STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	06/21/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00436905 and IN00436291. Complaint IN00436905 - No deficiencies related to the allegations are cited. Complaint IN00436291 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: June 20 & 21, 2024. Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 1 Medicaid: 56 Other: 12 Total: 69 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/25/2024	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 19th, 2024 for complaint survey completed June 21, 2024.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

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

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, and interview the facility failed to ensure the Memory Care Unit (MCU) was free from incontinence brief debris and failed to ensure adequate supervision was provided to a cognitively impaired resident on the MCU to prevent ingestion of the debris for 1 of 3 residents reviewed for accidents. This deficient practice resulted in Resident C experiencing a blocked airway, a change in level of consciousness and requiring emergent treatment from Emergency Medical Services (EMTs). (Resident C) Finding includes: A record review for Resident C was completed on 6/21/24 at 11:30 A.M. Diagnoses included, but were not limited to: dementia, depression, anxiety, congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation. A Quarterly Minimum Data Set (MDS), assessment, dated 3/21/24, indicated Resident C was severely cognitively impaired and displayed no behaviors. The resident required extensive assistance with all Activities of Daily Living, was ambulatory and did not require mobility devices to assist with walking. A review of Resident C's Indiana Physician's Orders for Scope of Treatment (POST) form, dated 11/17/24, indicated Resident C was a DNR (Do Not Resuscitate). A late entry nursing progress note authored by	F 0689	It is the practice of this facility that we ensure that residents receive adequate supervision, and the resident environment remains as free of accident hazards as possible. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident C no longer resides in the facility. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents on the memory care unit have the potential of being affected by the alleged deficient practice. Chart reviews for all residents on the memory care unit were completed to identify any resident with a history of consuming non-food items with no residents identified. The nursing schedule was reviewed to ensure that at least one staff member is always scheduled on the unit, and it is posted on the unit that staff need to call for a replacement if it is necessary to leave the unit when only one staff member is present on the unit. Rounding was	07/19/2024

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	the Director of Nursing (DON), dated for 6/8/24 at 10:25 P.M., indicated staff found Resident C on the floor of the activity room, had a white substance in the mouth, and had labored breathing. The note indicated nursing staff performed a finger sweep, but the resident was resistant to the procedure. Resident C independently moved to a standing position, continued coughing, nursing staff transferred him to a chair and activated a 911 call. The EMTs (Emergency Medical Technicians) arrived, continued with removing the white substance from the resident's mouth. Resident C became pulseless and respirations ceased during EMT care. On 6/21/24 at 10:45 A.M. the Administrator provided the daily assignment sheet for 6/8/24. The daily assignment sheet indicated RN 3 and CNA 2 were scheduled to work on Unit 4 (Memory Care) the evening and night shifts of 6/8/2024 into 6/9/2024. Review of CNA 2's punch history, indicated on 6/8/24 the CNA punched in at 8:12 P.M. and punched out at 10:16 P.M. During an interview on 6/21/24 at 9:56 A.M., Registered Nurse (RN) 3 indicated she had worked the evening shift on the Memory care unit on 6/8/24. The CNA who was scheduled to work with her on the evening and night shift from 6:30 P.M. to 6:30 A.M., called off work. RN 3 indicated CNA 2 agreed to come in to help put the residents in the Memory Care to bed. RN 3 indicated she was working on the Memory unit alone after CNA 2 left, and indicated the unit was usually staffed with 1 nurse and 1 CNA on the evening and night shifts. CNA 2 was observed to put everyone to bed except 3 male residents, including Resident C.		completed each shift on the memory care unit to ensure the environment is free of accident hazards with no issues identified. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policies “Staffing” and “Safety and Supervision of Residents” will be reviewed by the IDT. An in-service will be held with all nursing staff on the policies, including at least one staff member always being present on the nursing unit and rounding each shift to identify accident hazards and to clean up debris immediately if poses to be an accident hazard. A performance improvement tool has been developed to audit staffing coverage and environmental hazards on the memory care unit. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) shifts on the memory care unit to ensure at least one nursing staff member is present on the unit at all times and the environment is free of trash that could be an accident hazard. This performance improvement tool will be completed by the Administrator/ Designee weekly for four weeks; then monthly for three months, then quarterly x	

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	RN 3 indicated CNA 2 told her something was all over the floor in the activities area and she had cleaned it up and disposed of it outside the unit in the trash container. CNA 2 was going to go home around 10:15 P.M.. RN 3 had gone to the activities area and 3 male residents and CNA 2 were there and everything seemed fine. She asked CNA 2 if she would stay while she went to her car to get her lunch bag. RN 3 indicated when she returned to the unit, she announced her return to the unit, and then CNA 2 left to go home. RN 3 briefly went to another hall and returned to the Memory Care unit. When she returned to the unit, another resident called to her and told her Resident C was "eating popcorn." RN 3 indicated she went to the dining room where and found Resident C on the floor, gray in color and non-responsive. RN 3 thought he may have had a seizure so she turned him to his side. When she turned him, she saw something in his mouth, and while he was still unresponsive, she performed a mouth sweep 3 times and each time she removed a fluffy white material. . RN 3 briefly left the area to call another nurse, Licence Practical Nurse (LPN) 4, from the next unit and asked her to continue to perform mouth sweeps while she ran to call EMS. RN 3 indicated Resident C was doing better at that time and he got up in chair and was breathing. She went to the front doors to let the EMTs in the building while LPN 4 stayed with the resident. When the EMTs got to Resident C, he was non-responsive again. The EMTs layed the resident down and removed pieces of the Depends from the airway, but the resident still was not breathing.. During an interview on 6/21/24 at 10:51 A.M., CNA 2 indicated she was not scheduled to work on 6/8/24 on the evening shift, but another CNA called off, so she agreed to work from 8:00 P.M. to		three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* July 19th, 2024	

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	10:00 P.M., to help get residents ready for bed. When she arrived to the Memory Care unit, at 8:15 P.M., there was 1 nurse working the floor. CNA 2 indicated on arrival she found "fluff" all over the hall and dining room. She cleaned it up and placed the fluff in the trash on the housekeeping cart that was by the time-clock. She returned the cart with the fluff to the area of the time-clock, which was not accessible to the residents. She did not put Resident C to bed because he could be combative with care. Resident C was walking around in the dining room with 2 other male residents. CNA 2 left the facility at about 10:15 P.M. and no one replaced her. When she left there were no concerns with Resident C. During an interview on 6/21/24 at 12:45 P.M., the facility Corporate Nurse indicated there should always be at least 1 nursing staff member present on the Memory Care unit at all times. On 6/21/24 at 3:06 P.M., the Administrator provided a policy titled,"Staffing," dated 2017, indicated, "Staffing...Licensed nurses and certified nursing assistants are available 24 hours a day to provide resident care services..." This citation relates to Complaint IN00436291. 3.1-45(a)			