), 418.113(c)(3), 2.15(c)(3), 483.475(c)(3), 102(c)(3), 485.625(c)(3), 727(c)(3), 485.920(c)(3),			

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486.360(c)(3), 491.12(c)(3), 494.62(c)(3)

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024		
	PROVIDER OR SUPPLIEI	₹	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST IRT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	§403.748(c)(3), § §441.184(c)(3), § §441.184(c)(3), §4 §483.73(c)(3), §4 (3), §485.920(c)(3), §491.12(c)(3), §4	nust develop and maintain eparedness communication is with Federal, State and list be reviewed and updated ears [annually for LTC mmunication plan must following: Iternate means for ith the following: Iternate, tribal, regional, and local gement agencies. [\$483.475(c):] (3) Primary ans for communicating with pederal, State, tribal, all emergency management	E 0022			
	failed to ensure the communication pla alternate means for following: (i) LTC tribal, regional, or l agencies in accorda	view and interview, the facility emergency preparedness in includes (3) Primary and communicating with the facility's staff (ii) Federal, State, ocal emergency management ance with 42 CFR 483.73(c) (3). iice could affect all occupants.	E 0032	What corrective action(s) will accomplished for those residents found to have been affected by the alleged deficipractice: No residents were found to hat been affected by the alleged deficient practice. How other residents have the potential to be affected by the alleged deficient practice will alleged deficient practice will	n ient ve e e	07/04/2024

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Based on review of the facility's Emergency

Preparedness Plan (EPP) with the Administrator

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identified and what corrective

action(s) will be taken:

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	ſ ′	JILDING	ONSTRUCTION		SURVEY LETED 1/2024
	PROVIDER OR SUPPLIER AND MANOR		-	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST IRT, IN 46514	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
	preparedness plan d alternate means for interview at the tim Administrator was documentation or e means of communic	xplain a primary and alternate			All residents and staff have potential to be affected by the alleged deficient practice. What measures will be put place and what systemic changes will be made to expect that the alleged deficient practice does not recur: The Administrator/Designee updated the primary and altown means of communication from facility to (i) LTC facility's stafederal, State, tribal, region local emergency management agencies in accordance with CFR 483.73(c) (3) in the even an emergency. How the corrective action(be monitored to ensure the alleged deficient practice with place: The Administrator/Designeer review the primary and alter means of communication for emergency preparedness plany negative findings will be immediately remedied. The of the review will be address the Quality Assurance Proceeding the Quality Assurance Means of the Completed: July 4th, 2024	into insure has ernate om the aff (ii) al, or ent i 42 ent of evill evill mate the an and results sed by ess nthly eting.	
E 0039 SS=F		3.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2)					

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		IDENTIFICATION NUMBER 155086	 UILDING	NSTRUCTION	COMPL 06/11/	ETED
	PROVIDER OR SUPPLIER		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg	483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §48 §483.475(d)(2), §48 §485.625(d)(2), §49 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.99 §491.12, and ESR (2) Testing. The [faction of the entire of	102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §485.73(d)(2), 184.102(d)(2), §485.920(d), 8494.62(d)(2). 16.54, CORFs at §485.68, 200, RHCs/FQHCs at 10 Facilities at §494.62]: 18.113(d)(2), 9485.920(d), 9494.62(d)(2), 9495.727, 9495.72				

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER 155086	ľ	UILDING	nstruction 	COMPL 06/11/	ETED
	F PROVIDER OR SUPPLIER			343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
	led by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and enthe [facility's] emeth [facility'	ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and nation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not lect an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. dditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		UILDING	NSTRUCTION	(X3) DATE COMPL 06/11/	ETED	
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	led by a facilitator discussion using a clinically-relevant set of problem sta messages, or pre to challenge an er	emergency scenario, and a tements, directed pared questions designed mergency plan.						
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engage full-scale community (a) the community of the emergency exempt from engage (b) the emergency exempt from engage (c) the emergency exempt from engage (c) the emergency exempt from engage (c) the emergency event (c) the exercise (c) the	nunity-based exercise is not lect an annual individual extional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the						
	that may include, following: (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the h	ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086 A. BUILDING B. WING			COMPLETED 06/11/2024			
	PROVIDER OR SUPPLIEF	2	343 S N	DDRESS, CITY, STATE, ZIP COD APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU	exercises, and em	nergency events and revise ergency plan, as needed.	TAU			DATE
	§482.15(d), CAHs (2) Testing. The [If conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community. (A) When a commaccessible, condutacility-based function (B) If the [PRTF, If an actual natural of that requires activate plan, the [facility] its next required from individual, facility following the onse (ii) Conduct exercise or and the limited to the following the onse (C) A second full-community-based facility-based function (B) A monomorphism (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an error (iii) Analyze than maintain docutabletop exercises	PRTF, Hospital, CAH] must a to test the emergency ar. The [PRTF, Hospital, following: an annual full-scale exercise abased; or nunity-based exercise is not act an annual individual, stional exercise; or Hospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency as exempt from engaging in all-scale community based ty-based functional exercise at of the emergency event. In [additional] annual at may include, but is not wing: escale exercise that is or individual, a stional exercise; or ack disaster drill; or a exercise or workshop that for and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. The [facility's] response to amentation of all drills, and emergency events				
	or individual, facili following the onse (ii) Conduct a exercise or and the limited to the following to the facility-based facility-based facility-based facility-based facility-based facility-based facility-based facility-based function (B) A more (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or prefet to challenge an ere (iii) Analyze the and maintain documents.	ty-based functional exercise et of the emergency event. an [additional] annual eat may include, but is not wing: escale exercise that is or individual, a etional exercise; or eck disaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a etements, directed pared questions designed mergency plan. the [facility's] response to umentation of all drills,				

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	NT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155086	 UILDING	NSTRUCTION	COMPL 06/11/	ETED
	PROVIDER OR SUPPLIEF	R	343 S N	.ddress, city, state, zip cod APPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	conduct exercises plan at least annu organization must (i) Participate in a that is community (A) When a commaccessible, conduction facility-based function of the exempt from enfull-scale community-based functional exercise of this section is community-based functional exercise of the exempt full-community-based functional exercise functional exercises of this section is community-based functional exercise functional exercises of this section is community-based functional exercises functional exercises of problem star messages, or preto challenge an el (iii) Analyze the Functional exercises, and emercises	PACE organization must a to test the emergency cally. The PACE and the following: an annual full-scale exercise abased; or cally-based exercise is not not an annual individual, actional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE agaging in its next required cally based or individual, actional exercise following the gency event. In additional exercise every the year the full-scale or a under paragraph (d)(2)(i) conducted that may include, to the following: ascale exercise that is a or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed				

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	OF CORRECTION	IDENTIFICATION NUMBER 155086	ì í	UILDING	INSTRUCTION	COMPL 06/11/	ETED
	PROVIDER OR SUPPLIEF	3		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to test the emerge year, including un the emergency pr ICF/IID] must do to (i) Participate in a that is community (A) When a commaccessible, conducting facility-based functions and that matural or requires activation LTC facility is exercipated a full-scalindividual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional of (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the [I response to and response to and relative to the community that the com	ity] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, he following: an annual full-scale exercise based; or nunity-based exercise is not act an annual individual, etional exercise. ility] facility experiences an man-made emergency plan, the mpt from engaging its next alle community-based or based functional exercise at of the emergency event. In other emergency event. In other emergency event. It is not limited to the exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086		UILDING	NSTRUCTION	(X3) DATE COMPL 06/11/	ETED
	OF PROVIDER OR SUPPLIED	3	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION DATE
	exercises to test to twice per year. The following: (i) Participate in a sthat is community (A) When a community (A) When a community (B) If the ICF/IID of the facility-based function of the ending is exempt from endill-scale community-based function onset of the emer (ii) Conduct an activation of the emer (ii) Conduct an activation of the emer (ii) Conduct an activation onset of the emer (iii) Conduct an activation onset of the emer (iii) Conduct an activation onset of the emer (iii) A facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an endility in the community of the ICF/IID's emer (iii) Analyze the IC maintain document exercises, and endit in the ICF/IID's emer (d)(2) Testing. The exercises to test to least annually. The following:	he emergency plan at least he ICF/IID must do the in annual full-scale exercise based; or munity-based exercise is not not act an annual individual, ctional exercise; or. experiences an actual ade emergency that requires imergency plan, the ICF/IID agaging in its next required inity-based or individual, ctional exercise following the gency event. Iditional annual exercise but is not limited to the individual, ctional exercise that is in or an individual, ctional exercise; or iter drill; or exercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop mergency events, and revise regency plan, as needed.					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ATE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	is not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-ma activation of the exempt from enga full-scale commur facility based functionset of the emer (ii) Conduct an adyears, opposite the functional exercise of this section is conclude, but is not (A) A second community-based facility-based functionally-relevant is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an en (iii) Analyze the H maintain document exercises, and enthe HHA's emerged *[For OPOs at §44 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper service or contained to the conduct a paper service of the conduct a paper service of the conduct a paper service of the conduct a paper service or conduct and conduct a paper service or conduct and con	A experiences an actual ade emergency plan, the HHA is aging in its next required nity-based or individual, ational exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is a or an individual, ational exercise; or isaster drill; or present exercise or workshop that for and includes a group a narrated, emergency plan. HA's response to and antation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency land. The following: er-based, tabletop exercise.						
	1	ast annually. A tabletop a facilitator and includes a						

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Event ID:

MRF721 Facility ID: 000034

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086			A. BUILDING B. WING		COMPLETED 06/11/2024	
	ROVIDER OR SUPPLIER		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	relevant emergency problem statement prepared question emergency plan. It actual natural or marequires activation OPO is exempt from required testing extensive of the emergency (ii) Analyze the OF maintain document exercises, and emithe [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paperate at least annually. A group discussion In narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain document exercises, and emithe RNHCl's emer Based on record revisited to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based.	PO's response to and station of all tabletop ergency events, and revise OPO's] emergency plan, as a RNHCI must conduct the emergency plan. The efollowing: ex-based, tabletop exercise a led by a facilitator, using a relevant emergency et of problem statements, as, or prepared questions ange an emergency plan. SHCI's response to and station of all tabletop ergency events, and revise gency plan, as needed. It is an an interview, the facility ercises to test the emergency er year, including strills using the emergency C facility must do the sannual full-scale exercise that the control of all tabletop ergency er	E 0039	What corrective action(s) will accomplished for those residents found to have been affected by the alleged deficient practice: No residents were found to have been affected by the alleged deficient practice.	n i ent ve	
	a. when a communi	ty-based exercise is not		How other residents have the	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r f			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPLETED
		155086	B. W	TNG		06/11/2024
				STREET 4	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	£			NAPPANEE ST	
WOOD! 4	AND MANOR				RT, IN 46514	
				LLINIA	, 70017	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	· ·	an annual individual,			potential to be affected by th	
	facility-based funct				alleged deficient practice wi	
	b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt				identified and what corrective	⁄e
					action(s) will be taken:	
					All residents and staff have th	
	from engaging its next required full-scale				potential to be affected by the	
	-	community-based or individual, facility-based			alleged deficient practice.	
		l exercise for 1 year following			What measures will be put in	nto
	the onset of the actu				place and what systemic	
	1 1	itional exercise that may			changes will be made to ens	sure
		mited to the following:			that the alleged deficient	
	a. A second full-scale exercise that is				practice does not recur:	
	community-based or an individual, facility-based				The Administrator/Designee w	
	functional exercise.				participate in an annual full-sc	
	b. A mock disaster				exercise that is community ba	
	_	se or workshop that is led by a			and a second full-scale exerci	se
		des a group discussion, using			that is facility based within a	
		y relevant emergency scenario,			12-month period and provide	
	-	n statements, directed			documentation of any exercise	
		red questions designed to			test the emergency preparedr	ness
	challenge an emerg				plan. The facility will be	
		C facility's response to and			collaborating with the Elkhart	
		ation of all drills, tabletop			County Community Foundatio	n to
		gency events, and revise the			complete our two tabletop	
	-	gency plan, as needed in			exercises. The facility's	
	accordance with 42	CFR 483.73(d)(2).			emergency preparedness plar	n will
		11.00 11			be updated accordingly.	
	This deficient pract	ice could affect all occupants.			How the corrective action(s)	will
	TO 11 1 1 1				be monitored to ensure the	
	Findings include:				alleged deficient practice wi	
	D	tal at a A 1 of the co			not recur, i.e., what quality	,
	-	w with the Administrator on			assurance program will be p	out
	-	.m., the facility was unable to			into place:	,,,
	-	tion of any exercises to test			The Administrator/Designee w	/III
		aredness plan conducted			review the tabletop/full-scale	
	•	nonths. Based on interview at			exercises and any negative	
		eview, the Administrator			findings will be immediately	
		reises had been done during			remedied and the facility	
		en at the facility, and she was			emergency preparedness plan	
	not aware of any do	cumentation of previous			be updated. The results of the	;

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2024		
	PROVIDER OR SUPPLIER			343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and Maintenance D	viewed with the Administrator irector during the exit a time both stated the facility an exercise during the time nat facility.			review will be addressed by the Quality Assurance Process Improvement committee mont in the Quality Assurance Meet The date the systemic change will be completed: July 4th, 2024	hly ing.	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/11 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this LSC survey, not in compliance w Participation in Med Subpart 483.90(a), 1 2012 edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2. This one story facility Type II (000) constricts sprinklered. The factory with smoke detection open to the corridor detectors in the resi- partially protected by	00034 55086	KO	0000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We resulted the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect July 4th, 2024 to the life safety survey completed on June 11th 2024. We respectfully request paper review and will provide additional information requests	cic serve s or sility tive / h, a	

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PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-039

XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	A. BU	JILDING	nstruction 01		ETED
		343 S N	APPANEE ST		
STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 had a census of 67 at the					
d means of egress shall not a latch or a lock that a latch or a lock that a tool or key from the susing one of the following angements: OR SECURITY THREAT congramments for the locks of the patient are locking device shall be door and provisions shall pid removal of occupants of locks; keying of all locks; keying of all locks; keying of all locks; keying of all locks; locking arrangements for the locks arrangements for the locking arrangements for the locking arrangements and locking requirements and locking requirements and locking the locked locke					
	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and had a census of 67 at the apleted on 06/18/24 If a tool or key from the susing one of the following angements: OR SECURITY THREAT It ing arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1, LOCKING Sing arrangements for the expansion and provision and provision and provision and provision are with the patient are used, all of the patient are used	at the state of the state of the state of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the sepatient are used, all of urity Locking requirements addition, the locks must be trail safely so as to of power to the device; the ed by a complete smoke or is constantly monitored ation within the locked	A. BUILDING 155086 STREET A 343 S N ELKHAR TATEMENT OF DEFICIENCIE TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and had a census of 67 at the Appleted on 06/18/24 Id means of egress shall not a latch or a lock that if a tool or key from the a using one of the following angements: OR SECURITY THREAT Iting arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1, LOCKING Sting arrangements for the expatient are used, all of urity Locking requirements addition, the locks must be the fail safely so as to of power to the device; the ed by a supervised or system and the locked by a complete smoke or is constantly monitored ation within the locked	A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514 TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION and had a census of 67 at the alach or a lock that a tool or key from the using one of the following angements: OR SECURITY THREAT ding arrangements for the eds of the patient are king device shall be door and provisions shall pid removal of occupants of locks; keying of all ad by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1, LOCKING Sing arrangements for the ed patient are used, all of urity Locking requirements addition, the locks must be tf ail safely so as to of power to the device; the dby a supervised r system and the locked by a complete smoke or is constantly monitored attion within the locked attion within th	IDENTIFICATION NUMBER 155086 A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514 TATEMENT OF DEFICIENCIE ID PREFIX TAG PREFIX TAG TO STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514 ID PREFIX TAG PREFIX TAG TAG PROVIDERS PLAN OF CORRECTION SIDELD BIS PROVIDED SIDELD

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2024		
	PROVIDER OR SUPPLIEF		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	systems are arran upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, superior detection system automatic sprinklet 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controllection installed in according to be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exit accordance with 7 on door assemblied throughout by an automatic fire detection approved, supervisystem. 18.2.2.2.4, 19.2.2	ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S elayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted les in buildings protected leapproved, supervised lection system and an lesed automatic sprinkler 2.4 2.4			
	failed to ensure the 7 exit doors in the f for residents withou specialized security required means of e with a latch or lock or key from the egrepermitted by LSC 1	on and interview, the facility means of egress through 2 of facility were readily accessible at a clinical diagnosis requiring measures. Doors within a gress shall not be equipped that requires the use of a tool ess side unless otherwise 9.2.2.2.4. Door-locking be permitted in accordance	K 0222	What corrective action(s) we accomplished for those residents found to have been affected by the alleged deficiency. The facility will have the exist of codes posted in a manner of which that staff and visitors of readily access the door to exist premises in the case of an	en cient door an

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMPL 06/11/	ETED
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(VA) ID	CIDOLADY	CTATEMENT OF DEFICIENCIE		ID			0/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	R LSC IDENTIFYING INFORMATION	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		SC 7.2.1.5.3 requires if provided,		TAG			DATE
		iire of a key, a tool, or special			emergency. How other residents have the		
	_	t for operation from the egress					
	_	practice could affect			potential to be affected by the		
	approximately 20 r	-			alleged deficient practice wi identified and what corrective		
	approximately 201	esidents and starr.			action(s) will be taken:	/e	
	Findings include:				The alleged deficient practice	had	
	i manigs metade.				the potential to affect all resid		
	Based on observati	on with the			staff and visitors.	cino,	
		ntenance Assistant on			What measures will be put in	nto	
	06/11/24 at 09:52 a.m., the emergency exit door at				place and what systemic	no	
	the main entrance was marked as a facility exit,				changes will be made to ens	sure	
	was magnetically locked, and could be opened by				that the alleged deficient	,u. 0	
	entering a four-digit code on the access control				practice does not recur:		
		vas not posted at the exit.			A quality assurance audit tool	will	
	_	nergency exit door leading			be put into place to monitor		
		emory care unit was marked as			means of egress to doors not		
	a facility exit, mag	netically locked, and could be			equipped with a latch or a locl		
	unlocked entering a	a four digit code. When asking			that requires a tool to open.		
	the the Housekeepe	er/Maintenance Assistant if			Education provided to all staff	:	
	they knew the code	e, he stated that he had a few			How the corrective action(s)	will	
	codes in mind, but	after trying to enter the codes			be monitored to ensure the		
	they did not unlock	the door. Furthermore, when			alleged deficient practice wi	11	
	_	ent staff members who work			not recur, i.e., what quality		
		gnated for the memory care			assurance program will be p	out	
	unit did not know t	he code for the emergency exit.			into place:		
		at the time of observations,			An audit will be completed by		
	•	Iaintenance Assistant agreed			Maintenance/Designee on all	door	
	_	ecial knowledge of the code to			codes posted weekly for four		
	_	ency exit. He also confirmed			weeks, then monthly for five		
		e emergency exit at the front			months. Any negative findings		
	entrance was remov	ved.			be immediately remedied, and		
					Administrator notified. The res		
		reviewed with Maintenance			of the audits will be reviewed	-	
		nistrator during the exit			the Quality Assurance Commi		
	conference.				monthly in the Quality Assura	nce	
	2.1.10(1-)				Meeting.		
	3.1-19(b)				The deal deal deal deal deal deal deal dea		
					The date that systemic chan will be completed:	ges	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155086	B. WI	NG		06/11/	/2024
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				NAPPANEE ST		
WOODLA	AND MANOR			ELKHART, IN 46514			
		THE TENTE OF DEPLOYERS	1		,		775
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	KEGULATUKY OR	LSC IDENTIFYING INFORMATION	+	TAG			DATE
					July 4th, 2024		
K 0271	NFPA 101						
SS=E	Discharge from Ex	xits					
Bldg. 01	Discharge from Ex						
] 5	-	irranged in accordance with					
	_	vel walking surface meeting					
	· •	'.1.7 with respect to					
	-	on and shall be maintained					
	_	s. Additionally, the exit					
		a hard packed all-weather					
	travel surface.	·					
	18.2.7, 19.2.7						
	Based on observation	on and interview, the facility	K 0	271	It is the intent of the facility to		07/04/2024
	failed to maintain 1	of 8 exit discharges in			maintain egress were provided	d	
	accordance with NF	TPA 101 Section 7.7 as required			with an unobstructed level wal	lking	
	_	Section 7.7.1.1 state that the			surface.		
	_	be of the required width and			What corrective action(s) will	ll be	
		ccupants with a safe access to			accomplished for those		
		leficient practice could affect			residents found to have been	n	
	approximately 15 re	esidents and staff.			affected by the alleged defic	ient	
					practice:		
	Findings include:				No residents were found to be		
					affected by the alleged deficie	nt	
	Based on observation				practice.		
		ntenance Assistant on			How other residents have the		
	_	our of the facility from 09:50			potential to be affected by the		
	-	the exit discharge leading from			alleged deficient practice will		
		it to the back of the building,			identified and what correctiv	re	
		care dining room, had two			action(s) will be taken:		
	_	in front of the emergency exit			Potentially all residents, staff a		
	_	interview at the time of			visitors in the memory care un		
		usekeeping/Maintenance			could be affected by the allege		
		dged that the chairs were			deficient practice, no residents	5	
		scharge from a designated			were identified.	.4.	
	had an emergency e	later confirmed that the door			What measures will be put in	ıιυ	
	nau an emergency e	an sign.			place and what systemic	uro	
	This finding was re	viewed with the Maintenance			changes will be made to ens that the alleged deficient	ui e	
	-	uistrator at the exit conference.			practice does not recur:		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(x3) date survey completed 06/11/2024
	PROVIDER OR SUPPLIE	R	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			The Maintenance Director/Designee will audit all doors on the facility to ensure there are no obstructions in fro of the emergency exit dischars How the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be p into place: An audit will be completed by Maintenance/Designee on all d doors of the facility weekly for weeks, then monthly for five months. Any negative findings be immediately remedied, and Administrator notified. The res of the audits will be reviewed to the Quality Assurance Process Improvement meeting monthly The date the systemic chang will be completed: July 4th, 2024	that ont ge. will ut exit four will ults by s
K 0346 SS=F Bldg. 01	Fire Alarm - Out of Where required fit services for more period, the author be notified, and the evacuated or an aprovided for all pashutdown until the been returned to 9.6.1.6	re alarm system is out of than 4 hours in a 24-hour rity having jurisdiction shall be approved fire watch shall be arties left unprotected by the e fire alarm system has	K 0346	What corrective action(s) wil	T be 07/04/2024
		complete policy for the	K 0340	accomplished for those	0//04/2024

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Event ID:

MRF721 Facility ID: 000034

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r ´			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED
		155086	B. W	ING		06/11/2024
				CTREET	ADDRESS CITY STATE ZID COD	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	
MOODL	AND MANOD				IAPPANEE ST	
WOODLA	AND MANOR			ELKHA	RT, IN 46514	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	protection of reside	nts indicating procedures to			residents found to have been	n
	be followed in the e	event the fire alarm system has			affected by the alleged defic	ient
	to be placed out of	service for four hours or more			practice:	
	in a twenty four hour period in accordance with LSC, Section 9.6.1.6, as required by LSC Section				No residents were found to ha	ive
					been affected by the alleged	
	19.3.4.5.1 which red	quires an automatic smoke			deficient practice.	
	detection system in	accordance with Section 9.6.			How other residents have the	e
	This deficient pract	ice affects all occupants.			potential to be affected by th	
	_	-			alleged deficient practice wil	
	Findings include:				identified and what corrective	
	_				action(s) will be taken:	
	Based on record rev	view with the Administrator			All residents, staff and visitors	
	and Maintenance Director on 06/11/24 at 9:55 a.m.,				have the potential to be affect	
	a fire watch policy titled "Fire Watch Status" was				by the alleged deficient praction	
	produced. However, the plan did not address the				What measures will be put in	
	following items:				place and what systemic	
	-	s to when a fire watch shall be			changes will be made to ens	ure
		stage of more than 4 hours in a			that the alleged deficient	
	24-hour period				practice does not recur:	
	b) The provided pla	n did not address that fire			The facility policy has been	
	watch shall be cond	lucted by trained personnel			updated to reflect a) the time	
	c) The provided pla	n did not address personnel			frame as to when a fire watch	shall
		watch shall have no other			be conducted (out-of-service	
	duties and solely as	signed to fire watch			4hrs)b)that fire watch sha	all be
	Based on interview	at the time of record review,			conducted by trained personn	
	the Maintenance Di	rector acknowledged the			C)Personnel designated for	r fire
	missing elements of	f a fire watch and further stated			watch shall have no other duti	es
		ould be implemented if			and solely assigned to fire wat	tch.
	"working on gas or	something like that."			How the corrective action(s)	
					be monitored to ensure the	
	This finding was re	viewed with the Administrator			alleged deficient practice wil	ıı
	and Maintenance D	irector during the exit			not recur, i.e., what quality	
	conference				assurance program will be p	ut
					into place:	
	3.1-19(b)				Education will be provided to a	all
					new hires and an audit will be	
					completed by	
					Maintenance/Designee weekly	y for
					four weeks, then monthly for fi	
					months. Any negative findings	
			1			I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUI A. BUII		INSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155086	B. WIN		01	06/11/	
	PROVIDER OR SUPPLIE	R		343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	NEGOEM TONT O	K ESC INE. TING IN CRIMINION			be immediately remedied, and Administrator notified. The resof the audits will be reviewed the Quality Assurance Commitmentally in the Quality Assurance Meeting. The date of systemic change will be completed: July 4th, 2024	sults by ttee nce	
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of systel inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA	supply source RKS information on					
	automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observating failed to maintain to smoke compartment gases around the space to operate at a spece 2010 edition, 8.5.4 the sprinkler deflections		K 03:	53	It is the intent of the facility to maintain ease of accessible access to the automatic sprint system. What corrective action(s) will accomplished for those residents found to have been affected by the alleged defice	II be n	07/04/2024

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	/EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED)
		155086	B. W	ING		06/11/2024	4
		l .		STDEET /	ADDRESS, CITY, STATE, ZIP COD	l	
NAME OF F	PROVIDER OR SUPPLIER	8			IAPPANEE ST		
WOOD!	AND MANOR				RT, IN 46514		
VVOODL/	WAD MICHOU			LLINIA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	MPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	1 - 1	n. This deficient practice			practice:		
	could affect approx	imately 20 residents and staff.			No residents were found to be		
	TO 11 1 1 1				affected by the alleged deficie	nt	
	Findings include:				practice.		
	December 1				How other residents have the		
	Based on observation with the				potential to be affected by the		
	Housekeeping/Maintenance Assistant on				alleged deficient practice wil		
	06/11/24 between 09:50 a.m. and 12:18 p.m., in the				identified and what corrective	e	
	memory care unit, next to the double corridor doors leading into the service hall, one sprinkler				action(s) will be taken:	and	
	head on the ceiling had an approximately 1/4" gap				Potentially 20 residents, staff a visitors could be affected by the		
	between the escutcheon plate and ceiling tile.				alleged deficient practice.		
	Based on interview at the time of observation, the				What measures will be put in	nto	
	Housekeeping/Mair				place and what systemic		
		innular space and indicated			changes will be made to ens	ure	
	that it was not smok	-			that the alleged deficient		
					practice does not recur:		
	Findings were discu	issed with the Maintenance			The ¼" gap was immediately f	illed	
	_	nistrator at exit conference.			with a fire protectant sealant		
					between the escutcheon plate	and	
	3.1-19(b)				ceiling tile.		
					How the corrective action(s)	will	
					be monitored to ensure the		
					alleged deficient practice wil	<i>'</i>	
					not recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					An audit will be completed by		
					Maintenance/Designee to mor		
					for any gaps in fire rated doors		
					around sprinkler heads weekly		
					four weeks, then monthly for fi		
					months. Any negative findings		
					be immediately remedied, and		
					Administrator notified. The res		
					of the audits will be reviewed the Quality Assurance Commit	- 1	
					the Quality Assurance Commi		
					monthly in the Quality Assurar	ice	
					Meeting.		
			1		The date the systemic chang	ie	

STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	X3) DATE SURVEY COMPLETED 06/11/2024
	PROVIDER OR SUPPLIEI	3	343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) will be completed: July 4th, 2024	(X5) COMPLETION DATE
K 0354 SS=F Bldg. 01	extent and duratic been determined, are inspected and recommendations management or d and the fire depart having jurisdiction the sprinkler systet than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1 Based on record refailed to provide a protection of reside be followed in the esystem has to be plantours or more in a with LSC, Section sprinkler impairme NFPA 25, 2011 Ed Inspection, Testing Water-Based Fire F 15.5.2(4) states who system is out of service a 24-hour period, the arrange for one of to the commendation of the comments of the com	er system is impaired, the on of the impairment has areas or buildings involved a risks are determined, are submitted to esignated representative, the the thick and other authorities in have been notified. Where em is out of service for more a 24-hour period, the of the building affected are approved fire watch is sprinkler system has been e. 1, 9.7.5, 15.5.2 (NFPA 25) view and interview, the facility complete policy for the ents indicating procedures to event the automatic sprinkler aced out-of-service for 10 24-hour period in accordance 9.7.5. LSC 9.7.6 requires and Maintenance of Protection Systems. NFPA 25, there are required fire protection vice for more than 10 hours in the impairment coordinator shall the following: the building or portion of the system out of service	K 0354	What corrective action(s) will accomplished for those residents found to have been affected by the alleged deficient practice: No residents were found to have been affected by the alleged deficient practice. How other residents have the potential to be affected by the alleged deficient practice will identified and what corrective action(s) will be taken: All residents, staff and visitors have the potential to be affected by the alleged deficient practice. What measures will be put integlace and what systemic	ent ve e e t be e d e e

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(c)*Establishment of a temporary water supply

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changes will be made to ensure

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED
		155086	B. W	ING		06/11/2024
WOODLA	PROVIDER OR SUPPLIER		•	343 S N ELKHA	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE
		and implementation of an oliminate potential ignition			that the alleged deficient	
		e amount of fuel available to			practice does not recur:	
	the fire	e amount of fuel available to			The facility policy has been	
		ice could affect all occupants			updated to reflect a) the time frame as to when a fire watch	ahall
	in the facility.	ice could affect all occupants			be conducted (out-of-service	Silali
	in the facility.				10hrs)b)that fire watch s	hall
	Findings include:				be conducted by trained	oriali
	i mamgo metade.				personnel. C)Personnel	
	Based on record rev	view with the Administrator			designated for fire watch shall	
		irector on 06/11/24 at 9:55 a.m.,			have no other duties and sole	
		titled "Fire Watch Status" was			assigned to fire watch.	
		, the plan did not address the			How the corrective action(s)	will
	following items:.	, 1			be monitored to ensure the	
	_	s to when a fire watch shall be			alleged deficient practice wil	<i>u</i>
		rinkler system would be			not recur, i.e., what quality	
		nore than 10 hours in a 24-hour			assurance program will be p	out
	period				into place:	
	b) The provided pla	n did not address that fire			Education will be provided to	all
	watch shall be cond	ucted by trained personnel			new hires and an audit will be	•
	c) The provided pla	n did not address personnel			completed by	
	designated for fire v	watch shall have no other			Maintenance/Designee weekl	y for
	duties and solely as	signed to conduct fire watch			four weeks, then monthly for f	ive
		at the time of record review,			months. Any negative findings	s will
		rector acknowledged the			be immediately remedied, and	1
	_	f a fire watch and further stated			Administrator notified. The res	
		ould be implemented if			of the audits will be reviewed	-
	"working on gas or	something like that."			the Quality Assurance Commi	
					monthly in the Quality Assurar	nce
	_	viewed with the Administrator			Meeting.	
		irector during the exit				
	conference				The date of systemic change	•
	2.1.10(1)				will be completed:	
	3.1-19(b)				July 4th, 2024	
K 0355	NFPA 101					
SS=D	Portable Fire Extir	nauishers				
Bldg. 01	Portable Fire Extir	~				
Siag. 01		guishers are selected,				
		d. and maintained in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLETE B. WING 06/11/20:			LETED	
WOODL	PROVIDER OR SUPPLIER			343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514		_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 or extinguishers was in the Standard for Posection 7.2.1.2 state inspected either man electronic monitoring of 30-day intervals. In manual inspections manual inspections attached to the fire checklist maintaine method. This deficing kitchen staff. Findings include: Based on observation Director on 06/11/2 K-Class fire extinguisher extinguisher at 11 monthly fire extinguisher inspections of documentation of extinguisher inspections extinguisher but was documentation. The finding was revered.	ALSC IDENTIFYING INFORMATION AFPA 10, Standard for inguishers. 12, NFPA 10 on and interview, the facility of 1 portable "K-class" fire inspected monthly. NFPA 10, retable Fire Extinguishers, as Fire extinguishers shall be inually or by means of an ingidevice/system at a minimum Section 7.2.4.4 states Where are conducted, records for shall be kept on a tag or label extinguisher, on an inspection in don file, or by an electronic ent practice could affect all on with the Maintenance 4 at 11:15 a.m., the tag on the hisher in the kitchen did not spections had been record review with the inspections had been record review with the inspection of uishers indicated only ABC error were inspected monthly an informonthly K-Class fire the finance Director stated he did so of the K-Class fire	K 03	TAG	It is the intent of the facility to securely store and maintain fextinguishers. What corrective action(s) waccomplished for those residents found to have been affected by the alleged deficient practice: No residents were found to heen affected by the alleged deficient practice. How other residents have the potential to be affected by the alleged deficient practice with identified and what corrective action(s) will be taken: All residents, staff and visitor the main dining area have the potential to be affected by the alleged deficient practice. What measures will be put place and what systemic changes will be made to enthat the alleged deficient practice does not recur: All fire extinguishers are inspon a monthly basis as required State requirements. A new that was placed on the K class fire extinguisher and the tag was placed in a watertight bag to prevent the tag from being damaged and falling off again thow the corrective action(she monitored to ensure the alleged deficient practice was not recur, i.e., what quality not recur, i.e., what quality	irre irre irill be en cient ave the the tive s in e e e ed by ag e e n.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/09/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155086	B. Wl	NG		06/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		1	NAPPANEE ST		
WOODL	AND MANOR		ELKHART, IN 46514				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					assurance program will be p	ut	
					into place:		
					The Maintenance Director is		
					responsible for completing the		
					monthly inspections on all fire		
					extinguishers. Those results w		
					be reported to the Administrate	or	
					and the Quality Assurance		
					Process Improvement meeting	j	
					monthly for six months. Any		
					negative findings will be		
					immediately remedied.		
					The date the systemic chang	je	
					will be completed: July 4th, 2024		
					Odiy 411, 2024		
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
	Doors protecting	corridor openings in other					
	than required end	closures of vertical openings,					
	exits, or hazardοι	us areas resist the passage					
	of smoke and are	made of 1 3/4 inch					
	solid-bonded core	e wood or other material					
	capable of resistir	ng fire for at least 20					
	minutes. Doors in	fully sprinklered smoke					
	-	e only required to resist the					
		e. Corridor doors and doors					
	to rooms containi	_					
		erials have positive latching					
		latches are prohibited by					
	_	These requirements do not					
		spaces that do not contain					
	flammable or com						
	_	en bottom of door and floor					
	_	ceeding 1 inch. Powered					
		with 7.2.1.9 are permissible					
	I if provided with a	device capable of keeping					1

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the door closed when a force of 5 lbf is applied. There is no impediment to the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155086	B. W	ING		06/11/2024
	PROVIDER OR SUPPLIEF		•	343 S N	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST RT, IN 46514	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. 1. Based on observation failed to ensure 3 of completely resist the protecting corridor required enclosures hazardous areas resure made of 1 3/4 in other material capal 20 minutes. Doors in compartments are of passage of smoke. Or compartments are of passage of smoke. Or compartments do not contain flam Clearance between covering is not exception of the covering is not exception.	rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire or frames in window Parts 403, 418, 460, 482, As details of doors such as angs, automatics closing ation and interview, the facility of 68 doors in the facility would be passage of smoke. Doors openings in other than of vertical openings, exits, or ist the passage of smoke and and solid-bonded core wood or bele of resisting fire for at least an fully sprinklered smoke only required to resist the Corridor doors and doors to ammable or combustible tive latching hardware. Roller ed by CMS regulation. These that apply to auxiliary spaces that mable or combustible material. Bottom of door and floor deeding 1 inch. Powered doors and ple of keeping the door closed of its applied. There is no	K 0	363	The corrective action taken at those residents found to be affected by the deficient prainclude: Residents in rooms 400 and 2 were found to be potentially affected by the alleged deficie practice. How other residents that hat the potential to be affected by the same defective practice be identified and what corrective action(s) will be taken: Potentially all residents could affected by the alleged deficie practice. What measures will be put if	ctice 222 ent ove by will be ent

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155086	B. W	ING _		06/11/2024
				STPEET.	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R			NAPPANEE ST	
WOODI	AND MANOR					
VVOODL	UND INIVINOU			ELKHA	RT, IN 46514	<u> </u>
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	_	closing of the doors. Hold			place and what systemic	
	open devices that release when the door is				changes will be made to ens	
	pushed or pulled are permitted. Nonrated				that the deficient practice do	oes
		unlimited height are permitted.			not recur:	
	Dutch doors meeting 19.3.6.3.6 are permitted. Door					
		eled and made of steel or other			Doors 400, 222 and the janito	or's
	_	ance with 8.3, unless the smoke			closet have all had the 1/4"	
	compartment is sprinklered. Fixed fire window				penetration repaired. For sect	ion
	assemblies are allowed per 8.3. In sprinklered				3.1-19(b): All staff have been	
	compartments there are no restrictions in area or				educated on the facility policy	
	fire resistance of glass or flames in window				pertaining to "propping" doors	
		eficient practice could affect				
		esidents, as well as staff and			How the corrective action(s)
	visitors				will be monitored to ensure	the
					deficient practice will not re	cur,
	Findings include:				i.e., what quality assurance	
					program will be put into place	ce:
		on on 06/11/24 between 09:50				
	_	. during a tour of the facility			The Maintenance	
	_	ping/Maintenance Assistant,			Director/Designee is responsi	
		nt rooms 400 and 222 had			for ensuring all doors are com	•
		door penetrations. Each			and not propped open. A wee	-
	_	ed approximately 1/4 inches.	audit of complete doors and door closure will be completed, and any			
		por to the janitors' closet,			d any	
		t 1/2 nurses' station had			negative findings will be	
		ration that measured			immediately remedied, and	
		inches. Based on interview at			Administrator notified. The re	
	the time of observa				of these audits will be reviewed	
		ntenance Assistant confirmed			the Quality Assurance Proces	ss
	that the doors had t				Improvement meeting for six	
	_	rther agreed that the door was			months.	
	not smoke tight.					
	Eindings 1	ugged with the Maintenan				
	Findings were discussed with the Maintenance Director and Administrator at exit conference.				The data the sections to	
	Director and Admit	instrator at exit conference.			The date the systemic chan	ges
	2 1 10(b)				will be completed:	
	3.1-19(b)					
	2 Paged on absent	ation and intervious the facility			huly 4th 2024	
		ation and interview, the facility			July 4th, 2024	
	laned to ensure 1 o	f 2 kitchen corridor doors were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155086		ľ	JILDING	nstruction 01	(X3) DATE : COMPL 06/11/	ETED		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	provided with a mea door closed, had no latching and would This deficient practi	ans suitable for keeping the impediment to closing, resist the passage of smoke. ice could affect approximately nown number of residents.						
	Based on observation Housekeeping/Mair 06/11/24 from 09:50 door leading to the expropped open with a observation the Housekeeping/Mair that the door had be	ntenance Assistant on 0 a.m. to 12:48 p.m., the kitchen service corridor was initially a service cart. At the first usekeeping/Maintenance the cart and closed the door. servation at the end of the d that the food cart had been open the door. Based on						
		wed with the Maintenance istrator at exit conference.						
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using g complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided n 18.5.1.1, 19.5.1.1,	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0	511	It is the intent of the facility to		07/04/2024	

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ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/11/2024	
PROVIDER OR SUPPLIE	R	343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514		
SUMMARY (EACH DEFICIENT REGULATORY OF failed to ensure 1 of were protected access 2011 Edition, Artice (Cover Plates), require be installed so as to and seat against the deficient practice or residents and staff. Findings include: Based on observation Housekeeping/Mair (17/24 between 07/24 bet	STATEMENT OF DEFICIENCIE RECY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION f 4 ectrical outlets in room 405 ording to LSC 19.5.1. NFPA 70, the 406.6, Receptacle Faceplates urres receptacle faceplates shall to completely cover the opening to mounting surface. This ould affect approximately 4 ons with the intenance Assistant on 19:50 a.m. and 12:18 p.m., in behind the resident bed near usissing a coverplate for the terview at the time of ousekeeping/Maintenance dedged that the outlet was	343 S	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) provide proper electrical installation. What corrective action(s) wi accomplished for those residents found to have bee affected by the alleged deficient practice: The missing cover plate for th outlet in room 405 has been replaced. No other rooms identified as having the alleged deficient practice. How other residents have th potential to be affected by th alleged deficient practice wi identified and what correctiv action(s) will be taken: All residents have the potential be affected by the deficient practice. A facility-wide audit completed to ensure that no cover plates for outlets were missing. What measures will be put if place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:	ill be in scient ie ed ie he fill be ve al to was other	
			The Maintenance Director/Designee will audit 5 rooms weekly for four weeks, 5 rooms monthly for five monensure compliance. How the corrective action(s, be monitored to ensure the alleged deficient practice with not recur, i.e., what quality assurance program will be p into place: The Quality Assurance Audit	then ths to) will out	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155086	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/11/2024
	PROVIDER OR SUPPLIER		343 S I	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST .RT, IN 46514	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				will be completed by the Maintenance Director/Design weekly for four weeks; then monthly for five months. Thos results will be submitted to th Administrator weekly and inclin the Quality Assurance Proclimprovement meeting monthl six months.	se e luded cess
				The date the systemic chan will be completed: July 4th, 2024	ge
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the		V 0712	What corrective action(s) w	ill bo 07/04/2024
	facility failed to con 6 of 12 shifts. LSC conducted quarterly facility personnel (r engineers, and adm signals and emerger	aduct fire drills on each shift for 19.7.1.6 states drills shall be on each shift to familiarize surses, interns, maintenance inistrative staff) with the ney action required under this deficient practice affects	K 0712	What corrective action(s) we accomplished for those residents found to have been affected by the alleged deficiency actice. No residents were found to be affected by the alleged deficiency practice. How other residents have the potential to be affected by the alleged deficient practice were accomplished.	en cient e ent ne he

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
STATEM	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155086	B. WING	ŕ		06/11/	2024
					DDDEGG CUTY CTATE JID COD		
NAME O	F PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
WOOD	I AND MANOD		343 S NAPPANEE ST				
WOOD	LAND MANOR			ELKHA	RT, IN 46514		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)	16	DATE
					identified and what correctiv	е	
	Based on records re	eview with the Administrator			action(s) will be taken:		
	and Maintenance D	Director on 06/11/24 at 10:10			Potentially all residents, staff and		
	a.m., the following shifts were missing				visitors could be affected by th		
	documentation of a completed fire drill:				alleged deficient practice.	. •	
		shift fire drill for 2nd quarter of			What measures will be put in	ito	
	2023.	ann in a unin iai ana quanta ai			place and what systemic		
		nd third shift fire drill for 3rd			changes will be made to ens	uro	
	quarter of 2023	nd time sime ine dim for sid			that the alleged deficient	ui e	
	1 -	drill in the fourth quarter of			practice does not recur:		
	c) A third shift fire drill in the fourth quarter of 2023.				All fire drills have been complete.	stad	
	Based on interview at the time of record review,				•	eleu	
	the Administrator acknowledged that the fire drills				as required since the	_	
		icknowledged that the fire drifts			Administrator and Maintenanc		
	were missing.				Director started employment w	/itn	
	E: 1: 1:	t to district to			the facility in March 2024		
		ussed with the Maintenance			(Administrator) and April 2024		
	Director and Admii	nistrator at exit conference.			(Maintenance). This violation was		
					from prior employees in those		
	3.1-19(b)				roles not following through with		
	3.1-51(c)				State requirements for fire drill		
					We will continue to complete to	he	
		review and interview, the			tests as required.		
	1	sure 1 of 12 fire drills included			How the corrective action(s)	will	
		ransmission of the fire alarm			be monitored to ensure the		
	signal to the monitor	oring station in fire drills			alleged deficient practice wil	1	
		9:00 p.m. and 6:00 a.m. for the			not recur, i.e., what quality		
	last 4 quarters. LS0	C 19.7.1.4 requires fire drills in			assurance program will be p	ut	
	health care occupar	ncies shall include the			into place:		
		re alarm signal and simulation			The facility Maintenance Direc	tor	
	of emergency fire c	conditions. This deficient			is responsible for completing t	he	
	practice affects all	residents in the facility as well			facility fire drills. Any negative		
	as staff and visitors	i.			findings will be immediately		
					remedied, and Administrator		
	Findings include:				notified. Those results will be		
					submitted and included in Qua	lity	
	Based on records re	eview with the Administrator			Assurance Process Improvem	-	
	on 06/11/24 at 10:1	0 a.m., the fire drill form for a			meeting monthly for six month		
		lated 12/13/23 conducted at 8:30			The date the systemic chang		
		d as a silent drill which had			will be completed:	-	
	I F		ı	ı	20 00p.0.000.		i e

verification of the transmission of the fire alarm

July 4th, 2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 06/11/2024			ETED		
	PROVIDER OR SUPPLIER			343 S N	ADDRESS, CITY, STATE, ZIP COD IAPPANEE ST RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	not conducted within facilities are able to interview at the time. Administrator was a been conducted as a supposed to.	The designated fire drill was n the time range healthcare use silent drills. Based on e of record review, the ansure why the fire drill had a silent drill when it was not viewed with the Administrator irector at the exit conference.					
K 0761 SS=E Bldg. 01							
	interview, the facili inspection and testin transfilling/storage completed in accord Communicating operequired by 19.1.1.4 corridors and shall I self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D Protectives, except Code. NFPA 80 5.2 shall be inspected a annually, and a writ shall be signed and AHJ. NFPA 80, 5.2	dance of LSC 19.1.1.4.1.1 enings in dividing fire barriers dance of LSC 19.1.1.4.1 enings in dividing fire barriers dance of LSC 19.1.1.4.1 enings in dividing fire barriers dance of LSC 19.1.1.1 enings in dividing fire barriers dance of LSC 19.1.1 enings in dividing fire barr	K 07	761	It is the intent of the facility to provide annual inspection of the fire doors. What corrective action(s) will accomplished for those residents found to have been affected by the alleged deficiency practice: No residents were found to be affected by the alleged deficiency practice. How other residents have the potential to be affected by the alleged deficient practice will identified and what corrective action(s) will be taken: Potentially all residents, staff a visitors could be affected by the alleged deficient practice. What measures will be put in place and what systemic changes will be made to ensithat the alleged deficient practice does not recur:	I be n ient nt e ne II be re and ne	07/04/2024

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
155		155086	B. WING			06/11/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					NAPPANEE ST		
WOODLAND MANOR					RT, IN 46514		
	Т	OT A TEMPLIT OF DEPOSITS OF			· 		OV.5
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION assess the overall condition of door assembly.		+	TAG	The oxygen room fire door ha	•	DATE
	assess the overall co	ondition of door assembly.			been inspected and is current		
	NFPA 80 5242 st	tates as a minimum, the			oxygen room fire door has been		
	following items sha				added to the list of annual fire		
	_	or breaks exist in surfaces of			inspections. The roll down fire		
	either the door or fr				door/window between the kitc		
		light frames, and glazing beads			and main dining room has bee		
		ely fastened in place, if so			inspected and is scheduled fo		
	equipped.	1 /			repairs on July 5th, 2024 by		
		, hinges, hardware, and			SafeCare. The roll down fire		
		eshold are secured, aligned,			door/window has been added	to	
	and in working orde	er with no visible signs of			the list of annual fire door		
	damage.				inspections.		
	(4) No parts are missing or broken.				How the corrective action(s)	will	
	(5) Door clearances do not exceed clearances				be monitored to ensure the		
	listed in 4.8.4 and 6.3.1.7.				alleged deficient practice wil	ll .	
	(6) The self-closing device is operational; that is,				not recur, i.e., what quality		
	the active door completely closes when operated				assurance program will be p	ut	
	from the full open p				into place:		
	1 1	is installed, the inactive leaf			An audit will be completed by		
	closes before the ac				Maintenance/Designee on all		
		are operates and secures the			door inspections monthly for s		
	door when it is in the closed position.				months. Any negative findings		
		vare items that interfere or			be immediately remedied, and		
prohibit operation are not install		re not installed on the door or			Administrator notified. The res		
	frame. (10) No field modifications to the door assembly have been performed that void the label.				of the audits will be addressed	•	
					the Quality Assurance Proces		
_					Improvement committee mont	-	
	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.				in the Quality Assurance Mee	urig.	
	mspecied to verify	men presence and integrity.			The date the systemic chang	205	
	This deficient practice could affect all occupants				will be completed:	yes	
	in the smoke compa	_			July 4th, 2024		
	Findings include: During record review with the Administrator on				Odiy Till, 2027		
		.m., the facility was unable to					
	_	tion for annual inspection of					
	the oxygen transfil	ling/storage room fire door					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		JILDING	01	COMPL 06/11/	ETED		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
	assembly located ne tour of the facility b p.m., the fire rating hours. Based on into review, the Adminis documentation of an available for the oxin the last year.	ear the main entrance. During a etween 09:50 a.m. and 12:18 label on the door was 1-1/2 erview at the time of record					
	3.1-19(b)						
	failed to maintain and fire doors in accordance requires any device, condition, arrangement other feature is required provision of this Consystem, condition, approtection, or other maintained unless the maintenance. NFP assemblies shall be than annually, and a inspection shall be shy the AHJ. This decocupants in the directions of the condition	ance of NFPA 80. LSC 4.5.8 arequipment, system, sent, level of protection, or any sired for compliance with the de, such device, equipment, strangement, level of feature shall thereafter be the Code exempts such A 80 5.2.1 requires fire door inspected and tested not less a written record of the signed and kept for inspection efficient practice could affect all ling room and kitchen.					
	with the Housekeep on 06/11/24 betwee there was one rollin	on during a tour of the facility ing/Maintenance Assistant in 09:50 a.m. and 12:18 p.m., g fire door/window between ing area. During record review and 12:41 p.m., no					

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
K 0781 SS=E Bldg. 01	the rolling fire door past 12 months. Ba record review, the I that a contracted co inspections and wo retrieve the inspect. Findings were disconsisted by the Indian series of t	eaters eaters eating devices shall be eath care occupancies, ed in nonsleeping staff and where the heating elements 2 degrees Fahrenheit (100 on and interview, the facility of 1 portable space heaters e facility. This deficient et approximately 10 staff and an	K 0781	What corrective active accomplished for the residents found to he affected by the allege practice: No residents were four affected by the allege practice. How other residents potential to be affected and what continued and what continued action(s) will be taken potentially all residentially all re	ose ave been ed deficient und to be ed deficient have the eted by the ectice will be corrective en: ts could be ed deficient	07/04/2024	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		A. BUILDING B. WING	<u>01</u>	COMPLETED 06/11/2024		
	ROVIDER OR SUPPLIER		343 S	ADDRESS, CITY, STATE, ZIP COD NAPPANEE ST ART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PREFIX (EACH CORRECTION (EACH CORRECTION CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	He further clarified used and does not her Findings were discurbirector and Admin 3.1-19(b)	tenance Assistant pace heater was in the office. that the space heater is never ave a maintenance program. ssed with the Maintenance istrator at exit conference.		What measures will be put in place and what systemic changes will be made to ensith that the alleged deficient practice does not recur: Space heater was immediated removed from the Housekeep Directors office. Education was provided to all staff on the fact policy regarding space heater How the corrective action(s) be monitored to ensure the alleged deficient practice with not recur, i.e., what quality assurance program will be printo place: An audit will be completed by Maintenance/Designee on all space heater usage weekly for four weeks, then monthly for fronths. Any negative findings be immediately remedied, and Administrator notified. The resofthe audits will be reviewed the Quality Assurance Commitmenthly in the Quality Assurance Meeting. The date the systemic change will be completed: July 4th, 2024	y ing s illity use. will lity use will lity use will lity litee ince	
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone	ent - Power Cords and ent - Power Cords and eatient care vicinity are only ents of movable d electrical equipment				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED		
		155086	B. W	B. WING			06/11/2024	
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
WOODLAND MANOR					NAPPANEE ST			
WOODL	AND MANOR			ELKHA	RT, IN 46514			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	(PCREE) assemb	les that have been						
	assembled by qua	alified personnel and meet						
	the conditions of 1	10.2.3.6. Power strips in						
		cinity may not be used for						
	non-PCREE (e.g.	, personal electronics),						
	except in long-teri	m care resident rooms that						
	do not use PCRE	E. Power strips for PCREE						
	meet UL 1363A o	r UL 60601-1. Power strips						
	for non-PCREE in	the patient care rooms						
	(outside of vicinity	r) meet UL 1363. In						
	non-patient care r	ooms, power strips meet						
	other UL standard	ls. All power strips are						
	used with general	precautions. Extension						
	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon							
	completion of the	purpose for which it was						
	installed and mee	ts the conditions of 10.2.4.						
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8						
		(D) (NFPA 70), TIA 12-5						
		on and interview, the facility	K 0	920	What corrective action(s) will	ll be	07/04/2024	
		f 1 power cord daisy chains			accomplished for those			
		d as a substitute for fixed			residents found to have been			
	_	011, 400.8 state unless			affected by the alleged defic	ient		
		ed in 400.7 flexible cords and			practice:			
		used for (1) as a substitute for			No residents were found to be			
	_	e 400.8 (1) prohibits daisy			affected by the alleged deficie	nt		
		first extension cord (or power			practice.		1	
		as a substitute for the fixed			How other residents have th			
		e. This deficient practice could			potential to be affected by th			
	affect approximately 3 staff. Findings include:				alleged deficient practice will			
					identified and what corrective	'e		
					action(s) will be taken:	h -		
	Donad or street	one dyning a toyn of the feetile			Potentially all residents could			
		ons during a tour of the facility			affected by the alleged deficie	nt		
		ce Director and Administrator			practice, no residents were		1	
		4 a.m., in the front business			identified.	-4-		
		nain entrance, there was a			What measures will be put in	πο		
		power electrical equipment,			place and what systemic			
plugged into and supplied power by another				changes will be made to ens	ure	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155086		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2024		
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP COD 343 S NAPPANEE ST ELKHART, IN 46514			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	power strip. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant agreed that the power strips were daisy chained together and would work on getting them separated. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	that the alleged deficient practice does not recur: Power strip was immediately removed from the front office. Education was provided to all son the facility policy regarding power strip usage. How the corrective action(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be printo place: An audit will be completed by Maintenance/Designee on all power strip usage weekly for foweeks, then monthly for five months. Any negative findings be immediately remedied, and Administrator notified. The resof the audits will be reviewed by the Quality Assurance Commit monthly in the Quality Assurance Meeting. The date the systemic change will be completed: July 4th, 2024	will ut our will ults oy ttee nce		

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