STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. Building B. Wing	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	343 S Nappanee St Elkhart, IN 46514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32951 Based on record review and interview, the facility failed to ensure a resident who received a pureed diet for frequent choking episodes did not receive food items other than pureed consistency for 1 of 1 residents reviewed for dietary needs. (Resident B) The Immediate Jeopardy began on [DATE] when the facility failed to ensure Resident B was provided the appropriate diet consistency as a snack during an activity, resulting in her choking and requiring the Heimlich manuever and CPR (cardiopulmonary resuscitation) before being admitted to the hospital. The Administrator was notified of the Immediate Jeopardy on [DATE] at 4:40 P.M. The Immediate Jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding includes: On [DATE] at 10:30 A.M., a review of Resident B's clinical record was conducted. Resident B was admitted on [DATE] with diagnoses included, but not limited to, schizoaffective disorder, Parkinson's disease, dementia in other cases classified elsewhere with behavioral disturbance. A Nursing Progress Note, dated [DATE] at 1: 25 P.M., indicated . Resident noted choking on candy, resident was able to cough up the candy. Resident orientation the same as baseline prior to choking incident. No further choking incidents noted this shift Will continue to monitor A swallow study was completed, on [DATE], and indicated recommendations were mechanical soft solids with ground meats, supervision with meals due to impulsivity, thin liquids and may consider use of controlled flow rate cup due to impulsivity. Crush med's. Upright at 90 degress during PO and 45 minutes after meal. She would benefit from a skilled dysphagia feeding, exercise and or management plan directed by Speech Therapy. A Nursing Progress Note, dated [DATE] at 3:47 P.M., indicated .Res [resident] had 1 choking episode at lunch today. Res was observed by staff very rapidly eating lunch, begin coughing, then had small emesis of undigested food. No difficulty with respirations, no symptoms of aspiration noted (continued on next page)

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 B. Wing	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	343 S Nappanee St Elkhart, IN 46514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing Progress Note, dated [DATE] 09:03 A.M., indicated .Interdisciplinary Note Late Entry: regarding choking incident on [DATE]. resident was eating and taking large bites of food, started coughing and regurgitated all food in her mouth. res states I ate too fast. therapy to have speech eval.resident educated on eating slowly and making sure to chew food she verbalizes understanding at this time. CP [care plan] reviewed and updated A Nursing Progress Note, dated [DATE] at 12:23 P.M., indicated .Care Plan Note: Care conference held with [Resident B], her brother did not call in. [Resident B] says she is happy with her care and has no complaints with anything. [Resident B's name] is on a mech soft diet. [Resident B's name] participates in group activities, bingo, food, and special events. [Resident B's name] will continue with [psych] services for no further mood decline. [Resident B's name] will remain in the facility long term. A Nursing Progress Note, dated [DATE] 6:28 P.M., indicated .Res sat at nurses' station with this nurse observing. Needed frequent reminders to slow down et to take smaller bites. Consumed meal without any choking noted . A Therapy dysphagia/Self-feeding Screen, completed on [DATE], indicated the reason for the screen was for a choking episode. She received a mechanical soft diet with thin liquids and was observed at dinner. The observation included, but were not limited to, dentition/dentures impacted her ability to eat. No dental exams present for review. On [DATE] at 1:50 P.M., the ED indicated she had no dental service documented since admission ([DATE]). Physician's order indicated on [DATE] to [DATE] she received a mechanical soft diet with thin liquids and required close supervision with all meals. Her diet changed on [DATE] to a pureed diet, thin liquids for frequent choking episodes. A Nursing Progress Note, dated [DATE] at 2:07 P.M., indicated .This nurse observed res for both meals today. Needed frequent cuing to take smaller bites, chew food more thoroughly, et to slow down eating. No choking episodes noted A Nursing Progress Note, dated [DATE] at 12:56 P.M., indicated .Behavior Note: Res was in hallway being observed by staff during lunch. Res became choked x [times] 2 despite being watched et cued. Res placed large amounts of food in her mouth both times she became choked; was able to clear her throat with much coughing. Res being placed on pureed diet per orders, et will continue with staff closely monitoring A Physician's Order, dated [DATE], indicated .Regular diet. Puree texture, thin consistency, for frequent choking episodes A Nursing Progress Note, dated [DATE] at 10:01P.M., indicated .Interdisciplinary Note: Discussed recent eating behavior with team. Resident has history of attention seeking behavior. she was being monitored at time of incident and Nurse that was with her believes she was attention seeking at that time. she did not choke, she took large bites and coughed and spit all food out onto plate. to be safe we changed her to a pureed diet after event. further coughing noted. CP reviewed and updated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. Building B. Wing	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	343 S Nappanee St Elkhart, IN 46514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Care Plan, dated [DATE], indicated .I have attention seeking behavior of filling my mouth to full during meals, eating to fast causing coughing episode. Nursing provide cues and reminders to take small bites and to eat at slower pace, but I continue to overfill my mouth. I will not overfill my mouth during meals daily. Notify Dr and family of any changes. Nursing Observe for increased cough, changes in respiratory status, cyanosis. Provide cues and reminders to eat slow and take small bites. Provide diet as ordered A Care Plan, dated [DATE], indicated .I have the potential for aspiration related to I put to much food in my mouth at one time. I will be free from s/sx [signs/symptoms] of aspiration through the next review. Allow me ample time for swallowing. Elevate the HOB as needed and as I tolerate. Observe for coughing or clearing of throat after swallowing. Provide my diet as ordered A Nursing Progress Note, dated [DATE], indicated .at approximately 150pm CNA [Certified Nurses Aide] called for help as resident was not breathing in dining room on 400. 911 called by floor nurse. resident blue in the face and her hands. no pulse palpated radially or carotid and resident not breathing. laid her down on floor and started cpr. ADON [Assistant Director of Nurses] brought crash cart, orally suctioned with nothing out but clear liquid. cpr [Cardio Pulmonary Resuscitation] ongoing until EMS [Emergency Medical Services] arrived at 205pm. still no pulse or respirations noted. ems transported resident to ER [emergency room] at 220pm During an interview, at 12:07 P.M. on [DATE], CNA 1 indicated the activity aide came and got her saying she needed help in the 400 hall dining room. When she arrived Resident B was standing unresponsive so she asked LPN 1 to come help them. LPN 1 administered the Heimlich maneuver. Resident B then slumped over after the Heimlich maneuver was conducted and was lowered to the floor and cardiopulmonary resuscitation was initiated. She indicated she did not know what had happened but that she knew the resident was on a modified diet of puree consistency because she ate and drank fast. During an interview, at 12:19 P.M. on [DATE], LPN 1 indicated she was asked to assist in the 400 hall dining room, on [DATE], because a resident was choking. She indicated it was Resident B and that she had performed the Heimlich maneuver approximately 10 times before the resident just collapsed and they lowered her to the floor and initiated cardiopulmonary resuscitation until the emergency medical personal came and took over. She indicated she did not know what had happened as she was not present when the incident occurred, but she had been told that the activity assistant had given the resident a cookie. During an interview, at 12:30 P.M., on [DATE], CNA 2 indicated the activity aide came down the hall calling out for help in the dining room. When she got to the dining room, Resident B was sitting in a chair with her hands up against her throat and chest area. She indicated her fingertips and lips were blue. She asked the resident to move her hands up in the air and she got behind her and did the Heimlich maneuver. She approximated she did the maneuver 3 times before the nurse arrived and continued trying. She indicated the resident then slumped over and cardiopulmonary resuscitation was initiated until the ambulance arrived and they took over. She indicated she did not witness the incident but she heard the activity aide tell the staff that were assisting in the dining room, that she had given Resident B a cookie. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. Building B. Wing	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	343 S Nappanee St Elkhart, IN 46514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Activity Aide 1 was unavailable for interview, but in a documented statement, provided by the Administrator on [DATE] at 10:00 A.M. she indicated there was an activity going on and they were handing out cookies as part of a food related activity. She said Resident B was in the activity room at the time but had gotten up and walked away. She was checking on her when she saw her in the dining room by the sink. She told the Administrator she thinks she heard her cough and may have been breathing funny. She stated Resident B was following direction at the time and asked her to sit down, she called for CNA 2 to come help and she ran to the dining room and began performing the Heimlich maneuver. The Administrator asked the Activity Aide if she knew the Resident was on a pureed diet and she stated she did know she was on a puree diet but thought since the cookie was soft it would be alright to give it to her. An emergency room Urgent Care Report, dated on [DATE] at 8:54 A.M., indicated .The patient is a [AGE] year old female who presents to the Emergency department today from a nursing home status post cardiac arrest. The patient was in the cafeteria eating when she had a choking episode and then went into Cardiac Arrest. CPR was immediately initiated. EMS arrived and emesis was suctioned from the patient's throat and mouth. She was intubated with a 6.5 French endotracheal tube. CPR was continued by EMS and she received 3 rounds of epinephrine with spontaneous return of circulation. A Chest Tube Insertion r/t [related to] Rt. Pneumothorax and she was transitioned to a Ventilator. Impression/Assessment/Plan:Cardiopulmonary Arrest,Pneumothorax,Shock, Multiple Rib Fractures,Sternal Fracture, Lactic Acidosis,Leukocytosis, and choking episode. admitted under critical care on ventilator management and IV fluid resuscitation During an interview, on [DATE] at 1:00 P.M., the facility Administrator indicated she had reported an incident in which a resident of the Dementia Unit, had a potential choking episode and was sent to the hospital. She indicated an activity aide had given the resident a cookie during an activity that was going on that day. She indicated that all personnel that had anything to do with dietary knew diet orders and that they all had a list indicating residents with special diets. A policy, titled, Physician's Diet Order, with a revision date of [DATE], was provided by the Administrator on [DATE] at 1:03 P.M The policy indicated .All diets are precribed in writing by the physician in terms used in the approved diet manual. The diet manual is available in the Culinary& Nutrition Services Office, the Administrator or DON [Director of Nurses] office, as well as at each nursing station. 4. The Culinary & Nutrition Services Manager, or designee, will record the diet order in the electronic meal tracking system and prepare a diet tickket with the information. This diet ticket is placed on the meal tray for reference and identification when serving meals The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility completed a whole house diet audit, audited the resident diet communication system and inserviced staff on only serving residents food that is in accordance with their physician ordered diet, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for continued inservicing and monitoring. This Federal tag is related to Complaint IN00361677. 3XXX,d+[DATE](a)