STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 23, 24, 26, 27 and 30, 2023 Facility number: 000134 Provider number: 155229 AIM number: 100275430 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 4 Medicaid: 49 Other: 14 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 3, 2023.	F 0000	F000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 03-03-2023	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.			
	Based on observation and interview, the facility failed to ensure the carpet in hallways and common areas utilized by residents, staff, and visitors was maintained in a clean manner for 2 of 3 units reviewed for environmental cleanliness. (Hickory Hall Unit and Southern Pines Unit) Finding includes:	F 0584	**1. All carpet in facility was professionally cleaned by Stanley Steamer on 2/20/2023.** **2. In house carpet observed and it has been determined the carpet will be replaced. Project request form was put in to replace all facility carpet with LVT on 2/17/2023 to assure no**	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During a confidential interview, it was indicated the carpet in the Hickory Hall Unit and Southern Pines Unit had been heavily soiled and "disgusting" for at least five years. They pointed down the Hickory Hall Unit, where many dirty spots were dark enough to be seen in multiple areas from the Nurse's Station to the end of the Unit. The condition of the carpet had been brought to the attention of the Administrator and the Maintenance Director quite some time ago, but the carpet remained soiled. Additional confidential interviews confirmed and also agreed the carpet was "disgusting" but the condition of the soiled carpet remained unchanged. The soiled areas on the carpet were unsanitary for the residents, as bodily fluids were not able to be cleaned up on carpet. They were not aware of any plan to correct the soiled carpet concern. During an observation, on 1/23/23 from 11:24 a.m. to 11:45 a.m., the following was observed on the carpet in Hickory Hall Unit and Southern Pines Unit: a. A continuous, large, light brown soiled area on the carpet, approximately 10 feet in length, went from the Food Storage Room to the Mechanical Room on the Hickory Hall Unit. b. A continuous medium-sized brown spot on the carpet went from the Mechanical Room to the Beauty Shop on the Hickory Hall Unit. c. Three separate dark brown spots were noted on the carpet in front of the Nurse's cart at the Hickory Hall Nurse's Station, along with numerous, scattered, light brown spots. The light brown spots were too many in number to separately identify because they ran together. This area was so large it nearly covered the entire		**further noncompliance. (See Attached carpetform)** **3. Housekeeping Supervisor or designee have been educated by the ED to observe carpet daily Monday thru Friday and will continue to monitor carpet for new carpet issues and follow policy on addressing those issues while awaiting replacement of current carpet with LVT. Education completed by date of Compliance** **4. Housekeeping Supervisor or designee will continue to monitor carpet for new carpet issues and follow policy on addressing those issues while awaiting replacement of current carpet with LVT. Audits will be presented to QAPI x 6 months. QAPI will determine the need for further audits** **5. Date of Compliance** 03-03-2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	intersection of the Hallways at the Hickory Hall Nurse's Station. Though the carpet was originally green, it had a distinct brown, soiled color. d. A large,brown carpet stain was continuous along the east wall across from the Hickory Hall Unit Nurse's Station, where residents were in their wheelchairs. It was approximately the width of a wheelchair. e. A dark brown stained path was on the carpet along the wall at the Hickory Hall Nurse's Station and beneath the area where the television hung. The soiled carpet extended to the left and to the right of the large television on the wall. This carpet also extended up the wall about 3 inches and had a dark brown soiled area the entire height of the carpet a foot in length. f. A dried, white, thick crusty soiled area on the carpet was on the East side of the Hickory Hall Nurse's Station, slightly larger than a 50 cent coin, and had contained an apparent smear before it dried. The white soiled area had the appearance of dried phlegm that had been tracked through with a wheel before it dried. It was feet six to seven feet towards the Hickory Hall Nurse's Station from the lobby tile near the Administrator's Office. Another white dried white crusty spot on the carpet was closer to the fire doors between the lobby and the Hickory Hills Nurse's Station. g. Other scattered dark brown spots on the carpet to the East of the Hickory Hall Nurse's Station were noted as many staff members, to include the Administrator, walked through this area of heavily soiled carpet. h. A section of carpet in the lobby contained two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chairs separated by an end table, towards the Hickory Hall Unit after entrance to the facility. This carpet contained brown stains around the legs and front of the right chair and in front of the end table. A resident was seated in this chair. i. Intermittently, quarter-sized dark brown stains were on the carpet near Hickory Hall room 34. j. A large medium-brown stain was in the Hickory Hill Hallway in front of room 36 and was approximately the size of a full sheet of paper. k. A medium-brown carpet soil, the size of a grapefruit, was in the hallway on the right side of the doorway to Hickory Hill room 35. l. Three scattered dark-brown carpet spots were in the middle of the Hickory Hall Unit between rooms 35 and 37. m. A light-brown carpet soil, the size of an orange, was in the Hickory Hall just outside the doorway for room 39. n. A medium-brown carpet soil, slightly larger than a grapefruit, was in the Hickory Hall between the Staff Restroom and the Central Supply Room. o. A medium-brown spot on the carpet, approximately the size of a soccer ball, was in the Hickory Hall Unit, to the right of the activity bulletin board across from the Central Supply Room near the Director of Nursing Office. p. Various areas of carpet soil were readily visible down the Hickory Hall and South Pines Hallway from the Hickory Hall Nurse's Station. During an observation, on 1/23/23 at 2:42 p.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following soiled carpet areas were observed in the Hickory Hall Unit and Southern Pines Unit: a. A light-brown carpet spot, larger than the size of a basketball, in the center of the Southern Pines Hallway across from the lounge and in front of the shower room. b. A medium-brown stain just outside room 43 to the right of the doorway. c. An exterior door between Hickory Hall Unit Nurse's Station and Room 43 had a distinct, two to three feet long brown path on the carpet towards the Nurse's Station. d. A large brown spot, larger than a basketball, on the carpet in the Southern Pines unit near the doorway of room 60. During a random observation, on 1/24/23 at 4:00 p.m., the facility carpet remained soiled in the lobby, Hickory Hall Unit, and Southern Pines Unit. It was unchanged from the observations on 1/23/23. During an observation, on 1/26/23 at 11:03 a.m., the facility carpet remained soiled in the lobby, Hickory Hall Unit, and Southern Pines Unit. It was unchanged from the observations on 1/23/23. During an observation, on 1/27/23 at 9:27 a.m., the facility carpet remained soiled in the lobby, Hickory Hall Unit, and Southern Pines Unit. It was unchanged from the observations on 1/23/23. Three residents were seated along the East wall across from the Hickory Hall Unit Nurse's Station. One of the residents seated in the wheelchair had the front right wheel of her wheelchair next to the thick, white, crusty area dried on the carpet. Her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	right foot non-skid sock rested on the carpet right next to the white smeared and dried residue that remained in the same location from the beginning of the survey. During an interview, on 1/27/23 at 9:49 a.m., Certified Nurse's Aide (CNA) 7 indicated staff were required to identify and address any environmental cleanliness when it was identified or report it to housekeeping if it was something that needed further attention and/or could not be immediately corrected. During an interview, on 1/27/23 at 10:04 a.m., CNA 7 indicated if residents or resident representatives reported any environmental concerns, they were required to report them to the Director of Nursing. During an interview, on 1/27/23 at 10:32 a.m., the Housekeeping Supervisor indicated housekeeping was in charge of cleaning the carpet every 2 weeks. She was unable to provide any documentation of the dates when the carpets were cleaned by housekeeping. All staff were required to identify soiled carpet and report it to housekeeping or any management so it could be cleaned. Staff members had not notified her of any soiled carpet spots from 1/23/23 to 1/27/23. The carpet had some stained areas unable to be removed in high traffic areas, such as the following: outside the Beauty Shop, along the wall under the television in the Hickory Hall near the Nurse's Station (had been there for years), and along the East wall across from the Hickory Hall Nurse's Station where resident's frequently sat in wheelchairs (had been there for a very long time). Stains unable to be removed were reported to the Administrator, but she was unaware of any plan to further correct the heavily stained carpet. They used to have a contract carpet cleaner come in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility but this had not happened since the COVID-19 pandemic began. During an interview, on 1/27/23 at 11:09 a.m., the Maintenance Director indicated he did not have any outstanding work orders. He had an upcoming project to replace the flooring in the Occupational Therapy Suite, but not any other floors. He was aware of stains on the carpets which were unable to be removed, as the Housekeeping Supervisor had discussed the carpet concerns in morning meeting on more than one occasion when the Administrator and DON were in attendance. This had been a concern since March of 2019. He was unaware of any planned solution to the heavily stained carpet. During in interview, on 1/27/23 at 11:36 a.m., the Administrator indicated he had not had any residents or resident representatives report any carpet concerns. He was unable to provide any grievances regarding the heavily soiled carpet. He could not recall any times he was made aware of any carpet concerns. Environmental concerns could be brought to his attention during morning meeting, on maintenance forms, and also during Quality Assurance Performance Improvement meetings. In the event of carpet stains, he could have had an outside source come in to clean. He had not had any contracted carpet cleaners in to clean the carpet since prior to the COVID-19 pandemic. He asked corporate to replace the carpet six years ago and it was declined. During an interview, on 1/27/23 at 11:48 a.m., the DON indicated a family came in for a tour of the facility in December 2022 and inquired about a pending admission. They declined to bring their family member to the facility due to the condition of the carpet. A couple of CNAs also mentioned			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the DON the carpet needed replaced. It was not further discussed due to the past declination regarding the carpet. He was unable to recall any further discussion regarding the heavily soiled condition of the carpet. During an interview, on 1/27/23 at 1:07 p.m., the Administrator indicated the last time the carpet was professionally cleaned was over three years ago. Professional carpet cleaning was not common practice at the facility. A current facility policy, dated 3/2/22 and titled "Carpet Shampooing," provided by the Administrator on 1/27/23 at 11:40 a.m., indicated the following: "Policy... All carpeted floors will be cleaned in a thorough manner to ensure that carpets are free from obvious stains and spots and to ensure that carpets maintain a bacteriostatic-free environment...." Documentation of the last contracted carpet cleaning was not provided prior to the survey exit on 1/30/23. 3.1-19(f)(5)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on interview and record review, the	F 0684	1. Res # 49 had surgical	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure resident monitoring and treatment following a resident reported fall, which resulted in a delay for treatment for a fracture for 1 of 9 residents reviewed for accidents. (Resident 49) B. Based on record review and interview, the facility failed to follow physician's orders regarding medication administration parameters for a hypertensive medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 44) C. Based on observation, interview, and record review, the facility failed to obtain a therapy assessment/treatment per physicians order for 1 of 1 residents reviewed for therapy orders. (Resident 51) Findings include: A. The clinical record of Resident 49 was reviewed on 1/25/23 at 9:58 a.m. Diagnoses included, displaced fracture of the left femur, history of falling, lack of coordination, and mental health disorder. A quarterly Minimum Data Set (MDS) assessment, dated 9/9/22, indicated the resident had severe cognitive impairment, made self understood and understood others, had no hallucinations or delusions, and displayed no behaviors or rejection of care. The resident could transfer herself and walk using her walker, with supervision from staff. The resident's balance was not steady, but she was able to stabilize without assistance from staff. A Behavior Progress note, dated 9/7/22, indicated the resident had stated she was on the floor the		intervention to right hip and has since returned to facility and is doing well. 2. Other residents have the potential to be affected therefore any resident with fall in last 60 days will be reviewed for injuries, change in conditions or any missed process r/t falls by nursing management by date of compliance. Any issues identified will be addressed immediately. 3. Education will be provided to staff to notify the appropriate individual for any changes in condition including after a fall especially. Nursing staff will be educated on the entire process for events, the proper documentation required and the proper assessments as well as policy for event management and follow up. This will also include following event management policy if resident falls on LOA or if resident alleges they fell in house. Staff will also be educated on if ruling out an injury or possible fx, the resident is to be sent to ER not use portable x ray company. Education will be completed by date of compliance and no licensed nursing staff will work after date of compliance until education completed. 4. Nursing Management will review all events x 72 hours to assure all UDAS, assessments, including neuro checks if indicated, care plan and Kardex updated, test	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	day prior (9/6/22). However, staff did not find the resident on the floor or witness her being on the floor. She had a diagnosis of schizophrenia with delusional behaviors. She had no complaints of pain or discomfort reported. A late entry progress note, dated 9/9/22 at 12:15 p.m., indicated the resident had stated she fell and her left leg was hurting. x-rays were ordered, no bruising was noted to skin, and neurological checks were within normal limits. The resident had been noted to have a behavioral reaction to a recent room change, no staff witnessed a fall, and she ambulated independently. She was still able to ambulate. A Health Status Progress note, dated 9/9/22 at 4:59 p.m. indicated the resident stated she had a fall and complained of hip and pelvis pain. Pelvis and bilateral femur x-rays were scheduled immediately. A Health Status note, dated 9/9/22 at 10:39 p.m., indicated radiology presented to facility at 7:13 p.m. to perform the x-rays. The resident required assistance to roll and re-position as she was uncomfortable, and cussed out the radiology technologist. A Radiology report, dated 9/9/22 at 7:56 p.m., indicated an x-ray of the resident's right hip was obtained and showed no acute fracture or dislocation. The note lacked indication of a left hip x-ray being obtained. A Health Status note, dated 9/11/22 at 3:42 p.m., indicated the resident was aware of the recent x-ray results of the hip. She had been sitting in the dining room with her husband for hours during the shift, walking with a slow steady gait and		results, charting completed and all follow up in place including new orders as well per policy ongoing. Audits will be presented to QAPI monthly ongoing. 5. Date of Compliance: 03-03-2023 1. Resident # 44 had no adverse effects noted. MD and family notified. No new orders. 2. Other residents have the potential to be affected therefore an in house audit will be completed on residents with orders with perimeters going back 60 days to assure no other concerns. Any issues identified will be addressed, md and families notified, and any new orders received will be implemented. 3. Education will be provided to licensed nursing and QMAS on how to follow an order involving perimeters by nursing management by date of compliance. No licensed nursing staff or QMAS will work past date of compliance until education completed. Nursing management will complete med passes on all licensed nurses and QMAS by date of compliance. 4. Nursing management will complete 3 med passes weekly rotating shifts x 3 months then 2 med passes weekly x 3 months. Audit results will be presented to QAPI monthly and QAPI will determine the need for further audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	slight limp of the left leg at times." A Care Management note, dated 9/12/22 at 10:06 a.m., indicated the resident had started to exhibit new behavior of stating she had fallen. The resident had experienced no falls to staff knowledge, with no bruising or physical indications of falls. X-rays were obtained and were negative. Staff continued to monitor for changes related to behavior. A Rehabilitation Services Multidisciplinary Screening Tool, dated 9/12/22, indicated, the resident stated she fell and her left leg was sore. Nursing stated she was having behaviors after a room change. She had been walking with a walker. X-rays were ordered and were negative. The form indicated the resident was not appropriate for skilled therapy intervention. A Health Status note, dated 9/14/22 at 3:33 p.m., indicated her left and right femur/pelvis x-ray results indicated no fracture or dislocation noted. The medical doctor was made aware of the results. The resident complained of left leg pain and walked very little on it. The doctor was aware and wanted therapy to assess her and assist with walking. Therapy was made aware of the request. An Order note, dated 9/15/22 at 11:28 a.m., indicated a new order to make an appointment with orthopedics. Management was made aware and was to set up transportation for the walk-in clinic. A Health Status note, dated 9/21/22 at 1:15 p.m., indicated the resident was sent to the emergency room from the orthopedics provider due to a fractured left hip.		5. Date of Compliance 03-03-2023 1. Resident # 51 had no negative outcomes. Facility has contacted Central Indiana Ortho to determine if the MD wants to re-initiate therapy order at this time. Ortho MD re-instated therapy order on 02-15-23. 2. Other residents have the potential to be affected therefore an in house audit has been completed on all residents who have seen by Ortho in the last 90 days to assure no orders for therapy have been missed. Any issues will be identified and corrected including notify MD, and family, and following any new orders received by date of compliance. 3. Education will be completed to therapists and licensed nursing on the following. Education to include licensed nursing staff to validate all paper work on return to facility to validate any new orders. If orders present nurse to put orders into PCC, print off order, if therapy involved, copy of order to therapy and nurse to also fill out therapy/nursing communication form. New orders will be reviewed daily Monday through Friday in morning meeting to assure appropriate follow up. This education will be completed by date of compliance and during orientation. No licensed nursing and or therapist will work after	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An Orthopedic Consultation report, dated 9/22/22, indicated Resident 49 had been scheduled for surgical stabilization of her left hip fracture on 9/23/22. During an interview, on 1/26/23 at 2:43 p.m., the Rehabilitation Manager indicated the resident was using her walker and the x-rays were reported as negative. The resident was complaining of pain at the time. The Rehabilitation Manager indicated she had not realized at the time the radiology provider had been unable to x-ray the resident's left hip and the x-ray results were of the non-affected right hip. Therapy had needed to evaluate as requested by physician. Review of an undated, current facility procedure, titled "Fall management, long-term care," provided by the DON on 1/30/23 at 2:05 p.m., indicated the following: "...Introduction... In a health care facility, an accidental fall can change a short stay for a minor problem into a prolonged stay for serious-and possibly life-threatening-problems...Implementation...To determine the extent of the resident's injuries, look for lacerations, abrasions, and obvious deformities. Note any deviations from the resident's baseline condition. Notify the practitioner...Ask the resident or a witness what happened; find out whether the resident experienced pain...Even if the resident shows no signs of distress or has sustained only minor injuries, increase the frequency of monitoring...Notify the practitioner if you note any changes from baseline...." B. Resident 44's clinical record was reviewed on 1/24/23 at 3:19 p.m. Diagnoses included hypertensive heart and chronic kidney disease, end stage renal disease, and diastolic heart failure.		date of compliance without education completed. 4. Nursing management will audit all clinical records within 2 business days of residents going to orthopedic appointments ongoing to assure compliance. Upon receiving documentation from orthopedic appointments a registered physical therapist will review documentation and complete a screening tool to identify if any rehab needs for resident within 2 business days of date of orthopedic appointment ongoing. Audits will be presented to QAPI monthly ongoing. 5. Date of Compliance: 03-03-2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current physician's order, dated 12/16/22, indicated hydralazine hydrochloride (medication to treat high blood pressure) 50 mg (milligram), one tablet, three times a day. Hold medication for systolic blood pressure (top number) less than 110. A review of the electronic medication administration record (eMAR) for December 2022 indicated the following: a. The resident had a blood pressure of 106/57 on 12/19/22 at 8:00 a.m. and the medication was administered. b. The resident had a blood pressure of 106/57 on 12/19/22 at 4:00 p.m. and the medication was administered. A review of the eMAR for January 2023 indicated the following: a. The resident had a blood pressure of 105/60 on 1/4/23 at 8:00 a.m. and the medication was administered. b. The resident had a blood pressure of 106/68 on 1/11/23 at 4:00 p.m. and the medication was administered. c. The resident had a blood pressure of 100/59 on 1/17/23 at 8:00 a.m. and the medication was administered. d. The resident had a blood pressure of 101/56 on 1/18/23 at 8:00 a.m. and the medication was administered. e. The resident had a blood pressure of 109/58 on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/19/23 at 8:00 p.m. and the medication was administered. f. The resident had a blood pressure of 106/76 on 1/21/23 at 8:00 a.m. and the medication was administered. g. The resident had a blood pressure of 106/76 on 1/21/23 at 4:00 p.m. and the medication was administered. h. The resident had a blood pressure of 108/56 on 1/25/23 at 4:00 p.m. and the medication was administered. i. The resident had a blood pressure of 109/69 on 1/27/23 at 8:00 a.m. and the medication was administered. During an interview, on 1/30/23 at 11:04 a.m., the Director of Nursing (DON) indicated the resident should not have been administered the medication when the blood pressure was outside of physician ordered parameters. C. During an interview with Resident 51, on 1/30/23 at 10:22 a.m., he indicated he was upset regarding the lack of physical therapy he had received. He was receiving services and making progress of walking with a walker and then the sessions ceased. A review of Resident 51's clinical record was completed 1/30/23 at 11:25 a.m. Diagnoses included, history of stroke, muscle weakness and unsteadiness on feet. A document from an outside orthopedic provider, dated 12/13/22, indicated resident had arthritis of his left knee. A treatment order for physical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	therapy to evaluate and treat twice per week for a duration of six weeks was indicated on the physician signed document. The referral was good for twelve visits. A therapy order, dated 12/27/22, indicated therapy was notified of the referral from [orthopedic provider]. During an interview, on 1/30/23 at 10:53 a.m., the Rehabilitation Manager indicated she was not aware of an order from [orthopedic provider] in December and the resident had not been evaluated or treated in December of 2022. During an interview, on 1/30/23 at 11:04 a.m., the DON indicated the order had been provided to therapy and he was unsure why the resident had not been evaluated. A current facility policy, revised 3/17/22, titled, "Physician Orders," provided by the DON on 1/26/23 at 3:10 p.m., indicated the following: "Policy...The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines...." 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to monitor and document fluids consumed by 1 of 1 residents on fluid restrictions reviewed for dialysis. (Resident 44) Findings include: The clinical record for Resident 44 was reviewed on 1/24/23 at 3:19 p.m. Diagnoses included end stage renal disease and diastolic congestive heart failure. Current signed physician's orders included a regular diet with a 1500 ml (milliliter) daily fluid restriction, dated 12/16/22. A current health care plan, initiated on 8/18/22, with revisions on 1/19/23, indicated the resident was at risk for potential fluid deficit related to end stage renal disease and was non-compliant with the fluid restriction. An intervention, initiated 8/18/22, indicated to educate the resident/family/caregivers on importance of fluid intake. An intervention, initiated 1/19/23 indicated a 1500 ml fluid restriction and the resident was educated on risk factors of non-compliance with the fluid restriction. A review of Pre/Post Dialysis Communication forms indicated the following: a. On 12/3/22, dialysis center staff included instruction to encourage [Resident 44] to limit fluid intake. He was currently 8 kg (kilograms) (approximately 2.2 pounds) over his dry weight, which contributes to his SOB (shortness of breath). b. On 12/6/22, dialysis center staff included instruction to limit fluid intake. [Resident 44] had	F 0698	1. Res 44 remains in facility. Fluid restriction order was re started on 02-3-23. Resident is noncompliant and has been educated on risks and consequences. Care plan and Kardex updated. 2. Other residents have the potential to be affected therefore an in house audit has been completed by nursing management by date of compliance of residents with fluid restriction orders. Any issues will be addressed immediately. 3. Education will be provided to licensed nursing on assuring orders are transcribed accurately to MARS, dietary notified of any fluid restriction orders and fluids are divided accurately between nursing and dietary. The Care plan and Kardex is to be updated as well. This education will be presented on orientation and no nurse will work after date of compliance until education completed. 4. DON/Designee will review all admission, readmission and dialysis charts for accurate transcription of fluid restriction orders and on MARS/TARS appropriately ongoing. Audits will be presented to QAPI monthly x 6 months and QAPI will determine the need for further audits. 5. Date of Compliance: 03-03-2023	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a 6.6 kg gain since his last treatment and was 12.5 kg over his dry weight. This contributed to his SOB and they can only remove about 3 kg per treatment. c. On 12/8/22, dialysis center staff included comments of [Resident 44] being very lethargic when he arrived, but was better by the end of treatment. d. On 1/6/23, dialysis center staff included instruction of please restrict fluid to 1500 ml daily. e. On 1/20/23, dialysis center staff included instruction of please continue fluid restriction of 1500 ml. During a random observation, on 6/6/22 at 10:19 a.m., the resident's room was observed with a personal refrigerator and two insulated pitchers on his bedside table. A 12/8/22, nutrition/dietary progress note indicated the resident had fluid overload. The note lacked indication of a fluid restriction. A 12/10/22 health status progress note indicated the dialysis center had called to notify the facility the resident had been sent to the emergency room from the dialysis center due to fluid overload. A history and physical physician's note from the hospital, dated 12/10/22, indicated the resident had shortness of breath on admission, likely due to fluid overload. The resident was admitted to the hospital. A hospital discharge document, dated 12/16/22, indicated resident's diet as low carbohydrate, low sodium with a 2000 ml fluid restriction.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview, on 1/26/23 at 12:07 p.m., the Director of Nursing (DON) indicated Resident 44's fluid intakes had not been documented in the clinical record. There was no documentation regarding education provided to the resident or his family regarding his fluid restriction. He had no knowledge of the instructions present on the dialysis center's communication forms until this past week.

During an interview, on 1/30/23 at 2:50 p.m., Licensed Practical Nurse (LPN) 11 indicated she reviewed the communication sheets received from the dialysis center and if recommendations were present, she would document in nursing progress notes. She was not aware of the references to the resident's fluid restrictions and there fluid intakes had not been monitored for Resident 44.

During an interview, on 1/30/23 at 2:52 p.m., LPN 12 indicated she was not aware of Resident 44 being on a fluid restriction until this past week. She had not seen the documentation regarding a fluid restriction from the dialysis center. There had been no direction to monitor Resident 44's fluid intakes.

Review of a a current facility policy, revised 1/1/2007 and titled, "Fluid Restrictions," provided by the DON on 1/26/23 at 3:10 p.m., indicated the following:

"Policy: Fluid restrictions are coordinated between Nursing Services and Food and Nutrition Services...

Guidelines:...Upon notification of a fluid restriction order, the Director of Food and Nutrition Services or designee meets with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nursing Services representative to determine the amount of total fluid that will be provided by each department...." A current facility policy, revised 8/18/22 and titled, "Dialysis," provided by the DON on 1/26/23 at 2:37 p.m., indicated the following: "...General Guidelines:...2. Observe fluid restriction as ordered by the physician....10. Document any pertinent or relevant observations and information including compliance/non-compliance with food and fluid restrictions. 11. Document resident teaching regarding day and time of dialysis, fluid restriction if ordered by the physician...." 3.1-37(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to maintain cooking equipment in a clean, sanitary manner and failed to ensure dishes were washed in a manner to prevent cross contamination. This deficient practice had the potential to impact 67 of 67 residents who received meals from the kitchen. Findings include: During the initial kitchen observation, on 1/23/23 at 10:12 a.m., the following concerns regarding kitchen cleanliness were observed: a. The ledge of the oven hood had a heavy, thick, gummy, dark brown/black residue covering the hood's ledge. When using a paper towel to sweep across the ledge of the hood, the towel was covered with a thick black "Play-Doh" like residue. b. The drip pan located under the burners of the stove had a substantial build up of burnt-on liquid and food residue. c. Both inside doors of the stove had a yellow and brown sticky residue. The bottom of the stove had a powdery white gray residue. During an interview, on 1/23/23 at 10:17 a.m., the Dietary Manager indicated the stove should have been cleaned the previous Wednesday. During a meal preparation observation, on 1/30/23 at 11:10 a.m., the following concerns regarding dietary cleanliness concerns were again observed:	F 0812	**1. A) Oven Hood Ledge was cleaned on 1/31/23 by dietary staff** **B) Drip pans were emptied and cleaned on 1/31/23 by dietary staff** **C) Both stove doors were cleaned on 1/31/23 by dietary staff** **D) Aide 5 was educated by dietary manager on 2/23/23 on facility policy related to handling of dirty dishes.** **2. An in house audit of the kitchen items cited will be completed by date of compliance. Any issues noted will be addressed immediately. Other residents have the potential to be affected therefore DM made random observations to assure no further noncompliance.** **3. All dietary staff including dietary manger were educated on 2/2/23 by Registered Dietician on proper cleaning of all equipment in kitchen to include hood ledge, stove, drip trays, and handling of dirty dishes. New daily cleaning schedule for hood ledge and drip trays was put in to place on 2/1/23. New cleaning schedule for stove requiring**	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a. The ledge of the oven hood had a heavy, thick, gummy, dark brown/black residue covering the hood's ledge. When using a paper towel to sweep across the ledge of the hood, the towel was covered with thick black "Play-Doh" like residue. b. The drip pan located under the burners of the stove had a substantial build up of burnt on liquid and food residue. c. Both inside doors of the stove have a yellow and brown sticky residue. The bottom of the stove had a powdery white gray residue. During an interview, on 1/30/23 at 11:12 a.m., the Dietary Manager indicated the hood, stove and drip pan had been cleaned following the 1/23/23 observation. She did not know how the hood over the stove could have such a heavy thick build-up already. During an observation at this time, the Dietary Manager ran a paper towel over the hood ledge and removed a heavy thick black residue. During a dishwasher operation observation, on 1/30/23 at 11:15 a.m., the following dish handling concern was noted: Dietary Aide 5 was operating the dish machine. She was working on the soiled side of the machine. She was wearing disposable gloves. The picked up plates that were soiled with food particles using her gloved hands. She sprayed down the plates. She picked up glasses containing left over drinks and poured the drinks into the garbage disposal. She completed these tasks with the same set of gloves. She then opened the dish machine and pushed a soiled rack of dishes in resulting in the clean rack exiting the		**the outside to be wiped down after each meal and cleaned each night was put in to place on 2/1/23. This education will be completed by date of compliance and in orientation as well.** **4. Dietary manager or designee will audit stove, hood ledge, and drip trays daily for 1 month and then weekly for 6 months to ensure new daily cleaning schedule is being followed and areas are clean. Dietary manager or designee will ensure dirty dish handling policy is followed correctly by conducting random observations on dish aides. Dietary Manger will observe 2 dish aides weekly x 3 months then 1 dish aide weekly x 3 months to assure compliance. Any concerns will be addressed immediately. Results will be presented to QAPI x 6 months. QAPI will determine the need for further audits.** **5. Date of Compliance** 03-03-2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	machine to the clean/washed side of the dish machine. She moved to the clean/washed side of the dish machine and with her soiled gloved hand began to pick-up the clean dishes and move them to the clean dish storage rack. During an interview, on 1/30/23 at 11:18 a.m., Dietary Aide 5 indicated she wasn't sure if she should handle the clean dishes with the gloves she had used on the soiled side of the machine and maybe she should have changed them. At this time, the Dietary Manager asked if she was supposed to change gloves each time she moved from the soiled to clean side of the dish machine. A current, 9/8/22, facility policy titled "Sanitation and Maintenance", which was provided by the DON on 1/30/23 at 1:10 p.m., indicated the following: "...Cleaning Fixed Equipment: When cleaning fixed equipment ...that cannot readily be immersed in water), the removable parts must be washed and sanitized and none removable parts cleaned with detergent and hot water...." A current, 12/17/21, facility policy titled "Prevention of Cross Contamination", which was provided by the DON on 1/30/23 at 1:10 p.m., indicated the following: "...Handling of dirty dishes should be done separate from handling of clean dishes, if performed by one person, they must wash hands thoroughly after handling dirty dishes and transitioning to the handling of clean dishes...." 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0908 SS=E Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure wheelchair arms were in good repair in order to prevent possible skin tears or injury for 4 of 4 residents reviewed for equipment. (Resident 53, 20, 1 and 34) Findings include: 1. During the following observations, Resident 53 was observed in her wheelchair: 1/23/23 at 10:52 a.m., 1/26/23 at 10:51 a.m., 1/26/23 at 11:44 a.m., and 1/30/23 at 10:00 a.m. Her wheel chair had significant cracking on both the right and left armrest. The cracking revealed the padding underneath. The cracks made the wheel chair arm's surface rough and sharp with spiky vinyl pieces protruding in areas that could make contact with the resident's arms. Resident 53's clinical record was reviewed on 1/24/23 at 1:36 p.m. Current diagnoses included dementia, anorexia, and diabetics. A current, 12/21/22, Quarterly Minimum Data Set (MDS) assessment indicated the was severely cognitively impaired, required extensive assistance for locomotion on and off the unit and required a wheel chair for mobility. The resident had a current, 12/21/22, care plan problem/need regarding a risk for a break in skin integrity.	F 0908	**1. Concerns found on wheelchairs for residents 53, 21, 1, and wheelchair found in resident 34s room were repaired by maintenance on 1/31/2023.** **2. Facility wide audit was completed by DON on 2/03/2023 and any wheelchairs in need of repair were pulled out of circulation to be repaired or replaced.** **3. Education by ED to all staff will be completed by date of compliance. This education will include the following: Any staff member that notes any medical equipment that is faulty or in need of repair will be taken out of commission immediately and replaced.** **Staff is to fill out a work order for maintenance/therapy and follow up must be completed within 72 by those various departments. Staff that has not completed this education by date of compliance will be taken off the schedule. This education will also be presented in orientation.** **4. Maintenance director or designee will audit facility wheelchairs once a week for**	03/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During the following observations, Resident 21 was observed in her wheel chair: 10/23/23 at 10:53 a.m., 10/26/23 at 10:43 a.m., 10/26/23 at 11:43 a.m., and 10/30/23 at 10:02 a.m. Her wheel chair had significant cracking on both the right and left armrest. The cracking revealed the padding underneath. The cracks made the wheel chair arm's surface rough and sharp with spiky vinyl pieces protruding in areas that could make contact with the resident's arms. Resident 21's clinical record was reviewed on 1/24/23 at 2:04 p.m. Current diagnoses included dementia, depression and chronic kidney disease. The clinical record indicated the resident had poor safety awareness. A current, 1/6/23, Quarterly Minimum Data Set (MDS) assessment indicated the was moderately cognitively impaired, required supervision for locomotion on and off the unit and required a wheel chair or walker for mobility. 3. During the following observations, Resident 1 was observed in her wheel chair: 1/30/23 at 9:57 a.m. and 1/30/23 at 10: 10 a.m. Her wheel chair had significant cracking on both the right and left armrest. The cracking revealed the padding underneath. The cracks made the wheel chair arm's surface rough and sharp with spiky vinyl pieces protruding in areas that could make contact with the resident's arms. Resident 1's clinical record was reviewed on 1/30/23 at 10:28 a.m. Current diagnoses included dementia, diabetes, and hypothyroidism.		**one month then monthly times 6 months then quarterly thereafter to ensure facility wheelchairs are in good working order and free from any damage. Any concerns will be addressed immediately. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits** **5. Date of Compliance** 03-03-2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record indicated the resident moved to the secured/dementia unit on 1/26/23. The record also indicated the resident had poor safety awareness. A current, 11/2/22, Quarterly Minimum Data Set (MDS) assessment indicated the was severely cognitively impaired, required extensive assistance for locomotion on and off the unit and required a wheel chair for mobility. 4. During an observation on 1/30/23 at 9:58 a.m., a wheel chair was observed in Resident 34's room. The wheel chair had a small pea sized whole in the vinyl of the right armrest. The hole exposed the padding underneath and had a silver appearance as well. When touched the hole was very sharp and felt like the metal of a screw. The sharp pointed item in the hole was located in an area that could make contact with the residents arm. Resident 34's clinical record was review on 1/24/23 at 1:36 p.m. Current diagnoses included dementia, diabetics, and hypertension. A current, 11/30/22, Quarterly Minimum Data Set (MDS) assessment indicated the was severely cognitively impaired, required supervision for locomotion on and off the unit. During an interview, on 1/30/23 at 10:08 a.m., CNA 6 indicated if he saw a wheel chair with cracked arms he would need to inform the nurse, maintenance, and the Administrator. During an observation and interview, on 1/30/23 at 10:13 a.m., the Dementia Unit Manager indicated Residents 53, 20, 1 and 34's wheelchairs each had cracked area which resulted in sharp areas that could cause skin injuries. Additionally staff should inform the Maintenance Supervisor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 00 B. WING	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to request a repair of the arms. A current, 8/26/21, facility policy titled "Preventative Maintenance-Wheelchair ", which was provided by the DON on 1/30/23 at 1:10 p.m., indicated the following: "...3. Chairs which are found to have broken or missing parts or are in need of repair will be taken out of use immediately and reported to the maintenance department or rehab service for repair. 4. Needed repairs will be made and/or parts ordered for all broken chairs...." 3.1-19(bb)			