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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428613. Complaint IN00428613 - Federal/state deficiencies related to the allegations are cited at F600. Survey date: March 6, 2024 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 5 Medicaid: 61 Other: 1 Total: 67 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/11/24.	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. 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 March 28, 2024, to the Complaint Survey completed on March 6, 2024. We respectfully request a desk review for paper compliance.	
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure Resident C, a resident with dementia, was free from resident-to-resident sexual abuse by Resident B, for 2 of 2 residents reviewed for sexual abuse. Using the reasonable person concept, it is likely this would lead to fear, confusion and anxiety for Resident C. Findings include: An IDOH (Indiana Department of Health) Incident #432, dated 2/15/24 at 3:52 P.M., indicated Resident B was observed by a staff member, sitting on Resident C's bed while she was asleep. Resident B's fingers were partially touching Resident C, inside her brief. Resident B was immediately removed from the room and placed on 1:1 observation until he was discharged to a behavioral health facility. Resident C did not recall the incident. 1. On 3/6/24 at 10:15 A.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: dementia, anxiety, depression and a history of trauma. Quarterly Minimum Data Set (MDS) Assessment, dated 2/15/24, indicated the resident's cognition status was severely impaired. .	F 0600	The facility respectfully requests that this citation be reviewed under the Informal Dispute Process related to F600 regarding abuse. Although we disagree with the finding, the facility will work the submitted plan of correction accordingly. The facility contends preventive measures were part of the plan of care prior to the occurrence and were initiated after pre/post admission assessments. The facility also acted promptly, with no delay, and appropriately when Resident B exhibited sudden behavior changes on 2-15-24. Resident B was admitted to the facility on 1-12-24. The resident has a BIMS of 3. His known sexual behavior identified in the 12-6-23 pre-admission assessment were hypersexual behaviors, Alzheimer's Disease, anxiety, sexual dysfunction, and depression. *These behaviors and diagnosis are typical of admissions in long term care facilities.* In fact, the facility responded to behaviors identified, and as behaviors presented post	03/28/2024

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, dated 1/9/24, indicated the resident had a history of trauma, physical and mental abuse from an ex-spouse. The interventions were to allow resident time to express concerns, fears, feelings and expectations, reassure resident she was safe, have resident meet with psych services, offer resident a Harley Davidson stuffed animal to hold, and redirect by using positive conversation. A Care Plan, dated 11/12/23, indicated the resident had impaired cognitive function/dementia. The interventions were to keep routines consistent, provide consistent care givers, provide activities that accommodated the resident's abilities, administer medications as ordered, communicate with resident/family/caregivers regarding the resident's capabilities, identify self with each interaction, provide necessary cues-stop & return if agitated. A NeuroBehavioral Exam, dated 1/29/24, indicated "...Staff observe negative behaviors affecting care and safety, fall risk. Adaptive weaknesses, delusions, agitation, aggression, anxiety, elation/euphoria, disinhibition, irritability/lability. Shown in bed shouting most of the day, wandering the hallways; most often searching for her mother, reliving periods of her life. Believes peopled are trying to sleep with her for sex. Married 3x; son believes 3rd marriage resident sustained physical and emotional abuse..." A Progress Note, dated 2/15/24 at 4:52 P.M., indicated "Staff allege another resident was sitting on this resident's bed while she was sleeping with his fingers partially touching her inside her brief. Resident was wearing clothing on upper torso and had a brief on. Staff removed other resident immediately from room. Head to toe assessment completed...Police in...."		admission. 1/12/24 Care Plan indicated interventions were to administer medications as ordered, anticipate needs, explain all procedures, and provide a program of activities. On 1/15/24 the Care Plan interventions were modified to include, offer activities related to past work experiences, offer snacks, offer music- resident enjoys classic rock, offer resident to watch TV, redirect resident back to his room, and resident to be assessed by psychiatric services. Subsequent documentation amplified Care Plan interventions, including but not limited to, Progress note 1-12-24 indicated resident was placed on 15-minute checks to monitor adjustment to facility. Physicians order note 1-13-24 indicated order for Climara transdermal patch daily for sexual dysfunction. Behavior note 1-14-24 indicated resident remains easily re-directed. Behavior note 1-15-24 indicated resident to remain on 15-minute checks for inappropriate behaviors with staff. In fact, there are multiple documented notes reinforcing the pre-admission assessment, and that these were normal baseline behaviors. These inappropriate behaviors were almost exclusively	

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Progress Note, dated 2/16/24 12:36 A.M., indicated the resident was resting in bed with her eyes closed and there had been no signs or symptoms of distress noted. On 3/6/24 at 10:34 A.M., the resident was observed in activity, sitting in wheelchair. The resident was alert to self only. She did not participate in the activity, but her eyes followed voices. During an interview, on 3/6/24 at 10:36 A.M., an Activity Assistant (AA) 2 on the dementia unit indicated she was the staff member who found Resident B in Resident C's room. AA 2 indicated when she walked in, Resident C's room. Resident B had one hand on the Resident C's thigh and the other hand inside her brief, near her private parts. AA 2 told him to stop touching her and he immediately removed his hand from inside her brief. AA 2 could not visualize where his fingers were, but indicated hand was near Resident Cs private parts. Resident B was escorted out of the room and provided a diversion activity. AA 2 indicated Resident C was asleep when she entered her room and did not wake up while she was removing Resident B from the room. AA 2 indicated the male resident had the habit of wandering the unit, but she had never seen him in another resident's room. AA 2 indicated the two residents had never shown any interest in one another, as the female hollers out if anyone came near her. During an interview on 3/6/24 at 10:53 A.M., Qualified Medication Assistant (QMA) 3 indicated she had never seen Resident B approach another resident; however QMA 3 had seen him in his room touching himself. QMA 3		directed at staff, and mimic exactly what the facility was care planning. ***There was no reasonable way the facility could have identified what behaviors would manifest in the future.*** On 2-15-24 Resident B's behavior changed. He more aggressively touched another resident. Resident C was sleeping at the time, was assessed, and has shown no negative psychological outcomes. The facility acted immediately, following the abuse allegation protocol. Resident B was placed on 1:1 24/7 observation; contacted patient responsible party, notified attending physician, and police. The facility continued 1:1 24/7 observation until discharge. The facility facilitated a discharge to a facility where Resident B's daughter is employed per their choice. It was felt this would most likely ameliorate the resident's sexual behaviors. With a summary of the facts below, the facility requests further review related to the G that the facility received related to the occurrence, as evidenced in the documentation. The facility points out that all residents, including Resident B, have inherent rights. There is no way for the facility to reasonably have anticipated the change in behaviors, and we suggest a 1:1 24/7 is an intrusive	

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had seen him go into another resident's room, but not often and Resident B was always redirected out of the room. 2. On 3/6/24 at 1:05 P.M., a review of the clinical record for Resident B was conducted. The resident was admitted on 1/12/24. The Resident's diagnoses included, but were not limited to: non-traumatic brain dysfunction, Alzheimer's Disease, anxiety, sexual dysfunction and depression. A Pre-Admission Evaluation, dated 12/6/23, indicated the resident had hypersexual behaviors in the past, which consisted of exposing himself and wandering the facility. A Care Plan, dated 1/12/24, indicated the resident had a history of exposing himself to staff and being combative during care. The interventions were to: administer medications as ordered, anticipate needs, explain all procedures and provide a program of activities. On 1/15/24, the following interventions were added: offer activities related to past work experience, offer snacks, offer music-resident enjoys classic rock, offer resident to watch TV, redirect resident back to his room and resident to be assessed by psych services. A Care Plan, dated 1/12/24, indicated resident had an alteration in neurological status related to Alzheimer's Disease. The interventions included, but were not limited to: medication, cueing, reorienting and lab work as ordered. A Progress Note, dated 1/12/24 at 11:41 A.M., indicated the resident had arrived to the facility accompanied by his wife. Resident was oriented to his room and bathroom. At 3:01 P.M. the		intervention. This intervention was eventually warranted for this resident, but *not* warranted from the point of admission. We reserve appropriate interventions at the right time. The facility acted correctly throughout the various identified stages of behavior for Resident B. A preventive care plan was in place and implemented related to known actions of exposure at the time of admission. When the resident's behavior changed, the facility acted on the occurrence immediately. Resident B was immediately put on 1:1 monitoring. Follow-up assessment occurred with Resident C with no identified negative outcome. Respectfully Submitted Katherine Wright, Administrator **It is the practice of Woodland Manor to ensure all residents are free of abuse.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The family of Resident B participated in a transfer to a facility where his daughter is employed. Social Services has provided psychological support to Resident C since the incident. Resident C does not recall the	

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Progress Note indicated the resident was placed on 15 minute-checks to monitor adjustment to the facility. A Physician's Order Note, dated 1/13/24 1:15 P.M., indicated there was an order for Climara Transdemal patch to be applied daily for a sexual dysfunction. A Behavior Note, dated 1/14/24 at 1:44 A.M., indicated the resident occasionally wandered into other resident rooms, but was redirected easily. A Behavior Note, dated 1/15/24 at 12:44 P.M. indicated a CNA was unable to change the resident's clothes, as he attempted to remove the CNA's clothes. The resident was groping staff, and multiple attempts to redirect him were unsuccessful. A Behavior Note, dated 1/15/24 at 6:16 P.M., indicated the resident remained on 15 minute-checks for attempting to remove CNA clothing, no other behaviors noted. A Behavior Note, dated 1/27/24 at 4:15 P.M., indicated a CNA noted the resident to be in another resident's room, touching the resident on the leg. Resident B was easily redirected out of room, to his room and remained on 15 minute checks. A Behavior Note, dated 2/1/24 at 4:09 P.M., indicated, "...Resident observed in the hallway outside of the Activity Room with privates out, hand on top stroking. He was looking in the direction of the Activity Assistant Program Director redirected him to zip up his pants. I then educated him that if he would like to do that he needs to be in his room with the curtain drawn		episode, nor has she evidenced any psychological/physical effects. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who have a history of sexual behaviors have the potential to be affected by the alleged deficient practice. All resident charts have been audited to identify any resident that has a history of ongoing sexual behaviors. Behavior plans have been reviewed or initiated for those residents identified and a care plan has been developed with individualized interventions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The facility policy on abuse was reviewed by the IDT. An in-service was conducted with all facility staff on the policy and protocol for handling sexual behaviors. Behavior plans and individualized care plan interventions will be developed for all new admissions and for those residents identified as having ongoing sexual behaviors. A performance improvement tool has been created to monitor that any resident with sexual behaviors has behavior plan in place and a care	

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and door shut. Resident shook head with understanding and returned to his room. Resident was then laying down in bed watching television...." A review of the Progress and Behavior Notes, dated 2/7/24 through 2/14/24, indicated Resident B did not have incidents or behaviors noted, but remained on 15 minute-checks. A Progress Note, dated 2/15/24, indicated staff alleged resident was sitting in another resident's room, on her bed with his fingers partially touching other resident, inside her brief. Staff removed resident immediately from the room. His wife, a physician and police were notified of the incident and resident was placed on 1:1 observations. During an interview, on 3/6/24 at 10:56 A.M., CNA 4 indicated she worked the dementia unit and she had seen Resident B "be friendly with himself" but staff just would close the curtain or redirect him. She indicated he wandered the hallways and had always been on 15 minute checks, since he was admitted to the facility. On 3/6/24 at 3:08 P.M., CNA 4 indicated she was the one he tried to grope shortly after his admission. She described the resident as being inappropriate with his words, for example he would say, "Do you want to touch it". CNA 4 indicated he had attempted to reach out to touch her breasts when she had been providing care. When she got his pants on, he pulled out his penis over top of pants and she had to tell him to put it back inside pants. She indicated he was easy to redirect and would listen to her if she said "stop" or "don't do that"		plan developed with individualized interventions. The care plan and interventions will be reviewed and revised in morning clinical meeting if a sexual behavior is documented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A Quality Assurance tool has been developed and implemented that randomly audits (5) five resident's charts and any new admissions to ensure behavior plans are in place with individualized interventions if a history of sexual behaviors is identified. This tool will be completed by the Social Service Director and/or her designee weekly times three, then monthly times three and then quarterly times three. In event further concerns are identified, the issue will be corrected, and additional training initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. **By what date the systemic changes for each deficiency will be completed:** March 28, 2024	

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 3/6/24 at 11:31 A.M., the Dementia Director indicated Resident B was a new admission approximately 1 month ago. He had a history of being sexually inappropriate with himself - undressing and touching his private parts. When he entered the facility, he was placed on 15 minute checks, and had been occasionally found with hands in his pants and playing with his penis. Staff would pull the curtain to ensure no one else saw him or would redirect him to his room. She indicated he had been to a behavioral health facility since the incident and was put on some medications to decrease his sexual behaviors and would return to the facility today. During an observation, on 3/6/24 at 2:34 P.M., Resident B was observed participating in an activity. He was sitting, at the end of the table, with no female resident's near him except for AA 2. The resident was on 1:1 observations per staff. On 3/6/24 at 2:34 P.M., the Director of Nursing (DON) provided a policy titled, "ABUSE POLICY', dated 11/28/16 and revised on 9/2022 and indicated the policy was the one currently used by the facility. The policy indicated "...The resident has the right to be free from abuse...Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Facility shall have processes in place to include screening, training, prevention, identification, protection, investigation, reporting and response to allegations of potential or actual abuse...Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...It includes verbal abuse,			

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sexual abuse, physical abuse, and mental abuse...Sexual abuse: is defined as non-consensual sexual contact of any type with a resident...." This citation relates to Complaint IN00428613. 3.1-27(a)(1)			