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	07/27/2021

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on interview and record review, the facility failed to ensure an advance directive was in place for 1 of 3 residents reviewed for advance directives. (Resident 41) Finding includes: A clinical record review was conducted, on [DATE] at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. Resident 41's medical record indicated there was a discrepancy between the physician orders and the careplan. A physician order, dated [DATE], indicated .Do Not Resuscitate (DNR) A previous care plan indicated .My wishes are that CPR be performed if indicated No current care plan was in place at this time. During an interview, on [DATE] at 11:04 A.M., the Administrator indicated there was a discrepancy with the advance directives. A care plan, dated [DATE], indicated .My wishes are that no CPR be performed , following an interview with the Administrator. A policy was provided by the Administrator, on [DATE] at 1:13 P.M., titled ADVANCE DIRECTIVES POLICY AND PROCEDURE, dated [DATE], and indicated this was the policy currently used by the facility. The policy indicated .Information about whether or not the Resident has executeed an advance directive shall be displayed prominently in the medical record

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on interview and record review, the facility failed to ensure physician notification was completed following weight loss for 1 of 4 residents reviewed for nutrition. (Resident 41) Finding includes: A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. Resident 41's medical record indicated he weighed 138 pounds on 5/21/2021 and weight 117.4 pounds on 6/22/2021. A weight loss of 20.6 pounds, which was 15%. Resident 41's medical record indicated no physician was contacted for his weight loss. During an interview, on 7/27/21 at 11:22 A.M., the DON (Director of Nursing) indicated there were no documented physician notifications related to Resident 41's weight loss, in his medical record. A policy was requested, but one was not provided. 3.1-5(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on interview and record review, the facility failed to ensure a resident was not mistreated while in the facility and failed to ensure physical abuse/involuntary seclusion did not occur in the facility for 1 of 5 residents reviewed for abuse. (Resident 41) Findings include: A clinical record review was conducted, on 7/19/2021 at 10:30 A.M., and indicated Resident 41's diagnoses included but were not limited to: wernicke's encephalopathy, psychotic disorder with delusions and dementia. A Behavior Note, dated 4/5/2021, indicated .The CNA [certified nurses assistant] and I took an arm each and pulled him down the hall and put him in his room and closed the door. The male CNA opened the door and ask this resident [NAME] [how] he was doing. He yelled back Get out A Behavior Note, dated 5/12/2021, indicated .After about 2200 [10:00 P.M.] we put this resident in his room and stationed a CNA in front of his door. CNA redirected this resident multiple times and did not allow him to leave his room. At this point he has not tried to open his door for about 15mins A Behavior Note, dated 5/14/2021, indicated .When this resident is placed in his room with a CNA at the door, he pulls apart anything and everything On 7/21/2021 at 3:02 P.M., Resident 41 was observed to be sitting in his recliner with his feet elevated. A straight back chair sitting at the foot of the recliner, with a white blanket covering him from his chest down over his legs and feet and up over the top of the back of the straight back chair. A small amount of blood was observed on the white blanket. Splatters of blood the shape of half circles, silver dollar sized, were observed on the floor of his room surrounding his recliner. During an interview, on 7/22/2021 at 12:38 P.M., the DON (Director of Nursing) acknowledged these incidents took place. A policy was provided by the Administrator, on 7/27/2021 at 1:13 P.M., titled ABUSE PREVENTION, IDENTIFICATION, INVESTIGATION, AND REPORTING POLICY AND PROCEDURE, dated June 21, 2017. The policy indicated .All Residents have the right to be free from abuse, neglect, misappropriation of Resident property, exploitation, corporal punishment, involuntary seclusion, any physical or chemical restraint not required to treat the Resident's medical symptoms, and personal degradation 3.1-27(a)(1) 3.1-27(a)(4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident with known recurrent behaviors was not restrained to keep him from getting up from his room recliner for 1 of 1 randomly observed residents. (Resident 41) The Immediate Jeopardy began on 7/21/2021 when the facility failed to ensure Resident 41 was not restrained from rising from his room recliner and leaving his room. The Administrator was notified of the Immediate Jeopardy at 2:35 P.M. on 7/23/2021. The Immediate Jeopardy was removed on 7/26/2021, 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 7/21/2021 at 3:02 P.M., Resident 41 was observed to be sitting in his recliner with his feet elevated. A straight back chair sitting at the foot of the recliner, with a white blanket covering him from his chest down over his legs and feet and up over the top of the back of the straight back chair. A small amount of blood was observed on the white blanket. Splatters of blood the shape of half circles, silver dollar sized, were observed on the floor of his room surrounding his recliner. Nurse 5 pulled down the blanket, which showed that the straight back chair was lodged under the foot of the recliner, holding it in an upright position. Resident 41's right great toenail was observed to be bent upwards and bleeding. Resident 41 was unable to get up out of his chair. A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. A Behavior Note, dated 4/5/2021, indicated .Again in another resident's room. He was making the empty bed. We encourage him to go to his room and he refused. We pulled the curtain to do AM care but he pulled the blanket off the other resident's bed and started to put it on the empty bed. The CNA[certified nurses assistant] and I took an arm each and pulled him down the hall and put him in his room and closed the door. The male CNA opened the door and ask this resident [NAME] [how] he was doing. He yelled back Get out A Behavior Note, dated 5/12/2021 indicated .During the evening this resident went into multiple rooms and removed personal items of residents in each room. I redirected over and over and returned the items he removed. I gave him a PBJ sandwich and he ate all the sandwich. After about 2200 [10:00 P.M.] we put this resident in his room and stationed a CNA in front of his door. CNA redirected this resident multiple times and did not allow him to leave his room. At this point he has not tried to open his door for about 15mins [minutes] A Behavior Note, dated 5/14/2021, indicated . Resident remains very restless and unable to stay still. He continues going in and out of rooms and taking items. When this resident is placed in his room with a CNA at the door, he pulls apart anything and everything. He is now sitting in a chair sleeping (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 7/22/2021 at 12:38 P.M., the DON (Director of Nursing) shook her head and acknowledged the incident that occurred on 4/5/2021. During an interview, on 7/23/2021 at 11:05 A.M., the Administrator indicated CNA 7 admitted to putting the chair under the foot of Resident 41's room recliner. A policy was provided by the Administrator, on 7/23/2021 at 4:25 P.M., titled Restraints: Emergency Use, dated 9/15/2001, revised 6/1/2021, and indicated this was the policy currently used by the facility. The policy indicated .2. Obtain order for emergency use of a restraint either during the application of the restraint or immediately after the restraint has been applied The Immediate Jeoppardy that began, on 7/21/2021, was removed, on 7/26/2021, when the facility removed the chair from under the footrest, removed the employee involved from the schedule, observed residents to ensure there were not any unnecessary restraint devices, in -serviced staff on what constitutes a restraint and that an unnecessary restraint is not to be initiated and created/implemented and an audit tool to ensure unnecessary restraint devices are not in place. The 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, because of the need for continued inservicing and monitoring. 3.1-3(w) 3.1-26(o)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on record review and interview, the facility failed to ensure pertinent transfer and resident clinical information was completed for 3 of 3 residents reviewed for hospitalization . (Residents 47, 48 & 55) Findings include: 1. A clinical record review was completed on 7/22/2021 at 3:09 P. M., and indicated Resident 47's diagnoses included, but were not limited to: respiratory failure, obesity, hypertension, depression and gout. A nurses' note, dated 6/15/2021 at 5:32 P.M. indicated Resident 47 was sent to the emergency room for evaluation of a mouth abscess. A nurses' note, dated 6/27/2021 at 1:20 P.M., indicated the resident would be returning to the facility. The chart lacked the transfer documentation and clinical information for the transfer on 6/15/2021. During an interview, on 7/27/2021 at 1:37 P.M., the Administrator indicated she could not provide any transfer documentation, but it should have been completed. 44111 2. A clinical record review was conducted, on 7/22/2021 at 10:00 A.M., for Resident 55. The record indicated the resident was admitted on [DATE]. The resident's diagnoses included, but were not limited to: surgical amputation of the left leg below the knee, abscess buttock, end stage renal disease, type 1 diabetes. The Quarterly (MDS) Minimum Data Set assessment, dated 7/6/2021, revealed a brief interview for mental status of 15, which indicated Resident 55 cognition was intact. Resident 55's record lacked any documentation to show a transfer form with pertinent clinical information was completed for a transfer that occurred on 7/20/2021. On 7/22/2021 at 11:48 A.M. the Director of Nursing indicated that a transfer form was not sent with the resident and the medical record lacks documentation of the transfer which should have been done. 38844 (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A record review was conducted, on 7/21/21 at 12:53 P.M., for Resident 48. Diagnoses included, but were not limited to, fracture of one rib right side, chronic diastolic congestive heart failure, chronic pain syndrome, osteoarthritis, depressive disorder, disorders of bone density, Parkinson's disease and schizoaffective disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 6/29/21, indicated Resident 48 was cognitively intact. A Discharge MDS assessment, dated 5/17/21, indicated Resident 48 was discharged to an acute care hospital. A Progress Note, dated 5/17/21, indicated Resident 48 was transferred to the hospital due to complaints of shortness of breath and low oxygen saturation of 78% (percent). A Progress Note, dated 5/18/2021, indicated Resident 48 had been admitted for a hemothorax (an accumulation of blood within the pleural cavity (the area between the lungs and chest wall). No documentation was available to indicate what information was provided to the hospital for ongoing care of Resident 48. During an interview, on 7/22/21 at 2:51 P.M., the ED (Executive Director) indicated there were no transfer sheets available, the nurse is to make a copy of the transfer sheet and the paperwork that was sent with the resident. On 7/27/2021 at 10:42 A.M., the Administrator provided the policy titled,Resident Transfer and Discharge Policy and Procedure, revision date 11/28/2016, and indicated the policy was the one currently used by the facility. The policy indicated .(2) Documentation. When the facility transfers or discharges a Resident under any circumstances specified in paragraph (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the Resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information. (C) Advance Directive information. (D) All special instructions or precautions for ongoing care, as appropriate 3.1-12(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on record review and interview, the facility failed to ensure the Ombudsman was contacted upon discharging 3 of 3 residents reviewed for admission/transfer/discharge. (Residents 47, 48 & 55) Findings include: 1. A clinical record review was completed on 7/22/2021 at 3:09 P. M., and indicated Resident 47's diagnoses included, but were not limited to: respiratory failure, obesity, hypertension, depression and gout. A nurses' note, dated 6/15/2021 at 5:32 P.M. indicated Resident 47 was sent to the emergency room for evaluation of a mouth abscess. A nurses' note, dated 6/27/2021 at 1:20 P.M., indicated the resident would be returning to the facility. During an interview, on 7/27/2021 at 1:37 P .M., the Administrator indicated there was no ombudsman notification of the transfer to the hospital. 44111 2. A clinical record review was completed on 7/22/2021 at 10:00 A.M., for Resident 55. The record indicated the resident was admitted on [DATE]. The resident's diagnoses included, but were not limited to: surgical amputation of left leg below the knee, abscess buttock, end stage renal disease, type 1 diabetes. The Quarterly (MDS) Minimum Data Set assessment on 7/6/2021, revealed a brief interview for mental status score of 15, which indicated Resident 55 cognition intact. Resident 55 was transferred to a local emergency roiagnom on [DATE]. Resident 55's face sheet indicated the mother was the responsible party and no documentation was present to indicate she had been notified of the transfer. On 7/22/2021 at 10:00 A.M., the Director of Nursing indicated that notice of transfer was not filled out and sent with the Resident 55 and should have been. 38844 3. A record review was conducted, on 7/21/21 at 12:53 P.M., for Resident 48. Diagnoses included, but were not limited to, fracture of one rib right side, chronic diastolic congestive heart failure, chronic pain syndrome, osteoarthritis, depressive disorder, disorders of bone density, Parkinson's disease and schizoaffective disorder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly MDS (Minimum Data Set) assessment, dated 6/29/21, indicated Resident 48 was cognitively intact. A Discharge MDS assessment, dated 5/17/21, indicated Resident 48 was discharged to an acute care hospital. A Discharge MDS assessment, dated 5/25/21, indicated Resident 48 was discharged to an acute care hospital. A Progress Note, dated 5/17/21, indicated Resident 48 was transferred to the hospital due to complaints of shortness of breath and low oxygen saturation of 78% (percent). A Progress Note, dated 5/25/21, indicated Resident 48 was transferred to the hospital. No documentation was available to indicate a notice of transfer was provided to Resident 48 or to her representative when she was transferred to the hospital. No documentation was available to indicate the Ombudsman was notified of the 5/25/21 discharge to the hospital. During an interview, on 7/22/21 at 2:51 P.M., the ED (Executive Director) indicated there were no notifications of transfer available, the nurse is to make a copy of the paperwork that was sent with the resident. During an interview, on 7/27/21 at 2:21 P.M., the ED indicated the Ombudsman should have been notified of the transfers to the hospital. On 7/27/2021 at 10:42 A.M., the Administrator provided the policy titled,Resident Transfer and Discharge Policy and Procedure, revision date 11/28/2016, and indicated the policy was the one currently used by the facility. The policy indicated .(ii) Notice must be made as soon as practicable before transfer or discharge when-(D) An immediate transfer or discharge is required by the Resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section. (5). Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include at least the following and any additional notice requirements imposed by the state of Indiana: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;(iii) The location to which the Resident is transferred or discharged . 3.1-12(a)(6)(A)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on record review and interview, the facility failed to provide written bed hold information for 4 of 4 residents reviewed for hospitalization . (Resident 47, 48, 55 and 211) Findings include: 1. A clinical record review was completed on 7/22/2021 at 3:09 P. M., and indicated Resident 47's diagnoses included, but were not limited to: respiratory failure, obesity, hypertension, depression and gout. A nurses' note, dated 6/15/2021 at 5:32 P.M. indicated Resident 47 was sent to the emergency room for evaluation of a mouth abscess. A nurses' note, dated 6/27/2021 at 1:20 P.M., indicated the resident would be returning to the facility. During an interview, on 7/27/2021 at 1:37 P.M., the Administrator indicated she could not provide any transfer or bed hold documentation, but it should have been completed. 44111 2. A clinical record review was conducted, on 7/22/2021 at 10:00 A.M., for Resident 55 and indicated he was admitted on [DATE]. His diagnoses included, but were not limited to: surgical amputation of left leg below the knee, abscess buttock, end stage renal disease and type 1 diabetes. The Quarterly (MDS) Minimum Data Set assessment, dated 7/6/2021, revealed a brief interview for mental status score of 15, which indicated Resident 55 cognition was intact. Resident 55 was transferred to a local emergency roiagnom on [DATE]. No documentation was present to indicate a notice of bed hold had been issued to Resident 55 or their representative at the time of transfer. During an interview, on 7/22/2021 at 11:48 A.M., the Director of Nursing indicated that a notice of bed hold policy was not issued to Resident 55 or her representative at the time of transfer and should have been. 3. A clinical record review was conducted, on 7/26/2021 at 2:38 P.M., for Resident 211. The record indicated the resident was admitted on [DATE]. The resident's diagnoses included, but were not limited to: surgical amputations, poliomyelitis left ankle and foot, type 2 diabetes and peripheral vascular disease. The 5-day (MDS) Minimum Data Set assessment, dated 7/12/2021, revealed a brief interview for mental status score of 15, which indicated Resident 211 cognitive status was intact. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 211 transferred to the hospital, on 6/29/2021, for worsening wound to the left foot. No documentation was present to indicate a notice of bed hold had been issued to Resident 211 at the time of transfer. On 7/27/2021 at 2:17 P.M., the Administrator indicated no bed hold policy was found and one should have been filled out. 38844 4. A record review was conducted, on 7/21/21 at 12:53 P.M., for Resident 48. Diagnoses included, but were not limited to, fracture of one rib right side, chronic diastolic congestive heart failure, chronic pain syndrome, osteoarthritis, depressive disorder, disorders of bone density, Parkinson's disease and schizoaffective disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 6/29/21, indicated Resident 48 was cognitively intact. A Discharge MDS assessment, dated 5/17/21, indicated Resident 48 was discharged to an acute care hospital. A Progress Note, dated 5/17/21, indicated Resident 48 was transferred to the hospital due to complaints of shortness of breath and low oxygen saturation of 78% (percent). No documentation was available to indicate a bed hold policy was provided to Resident 48 or to her representative when she was transferred to the hospital. During an interview, on 7/22/21 at 2:51 P.M., the ED (Executive Director) indicated there were no bed hold policy available, the nurse is to make a copy of the paperwork that was sent with the resident. On 7/27/2021 at 10:42 A.M., the Administrator provided the policy titled,Resident Transfer and Discharge Policy and Procedure, revision date 11/28/2016, and indicated the policy was the one currently used by the facility. The policy indicated .(d) Notice of bed-hold policy and return--(1) Notice before transfer. Before a nursing facility transfers a Resident to a hospital or the Resident goes on a therapeutic leave, the nursing facility must provide written information to the Resident or Resident representative. (i) The duration of the state bed-hold policy, if any, during which the Resident is permitted to return and resume residence in the facility .2. Bed-hold notice upon transfer. A the time of the transfer of a Resident for hospitalization or therapeutic leave, a nursing facility must provide to the Resident and the Resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section 3.1-12(a)(25)(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on interview and record review, the facility failed to ensure individualized and comprehensive care plans were in place and implemented for 6 of 26 residents whose care plans were reviewed. (Resident 41, 20, 14, 49, 31 & 51) Finding includes: 1. A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. Resident 41's care plan indicated no seizure care plan was in place. During an interview, on 7/23/21 at 11:05 A.M., the Administrator indicated Resident 41 needed a seizure care plan in place. 2. A clinical record review was completed, on 7/23/2021 at 3:10 P.M., and indicated Resident 20's diagnoses included but were not limited to: dementia with behavioral disturbance, major depressive disorder and parkinson's disease. Resident 20's medical record indicated no care plan for her diagnoses of dementia had been put into place. During an interview, on 7/23/2021 at 4:10 P.M., the Administrator indicated Resident 20 needed to have a dementia care plan in place. 38845 3. On 7/19/2021 at 12:31 P.M., Resident 14 was observed to have skin issues (redness and open area) to his bilateral outer ankles. A clinical record review was completed on 7/22/2021 at 1:18 P.M., indicating Resident 14's diagnoses included, but were not limited to: hemiplegia, vascular dementia, diabetes, bipolar, stroke and hypertension. A quarterly MDS (Minimum Data Set) assessment, dated 5/26/2021, indicated Resident 14 had a BIMS (Brief Interview for Mental Status) score of 14, intact cognition. He required limited assist of 1 staff for bed mobility, transfers, supervision for eating and extensive assist of 1 staff for toilet use and dressing. Had an impairment in range of motion to one side of his body and used a wheel chair for mobility. A care plan, dated 7/21/2021, indicated the resident had actual open areas to right and left ankle related to the wheel chair leg rest. Interventions included, but were not limited to: observe skin with care and report any further skin breakdown to nurse. Pad wheelchair to protect ankles. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a random observation, on 7/24/2021 at 1:58 P.M., Resident 14 was observed sitting in his wheelchair with no padding to the wheelchair. During a random observation, on 7/26/2021 at 10:02 A.M., Resident 14 was observed sitting in his wheelchair with no padding to the wheelchair During a random observation, on 7/26/2021 at 2:03 P.M., Resident 14 wheelchair was without padding. During an interview, on 7/26/2021 at 2:05 P.M., CNA (certified nursing assistant) 17 indicated there was no padding on Resident 14's wheel chair, and if it was on the care plan he should have it on. 4. During a random observation, on 7/19/2021 at 10:19 A.M., Resident 49 was observed laying in bed with the oxygen tubing on the floor. A clinical record review was completed on 7/20/2021 at 3:05 P.M., and indicated Resident 49's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, compression fractures T 5-T 6, anxiety, fibromyalgia, moderate protein -calorie malnutrition, dependence on supplemental 02, lymphoma, and intercostal pain. A significant change MDS (Minimum Data Set) assessment, dated 6/30/2021,indicated Resident 49 had a BIMS (Brief Interview for Mental Status) score of 13, cognition intact. She required supervision with 1 staff for bed mobility, transfers, limited of 1 staff for dressing, eating and toilet use and required continuous oxygen. A nurses' note, dated 5/9/2021 at 12:10 A.M., indicated Resident 49 was sitting on the floor by the door yelling help. The resident had a large laceration (skin tear) to left lower leg. The staff instructed her to use the call light. An IDT (Interdisciplinary Team) note, dated 5/10/2021 at 11:27 A.M., indicated Resident 49 was trying to self transfer from her bed to go to the bathroom and had fallen. She received a skin tear to her right upper arm. The intervention was educated on using call light. A nurses' note, dated 5/10/2021 at 9:18 P.M., indicated the resident is resting in bed. Will continue to monitor. Instructed again not to get up without calling for help resident states she understands. A nurses' note, dated 7/9/2021 at 1:33 P.M., indicated Resident 49 was transferring from the wheelchair to bed and tripped on the 02 tubing, landing on her knee causing a skin tear to the knee. An IDT note, dated 7/12/2021 at 12:15 P.M., indicated the resident was self transferring from the wheelchair to the bed and became tangled in her 02 tubing and fell , grabbing onto wheelchair, the cushion slipped and she fell to floor on her knees. New intervention was dycem (non skid sheet) added to cushion seat of wheelchair at time of fall. Resident educated on using call light for assistance and can return demo and verbalize when she needs to do that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current care plan, dated 4/2/2021, indicated the resident was at risk for falls/have experienced a recent fall/due to Medications (i.e. :Psychotropic/Diuretic/Cardiovascular/Pain/Other Medications) or Medical Conditions; Fracture/Bone Weakness, Incontinence, and Osteoporosis. Interventions included, but were not limited to: anticipate my need, assess my bowel patterns since there are times that I exhibit alterations in my memory, dycem to wheelchair, educate and remind resident of safety. During a random observation, on 7/26/2021 at 1:55 P.M., Resident 49's wheelchair had no dycem on the wheel chair. During an interview, on 7/26/2021 at 1:57 P.M., LPN (licensed practical nurse) 5 indicated the dycem should be on her wheelchair and the 02 tubing should not be on the floor. 38844 5. During an interview, on 7/20/21 at 10:10 A.M., Resident 31 complained of pain to his right heel. A record review was conducted, on 7/22/21 at 3:00 P.M., for Resident 31. Diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, contusion of right hip, pain in right leg and fracture of superior rim of right pubis. A Quarterly MDS (Minimum Data Set) assessment, dated 6/16/21, and indicated Resident 31 had severe cognitive impairment a diagnoses of other fracture, he had occasional pain that he rated at a 7 (on a 1-10 scale, 10 being the worst pain) during the last 5 days of the assessment date, and received as needed pain medication, had 1 fall and required extensive assist of 1 for transfers. For June 2021 MAR (Medication Administration Record) indicated Resident 31 received Extra Strength Tylenol 500 mg (milligrams) on 6/8 (x 2), 6/9, 6/18 (x 2), 6/20 and 6/30 and Tylenol 325 mg on 6/4, 6/5, 6/6 (x 2), 6/7 (x 2), 6/12, 6/13 and 6/29 and rated his pain from a 4 to a 10. He rated his pain a 10 x 2 on 6/7 and x 1 6/9. The July 2021 MAR indicated Resident 31 received Extra Strength Tylenol 500 mg (milligrams) on 7/1, 7/3, 7/9, 7/11 and 7/24 and Tylenol 325 mg on 7/1, 7/17 and 7/24 and they were effective. He had rated his pain from a 5 to a 8. During an observation, on 7/22/21 at 3:10 P.M., Resident 31 was laying in his bed, he had no facial indications he was in pain and declined incontinent care from C.N.A. (Certified Nursing Assistant) and did not indicate he was having pain. A care plan for pain was not available for review. During an interview, on 7/22/21 at 4:51 P.M., the ED (Executive Director) indicated there was no care plan available for pain for Resident 31, but indicated he should have one. 6. A record review was conducted, on 7/21/21 at 9:44 A.M., for Resident 51. Diagnoses included, but were not limited to, type 2 diabetes, chronic obstructive pulmonary disease, chronic kidney disease, paranoid schizophrenia, cerebral infarction, depressive disorder, dysphasia and delusional disorders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Significant Change MDS (Minimum Data Set) assessment, dated 7/1/21, indicated Resident 51 was cognitively intact and received hospice services. A Care Plan, revised on 6/29/21, indicated Resident 51 was receiving hospice services related to CVA (cerebral vascular accident). The Care Plan interventions indicated, the facility staff and hospice personnel to collaborate together to provide me comfort and support for myself and my family, administer medications as ordered, if unable to tolerate oral medications consult with hospice nurse/physician for alternate routes, assess her respiratory and cardiac status as needed and indicated, be available for her to verbalize and questions/concerns in regards to her care, encourage her family and friends to visit and be supportive of her needs, ensure she is comfortable and pain free and turn and reposition to ensure comfort. The Care Plan did not include Resident 51's care providers related to hospice, and hospice provided care, how to contact the hospice provider 24 hours a day and who to call and when to call them and does not include hospice provider specific information. During an interview, on 7/21/21 at 2:53 P.M., SSD (Social Service Director) indicated the care plan is not resident specific with provider information. A policy was provided by the ED on 7/22/21 at 10:17 A.M., titled CARE PLANNING POLICY AND PROCEDURE, updated 7/24/19, and indicated this was the policy currently used by the facility. The policy indicated .The comprehensive care plan will include the Resident's needs, strengths and weaknesses, goals and time frames to meet a Resident's medical, nursing, and mental and psychosocial needs. The care plan is based on the Resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team .Each resident's care plan shall be reviewed at least quarterly .The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37147 The facility failed to revise the resident's care plan to reflect new or changed interventions after a change in condition and following falls to prevent further falls for 1 of 5 residents reviewed for care plan revision (Resident 29). Findings include: On 7/23/21 at 11:04 A.M., the record for Resident 29 was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia with behavioral disturbance, muscle weakness, repeated falls and lower leg contractures. A annual MDS (Minimum Data Set) assessment, dated 6/15/21, indicated Resident 29 had a BIMS (Brief Interview Mental Status) score of 10-moderately impaired cognition. He required extensive assistance from 2 staff members for transfers and bed mobility, was non-ambulatory, and had limited range of motion to all extremities. He required limited assistance of 1 staff member for locomotion in his wheelchair both on and off the unit. A Care Area Assessment for falls, indicated the resident had a fall resulting in a hematoma and bruising and required extensive to total assist with transfers. A Care Plan, initiated on 9/9/20 and revised on 9/24/20, indicated the resident was at risk for falls and had experienced a recent fall due to Parkinson's diagnoses. The goal, revised on 6/25/21, was for the resident to exhibit safe practices to prevent falls through the next review. Interventions and dates initiated were: 2/21/21-fall mat to floor beside bed; 11/9/20-Sign placed in resident's room to remind him to call for help before transferring; 9/24/20-Anticipate his needs; 9/24/20-Assess fall risk at least quarterly and when declines in condition are observed; 9/24/20-Assess pain management plan of care and provide interventions that effectively maintain pain at acceptable levels; 9/24/20-Encourage him to avoid sudden changes in position; 9/24/20-Ensure the walkway paths are clear in his room; 9/24/20-Ensure that there is adequate lighting in his personal space; 9/24/20-Restorative program for strengthening; 9/24/20-Make sure personal items are within reach; and 9/24/20-Provide resident with a low bed. A Care Plan, initiated on 9/9/20 and revised on 9/24/20, indicated the resident required assistance with activities of daily living due to Parkinson's diagnosis and poor mobility. The goals, updated on 6/25/21, were for the resident to feed himself all 3 meals and to be appropriately dressed and groomed daily. Interventions included, but were not limited to, 11/9/20-complete bed mobility with one person assist; 11/9/20-complete transfers with one person assist; 11/9/20-complete walking tasks with one person assist using walker; and 11/9/20-perform locomotion with one person assist using the walker. The care plan did not indicate Resident 29's current functional status per the MDS assessment completed on 6/15/21. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/21 at 11:36 A.M., Resident 29 was observed wearing a hospital gown and lying in his bed with the head of the bed elevated. There was no floor mat next to his bed. He had contractures to both hands and extensive bruising to the right side of his forehead and around and below his right eye. He indicated he had fallen recently and injured the same side of his head as when he'd fallen previously. He indicated both falls occurred from his wheelchair and the falls needed to stop; he had tried to get up by myself and probably shouldn't have. On 7/23/21 at 11:39 A.M., CNA (Certified Nurse Assistant) 28 was interviewed. During the interview, she indicated she provided care to Resident 29 according to the Resident Care sheet that she received at the beginning of her shift in addition to report received by the charge nurse. CNA 28 didn't have her Resident Care sheet with her but went to get one from the nurses station where she found one that was dated for June 2021 but was unable to find a current copy. On 7/23/21 at 2:08 P.M., the Assistant Director of Nursing (ADON) provided a current copy of the Resident Care sheet for Resident 29. The Resident Care sheet indicated he was independent with eating, resided on the memory care unit, had no safety protocols, transferred with assistance of 1 staff member, had behaviors which were not specified, and used a wheelchair. A policy was provided by the ED (Executive Director), on 7/22/21 at 10:17 A.M., titled, CARE PLANNING POLICY AND PROCEDURE, updated 7/24/19, and indicated this was the policy currently used by the facility. The policy indicated .The comprehensive care plan will include the Resident's needs, strengths and weaknesses, goals and time frames to meet a Resident's medical, nursing and mental and psychosocial needs. The care plan is based on the Resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team .Each resident's care plan shall be reviewed at least quarterly .The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status and assuring all care plan interventions are communicated to the appropriate staff that provides the care 3.1-35(d)(2)(B)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on interview and record review, the facility failed to ensure a discharge summary was completed for 1 out of 1 resident reviewed for admission/discharge. (Resident 61) Finding includes: A clinical record review was completed on 7/21/2021 at 2:40 P.M., for Resident 61. The record indicated the resident was admitted on [DATE]. The resident's diagnoses indicated, but were not limited to: chronic obstructive pulmonary disease, alcohol dependence, left tibia fracture. The Quarterly (MDS) Minimum Data Set assessment, dated 4/26/2021, revealed a brief interview for mental status score of 15, which indicated Resident 61 cognition was intact. Resident 61 signed herself out, on 5/11/2021. She informed the facility she was going to her Mom's house with plans on returning before midnight. She never returned. On 7/23/2021 at 9:47 A.M. the Administrator indicated that once they knew she was not coming back they should have completed the discharge summary. On 7/22/2021 at 4:20 P.M., the administrator provided a policy titled, Discharge Summary and Plan, dated December 2016, and indicated the policy was the one currently used by the facility. The policy indicated .The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and a permitted by the resident 3.1-36(a)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on observation, interview and record review, the facility failed to provide adequate care and supervision, including behavior care planning and interventions, to prevent a confused resident from repeatedly acting out against other residents, resulting in imminent danger to himself and other residents. (Resident 41) In addition to the residents in Immediate Jeopardy, the facility failed to ensure adequate supervision to prevent falls, consistently implement appropriate and individualized interventions to reduce risk of further falls, monitor the effectiveness of each residents' fall interventions, thoroughly analyze each fall incident to determine the root cause of the fall and revise the resident's care plan to reflect new or changed interventions after each fall as needed for 3 of 5 residents reviewed for falls. (Residents 29, 48 & 49) The Immediate Jeopardy began on 10/2/2020 when the facility failed to ensure Resident 41's aggressive behaviors did not result in potential or actual harm towards others. The Administrator was notified of the Immediate Jeopardy at 2:34 P.M. on 7/23/2021. The Immediate Jeopardy was removed on 7/26/2021, 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: 1. During intial tour of the facility, on 7/19/2021 at 10:45 A.M., Resident 41 was observed to have feces on himself, the wall, the air conditioner, his bed, his recliner and his call light. The air conditioner was missing its cover, the outlet was missing from the wall, the outlet was broken for air conditioner, foot board was missing from his bed, leaving metal bars standing up in the air. On 7/19/21 at 11:05 A.M., Resident 41's call light was still covered in feces and stretched across the newly made bed. On 7/19/2021 at 11:53 A.M., Resident 41 was observed standing at the head of his bed bent over with his socks halfway off his feet. Feces was observed running down the air conditioner and a broken electric outlet laying on the ground. On 7/19/2021 at 12:32 P.M., the Administrator acknowledged Resident 41 needed assistance/care to help with his situation. She indicated the staff did not finish cleaning up Resident 41's room. A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. A Nurses Note, dated 10/1/2020, indicated .resident entered nurses station, and upon attempt to redirect resident out of this area, resident physically attacked this nurse . slapping glasses off face, and punching this nurse . the aide arrived and attempted to talk resident down at which time resident picked up the chair from the nurses desk and threw it . both the aide and this nurse attempted to escort the resident back to his room . he began throwing everything he could get his hands on down the hallway (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurses Note, dated 10/8/2020, indicated .Resident going in others rooms and not listening to redirection. Attempted to throw a tennis shoe at this writer. Call to 911 for police A Behavior Note, dated 11/13/2020, indicated .Most of shift resident walked up and down hall and at times went into other resident's rooms A Behavior Note, dated 11/15/2020, indicated .Resident is physically aggressive toward staff, throwing books, roaming into other residents' rooms and messing with their things. Resident refused to take evening medications and attempting to punch at nurse while attempting to give meds and redirect A Behavior Note, dated 12/6/2020, indicated .Res has past behavior of crawling under other res' [residents] beds. Res' roommate is currently on O2 [oxygen]. While doing rounds, observed roommate's O2 off, et [and] machine under bed unplugged. This res was the only person in room with roommate at the time. Res has history of destroying electronic devices, such as Tvs, VCRs, computers, phones, and radios. This res also pulls the curtains around his roommate on a constant basis, obstructing staff's view of dying roommate A Behavior Note, dated 12/10/2020, .Found in another res' room, going through their closet earlier this am. Became agitated et verbally aggressive towards staff, refusing to leave room. Did finally allow staff to show him his room, where he continued to push things off of his bed angrily A Behavior Note, dated 12/16/2020, indicated .Res was going in et out of other res' rooms, taking their belongings and refusing to give them back, becoming agitated towards staff when attempting to re-direct res towards his room A Behavior Note, dated 12/31/2020, indicated .Resident up all morning, wandering into others rooms, touching/taking belongings . when staff attempts to redirect, resident ignores staff or becomes physically aggressive A Behavior Note, dated 1/1/2021, indicated .Resident entered another resident's room and could not be re-directed verbally. Became combative and aggressive. Inside other resident's room resident forcefully closed door A Behavior Note, dated 1/5/2021, indicated .resident is wandering the halls and going in and out of resident rooms A Behavior Note, dated 1/14/2021, indicated .Resident came out of room upon this nurses arrivial . covered in feces, male aide attempted to take resident to his room to get cleaned up when resident began punching staff member . two more staff came to assist. Resident fighting staff the entire time . staff successful in cleaning resident up, then staff cleaned up resident room as he had trashed it and defecated in the laundry basket as well, . A Behavior Note, dated 1/25/2021, indicated .Res in et out of other res' rooms frequently this shift. While in rooms, res found to be going through other resident's belongings A Behavior Note, dated 3/8/2021, indicated .Res frequently in other res' rooms today. Noted res covered up another res' head while they were lying in bed. Also noted to be messing with the heater in another res' room (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 4/5/2021, indicated .Up in the hall and going into other resident's rooms. Tried to redirect and he started trying to hit the CNA [certified nurses assistant]. He had a cup of water in his hand and he tried to throw it on the CNA. I took the water and emptied it. He walked ahead of me and picked a bottle of body wash off the CNA cart and throw it at me A Behavior Note, dated 4/5/2021, indicated .Again in another resident's room. He was making the empty bed. We encourage him to go to his room and he refused. We pulled the curtain to do AM care but he pulled the blanket off the other resident's bed and started to put it on the empty bed A Behavior Note, dated 4/5/2021, indicated .Became physically aggressive with staff a few minutes ago as staff was attempting to assist res with changing clothing. Res picked up a metal car decoration et was going to throw it at CNA until staff was able to get object away from him. Is now ambulating around unit, attempting to exit locked doors. Unable to redirect A Behavior Note, dated 4/5/2021, indicated .Ambulating up et down hallway at a very rapid pace. Going into other res' rooms et refusing to leave, flipped one res off, attempting to strike staff whenever care is attempted, et also attempting to go out locked doors A Behavior Note, dated 4/9/2021, indicated .At approx 0820 this am, staff member was attempting to deliver res' breakfast tray. Res had room door blocked with his bed. Staff able to move bed to allow entrance. Res became very angry et aggressive, Punched CNA in the face with his fist, attempted to spit in staff's faces et kicked a hole in the wall of his room. Unable to calm res. Res had also torn covering on bed in room, as well as fully destroying the heater/ air conditioning unit A Behavior Note, dated 4/9/2021, indicated .Found res in another res' room, attempting to pull apart the call-light system and the remote to other res' bed. Was able to redirect res back into his room, where this nurse found that res had torn off the footboard of his bed, as well as ripped mattress cover on his bed even further than he had previously A Behavior Note, dated 4/27/2021, indicated .Patient was pulling on electrical cord of the bed and the control unit trying to pull them out of the bed. he pushed the bed and table out of the room (412) the tv cable end had been pulled off, on the unit by pulling on the cords he could cause himself or others to trip or possibly be electrocuted from a bear wire contact . A Nurses Note, dated 5/8/2021, Indicated .Res in constant motion today. In other res' rooms . and .Went into another res' room, grabbed their package of snacks et had most of them consumed before staff could remove them. Found in his room et other res' rooms tinkering with the the heaters/ AC units A Behavior Note, dated 5/12/2021, indicated .During the evening this resident went into multiple rooms and removed personal items of residents in each room A Behavior Note, dated 5/14/2021, indicated .Resident remains very restless and unable to stay still. He continues going in and out of rooms and taking items A Behavior Note, dated 5/14/2021, indicated .Res has been in other res' rooms numerous times this shift, despite numerous staff attempts to redirect. Early in shift found res pushing a bed out into hallway with another res lying on it (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 7/18/2021, indicated .Res has been in et out of other res' rooms most of day- taking other res' small belongings. Not always easily redirected. Raised his fist at CNA as she was redirecting him out of a res' room During an interview, on 7/26/2021 at 9:55 A.M., the Administrator indicated after reading the progress notes, she indicated Resident 41 was a harm to himself and other residents. She indicated he is now on 1:1 supervision. 38844 2. A record review was conducted, on 07/21/21 at 12:53 P.M., for Resident 48. Diagnoses included, but were not limited to, fracture of one rib right side, extrapyramidal and movement disorder, chronic diastolic congestive heart failure, chronic pain syndrome, osteoarthritis, depressive disorder, disorders of bone density, Parkinson's disease and schizoaffective disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 6/29/21, indicated Resident 48 was cognitively intact, had 1 fall and required extensive assist of 1 for transfers. A Progress Note, dated 8/1/2020 at 9:42 P.M., indicated Resident 48 slipped while being assisted out of bed and landed on her left arm. She complained of her left arm being a little sore, but no broken bones were noted or any new injuries. A Progress Note, dated 8/2/2020 at 1:10 P.M., indicated Resident 48 had swelling and purple bruising around knuckles to her left ring and pinky finger, denied pain and was able to move her fingers and there were no apparent injuries noted. No documented IDT (Interdisciplinary) team note related to the fall she had with updated interventions and or root cause analysis being completed. The current care plan at the time of the fall for Resident 48 did not indicate an intervention was implemented to prevent further falls. A Progress Notes, dated 9/4/2020 at 6:22 A.M., indicated Resident 48 slid from her bed on to the floor mat while attempting to transfer herself. She was educated on calling for assistance. An IDT (Interdisciplinary) team note, dated 9/4/2020 at 3:25 P.M., indicated Resident 48 was attempting to self transfer and slid to the floor from the bed and the care plan was reviewed and updated as need. The intervention of education was done and Resident 48 understood. The current care plan at the time of fall indicated an intervention, dated 9/4/20, for therapy to screen due to a fall. A Progress Note, dated 10/10/2020 at 7:19 A.M., indicated Resident 48 was found sitting on her buttocks beside her bed, no injures were noted. She was assisted back to bed with the assist of 3 staff. She was encouraged to call for assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IDT team note, dated 10/12/2020 at 1:26 P.M., indicated Resident 48 was reaching for something on her bedside table and ended up on the floor. An intervention of therapy would screen and the care plan was reviewed and updated. The current care plan at the time of fall indicated there were no new interventions implemented to prevent further falls, the intervention for therapy to screen was in place on 9/4/20. A Progress Note, dated 11/11/2020 at 9:10 A.M., indicated Resident 48 was found lying on her stomach with a laceration above her right eye and small laceration below her right eye and was sent to the ER (emergency room) for evaluation. A Progress Note, dated 11/11/2020 at 5:00 P.M., indicated Resident 48 returned from the ER with 3 sutures above her right eye and 2 sutures to below her right eye and purple bruising to right eye. A IDT team note, dated 11/12/2020 at 4:31 P.M., indicated Resident 48 was found laying on the floor after attempting to self transfer, and the care plan was updated the facility would continue to monitor and the intervention would be to educate her for calling for assistance and therapy to screen. The current care plan in place at the time of the fall indicated an intervention, dated 6/13/20, and revised 11/9/20, for a sign placed in her bathroom to remind her to use her call light before transferring by herself, and on 11/2/20 an intervention for a low bed, but no new intervention was found to be put into place after the fall on 11/11/20 to prevent further falls with injuries. A Progress Note, dated 12/6/2020 at 3:35 P.M., indicated Resident 48 was found sitting on the floor in front of the bed with regular socks on her feet, and indicated no obvious injuries. She was educated about the injuries that could occur if she continued to attempt to transfer herself and gripper socks were applied to her feet for safety. An IDT team note, dated 12/6/2020 at 4:37 P.M., indicated Resident 48 slid down to the floor. She was educated about attempting to transfer self and the injuries that could occur if she continued to transfer herself, and gripper socks were applied to her feet. The facility would continue to monitor. The current care plan at the time of the fall indicated there were no new interventions implemented to prevent further falls. A Progress Note, dated 12/12/2020 at 6:17 P.M., indicated Resident 48 was found kneeling on her wheelchair in her bathroom. She was educated on using her call light to get assistance with transfers. There were no ID team notes available for review for the fall on 12/12/20. The current care plan at the time of the fall indicated no new interventions implemented to prevent further falls. A Progress Note, dated 1/16/2021 at 6:50 A.M., indicated Resident was found sitting on the floor of her bathroom and no injuries were noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note, dated 1/16/2021 at 9:12 A.M., indicated Resident was found sitting on the floor in her bathroom with her wheelchair behind her in the bathroom doorway. She indicated she was in a hurry to go to the bathroom, she kept going and her wheelchair did not and she landed on the floor. There were no IDT team notes available related to falls on 1/16/21. The current care plan at the time of the fall indicated an intervention was initiated, on 1/11/21, and revised on 1/26/21, to educate resident on use of call light and importance of calling for assistance and an intervention, initiated 1/11/21, to place a sign in her room reminding her she needed help with transfers. There were no new interventions in place for the fall on 1/16/21 to prevent further falls. An intervention, dated 2/12/21, was documented on the care plan for therapy to provide a wiping extender for the resident to use related to the fall on 1/16/21. A Progress Note, dated 2/23/2021 at 5:30 A.M., indicated Resident 48 was found on the floor and had a large knot over her right eye. An IDT team note, dated 2/23/21, indicated the resident attempted to self transfer and sat on the floor, hitting her head on the bedside table. Her right eye is purple and measured 2 x 1 cm (centimeter) and indicated the care plan had been reviewed and updated for a toileting program. The current care plan at the time of the fall, indicated no toileting program intervention had been added as an intervention on the care plan. There were no new interventions in place for the fall on 2/23/21 to prevent further falls. A Progress Note, dated 3/2/21 at 1:45 A.M., indicated at 12:05 A.M., Resident 48 was found laying on the floor on her back in her room. The resident indicated she was trying to go to the bathroom. Staff were educated to assist Resident 48 to the bathroom every 2 hours. A IDT team note, dated 3/2/2021 at 10:11 A.M., indicated Resident 48 had gotten up to the bathroom without assistance and fell from wheelchair during self transfer. She was educated on the importance to call for assistance and an intervention for the pharmacist to review meds for side effect and the careplan had been reviewed and updated. The current care plan at the time of the fall indicated interventions, dated 3/2/21, for the pharmacist to review medications for side effects and review the genetic test results by the psychiatric NP (Nurse Practitioner). A Progress Note, dated 4/16/21 at 3:30 P.M., indicated Resident 48 attempted to transfer herself from toilet to wheelchair and lost her balance and fell to the floor on her right side and hit the right side of her forehead on toilet paper holder sustaining a laceration above right eye 3.0cm x 0.8 cm. She was sent to the ER for evaluation. A Progress Note, dated 4/16/21 at 11:16 P.M., indicated she returned to the facility with stitches to her right forehead. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IDT team note, dated 4/19/2021 at 9:21 A.M., indicated Resident 48 transferred herself and was unstable and fell and it had been reported the resident had been using her call light frequently throughout the day, but did not use for going to the bathroom. The intervention would be to send a UA (urinalysis) for an evaluation for a UTI (urinary tract infection) and the care plan was reviewed and updated. There was no documentation available to review related to a urinalysis being obtained. The current care plan at the time of the fall indicated there were no new interventions implemented to prevent further falls. A Progress Note, dated 5/6/21 at 3:15 P.M., indicated Resident 48 had been found sitting on the bathroom floor, she indicated she was brushing her teeth and was trying to sit back in her wheelchair when she sat on the floor. She denied any injuries at the time, but complained of right rib pain. A order was to get x-rays 3 views with chest. The chest x-ray was obtained, on 5/6/21, and indicated no fractures were present. A Progress Note, dated 5/8/21 at 7:00 A.M., indicated Resident 48 complained of severe right sided pain and was guarding her right side. The nurses assessment indicated no bruising, redness or swelling was noted to the resident's right side. The resident was sent to the ER for an evaluation. A Progress Note, dated 5/8/21 at 10:30 A.M., indicated Resident 48 had returned from the ER with a diagnoses of 11th right rib fracture. An IDT team note, dated 5/10/2021 at 9:27 A.M., indicated regarding a fall on 5/6/21 Resident 48 was up by herself at the bathroom sink and she went to sit down in the wheelchair and missed the seat, the wheelchair was unlocked and rolled back and hit her right side upon the fall. Resident 48 had been educated at the time of the fall on how to lock her wheelchair and to call for assistance with transfers and activities of daily living. It was indicated the care plan was reviewed and updated. The current care plan at the time of the fall indicated there were no new interventions implemented to prevent further falls. A Progress Note, dated 5/10/21 at 9:30 P.M., indicated Resident 48 complained of extreme pain in her right ribs and requested to go to the hospital and she was sent to the ER for an evaluation. A Progress Note, dated 5/11/21 at 3:32 A.M., indicated Resident 48 returned to the facility. A Progress Note, dated 5/17/21 at 6:25 P.M., indicated Resident 48 had complained of being short of breath and had been noted to have been very pale with extreme labored breathing. Oxygen had been applied per nasal cannula at 2 liters per minute due to her oxygen saturation was at 78% (percent) and the nurse increased her oxygen to 3 liters per minute and her oxygen saturation went to 87% (normal oxygen saturation is 95-100% for healthy adults). The resident was sent to the ER for evaluation. A hospital History & Physical, dated 5/17/21, indicated she was being admitted to the hospital with a right rib fracture and a large probable right hemothorax (an accumulation of blood between the linings of the lung and the chest wall) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note, dated 5/25/21 at 2:06 P.M., indicated Resident 48 returned from the hospital at approximately 12:00 P.M. and indicated she had been in the hospital for hemothorax from a fall. A Progress Note, dated 5/25/2021 at 1:30 P.M., indicated the nurse was called to Resident 48's room and she had been found laying on the floor on her left side with a large hematoma above her left eyebrow, she complained of her head hurting and was holding her head and was sent to the hospital for an evaluation. An IDT team note, dated 5/26/21 at 12:05 P.M., indicated Resident 48 had been readmitted from the hospital, on 5/25/21 at 12;05 P.M., and by 1:30 P.M., she had fallen and was experiencing shortness of breath and was sent to the ER for evaluation and was readmitted to the hospital. She had poor safety awareness and refuses to call for assist to transfer, but will put on call light for staff to sit with her and indicated the care plan had been updated. The current care plan at the time of the fall indicated there were no interventions implemented to prevent further falls. A hospital History & Physicial, dated 5/25/21, indicated Resident 48 had been discharged at 11:00 A.M., on 5/25/21 and returned back to the facility where she had fallen and returned back to the hospital. She was found to have a hemothorax and underwent a chest tube placement and was found to have a right 10th rib fracture. A Progress Note, dated 6/3/21 at 12:12 P.M., indicated Resident 48 had been readmitted to the hospital. A Progress Note, dated 6/15/21 at 4:40 P.M., indicated Resident 48 was found on the floor next to her wheelchair, lying on her right side and her gripper socks were intact. She indicated she was trying to get back in bed. She had been educated on using her call light. An IDT team note, dated 6/16/2021 at 11:09 A.M., indicated Resident 48 had a fall from her wheelchair during a self transfer. She had been educated on calling for assistance and therapy would assess wheelchair cushion for positioning, and indicated the care plan was reviewed and updated. The current care plan at the time of the fall indicated there were no new interventions implemented to prevent further falls. A care plan, dated 3/21/2018 revised 4/19/2021, indicated Resident 48 was at risk for falls and has experienced a recent fall due to poor balance, ankle issues, osteoarthritis and the use of psychotropic medications, she required the use of a walker and wheelchair, she transferred herself even with knowledge of requiring assist and did not use her call light for assist, and used the call light to gain attention from staff. The goal, dated 3/21/18 and revised 2/7/20, indicated Resident 48 risk for falls and or minimal injuries would be decreased. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 48's interventions were to educate her on the use of call light and importance of calling for assistance (revised 1/26/21); to place a sign in her room reminding her she needs help with transfers (revised 2/4/21); Sign placed in residents bathroom to remind her to use the call light before trying to transfer off the toilet by herself (revised 11/9/2020); Therapy will provide a wiping extender for resident to use related to fall on 1/16/21 (dated 2/12/21); Pharmacist to review meds for side effects (dated 3/2/21); Review of genetic test results by psychiatric NP (dated 3/2/21); Social services to follow up with psych services (revised 11/9/2020); Will review genetic results with psych services due to actual fall on 2/28/21 (dated 2/28/21 and revised 3/3/21); anticipate her needs (dated 3/21/2018); Assess her falls risk at least quarterly and when declines in her condition are observed (Date 03/21/2018); Assess her pain management plan of care and provide her with interventions that will effectively maintain my pain at an acceptable level (Date 03/21/2018); Ensure that the walkway paths are clear in her room (Date 03/21/2018); Ensure that there is adequate lighting in her personal space (Date 03/21/2018); Make sure her glasses are clean daily (Date 03/21/2018); Make sure that all of her personal items that she may want to use are within her reach and at her level (Date 03/21/2018); Provide her with a low bed (Date 11/02/2020); Review her medications and discontinue any unnecessary meds that may contribute to her falls risk (Date 03/21/2018). There were no root cause analysis documentation available for review for Resident 48's falls. A Fall Risk Evaluation, dated 6/15/21, indicated Resident 48 fall score was 17 representing being high risk for falls. No other Fall Risk Evaluations were provided for review. During an interview on, 7/22/21 at 11:47 A.M., the DON indicated they had IDT meetings to discuss her falls and the MDS nurse is responsible for updating the care plan after a fall, but the facility has not had a MDS person. She indicated the residents care plan should have been updated after each fall to prevent further fall and injuries. During an interview, on 7/26/21 at 11:29 A.M., RN3 indicated the nurse completes a fall report and completes a risk management report for falls and pain management and puts an intervention on the risk management form for each fall, but the DON (Director of Nursing) is who updates the care plan with the intervention. She indicated the Floor nurse doesn't participate in IDT meetings, but management may come around and get input from them. During an interview, on 7/27/21 at 9:40 A.M., the ED (Executive Director) indicated the DON had indicated everything about the fall is discussed in the IDT meetings and there should be a root cause analysis completed. 37147 3. On 7/23/21 at 11:04 A.M., the record for Resident 29 was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, dementia with behavioral disturbance, muscle weakness, repeated falls and lower leg contractures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An annual MDS assessment, dated 6/15/21, indicated Resident 29 had a BIMS score of 10-moderately impaired cognition. He required extensive assistance from 2 staff members for transfers and bed mobility, was non-ambulatory, and had limited range of motion to all extremities. He required limited assistance of 1 staff member for locomotion in his wheelchair both on and off the unit. A Care Area Assessment for falls, indicated the resident had a fall resulting in a hematoma and bruising and required extensive to total assist with transfers. Fall Risk Assessments, dated 11/24/20, 2/20/21, 6/2/21 and 7/18/21, indicated the resident was at high risk for falls. A Care Plan, initiated on 9/9/20 and revised on 9/24/20, indicated the resident was at risk for falls and had experienced a recent fall due to Parkinson's diagnosis. The goal, revised on 6/25/21, was for the resident to exhibit safe practices to prevent falls through the next review. Interventions and dates initiated were: 2/21/21-fall mat to floor beside bed; 11/9/20-Sign placed in resident's room to remind him to call for help before transferring; 9/24/20-Anticipate his needs; 9/24/20-Assess fall risk at least quarterly and when declines in condition are observed; 9/24/20-Assess pain management plan of care and provide interventions that effectively maintain pain at acceptable levels; 9/24/20-Encourage him to avoid sudden changes in position; 9/24/20-Ensure the walkway paths are clear in his room; 9/24/20-Ensure that there is adequate lighting in his personal space; 9/24/20-Restorative program for strengthening; 9/24/20-Make sure personal items are within reach; and 9/24/20-Provide resident with a low bed. A Care Plan, initiated on 9/9/20 and revised on 9/24/20, indicated the resident required assistance with activities of daily living due to Parkinson's diagnosis and poor mobility. The goals, updated on 6/25/21, were for the resident to feed himself all 3 meals and to be appropriately dressed and groomed daily. Interventions included, but were not limited to, 11/9/20-complete bed mobility with one person assist; 11/9/20-complete transfers with one person assist; 11/9/20-complete walking tasks with one person assist using walker; and 11/9/20-perform locomotion with one person assist using the walker. The care plan did not indicate Resident 29's current functional status per the MDS assessment completed on 6/15/21. A Resident Care sheet, dated 7/23/21, indicated the resident was independent with eating, resided on the memory care unit, had no safety protocols, transferred with assistance of 1 staff member, had behaviors which were not specified, and used a wheelchair. An Occupational Therapy Evaluation and Plan of Treatment form indicated the resident had received therapy services to increase his activity tolerance and safety with transfers from 6/14/21-7/13/21. A Physical Therapy Evaluation and Plan of Treatment form indicated he had received physical therapy to improve his functional mobility to decrease his fall risk from 6/9/21-7/6/21. On 7/23/21 at 11:36 A.M., Resident 29 was observed wearing a hospital gown and lying in his bed with the head of the bed elevated. There was no floor mat to his bed. He had contractures to both hands and extensive bruising to the right side of his forehead and around and below his right eye. He indicated he had fallen recently and injured the same side of his head as when he'd fallen previously. He indicated both falls occurred from his wheelchair and the falls needed to stop; he had tried to get up by himself and probably shouldn't have. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/24/21 at 11:50 A.M., The resident was observed wearing a hospital gown and lying in his bed with the head of the bed elevated and an overbed table placed in front of him. There was no floor mat next to his bed. He indicated he was uncomfortable and needed someone to reposition him before eating lunch. A Nursing Note, dated 6/2/21 at 2:06 p.m., indicated Resident 29 was found face down on the floor of his room, under his roommates bed. He indicated he had fallen out of his wheelchair. The NP (Nurse Practitioner) was notified and staff were to continue to assess him. Nurse Practitioner Notes indicated the following: 6/2/21 at 2:20 p.m., resident was assessed after a fall that occurred on this day. He was found by nursing staff in his room, lying face down under his roommate's bed after activities returned him to his room. The resident indicated he had fallen out of his chair when he tried to reach for the call light. Nursing staff reported the roommates call light was not on the floor and that no items were on the floor for him to try and pick up. There were multiple areas of trauma-a large hematoma to the right side of his forehead, redness to

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on observation, interview and record review, the facility failed to ensure incontinence care was provided to 1 of 3 residents reviewed for bowels ad bladder annd failed to provide catheter care and prevent a resident with a indwelling urinary catheter from getting an UTI in 1 of 3 residents reviewed for catheters. (Resident 20 & 39) Finding includes: 1. On 7/21/2021 at 12:40 P.M., Resident 20 was observed sitting in her wheelchair, wet with urine, showing from the front of her pants. CNA 19 was observed to walk past Resident 20 and say hi, however she did not offer to assist resident to get cleaned up. On 7/21/2021 at 12:57 P.M., Resident 20 was observed in her wheelchair in the hallway wearing the same wet pants as on prior observation. On 7/21/2021 at 3:16 P.M., Resident 20 was observed in activities with the same pants on as the prior observation. She was observed to be wet and had a foul odor of urine. On 7/21/2021 at 4:57 P.M., Resident was observed being assisted to get cleaned up. Resident 20 was observed to be soaking wet with urine with a foul odor. Her pants were wet and the wheelchair was wet and dripping urine as the resident stood up. A clinical record review was completed, on 7/21/2021 at 2:45 P.M., and indicated Resident 20's diagnoses included but were not limited to: dementia, Parkinson's disease and cerebral palsy. A Care Plan, dated 2/18/2020, indicated .Initiate prompted voiding program to increase resident awareness of continence/incontinent episodes and increase continence During an interview, on 7/21/2021 at 5:00 P.M., the Administrator indicated Resident 20 should not have gone that long without being assisted to be changed/cleaned up. She indicated her brief and wheelchair was wet with urine. A policy was provided by the Administrator, on 7/27/2021 at 1:13 P.M., titled Urinary/Bowel Incontinence, dated June 2008, and indicated this was the policy currently used by the facility. The policy indicated, .1. The facility staff shall strive to help the residents maintain or maximize urinary/bowel continence as much as possible 38845 2. During an interview, on 7/20/2021 at 10:54 A.M., Resident 39 indicated his catheter plugs up at times. The catheter drainage bag was observed uncovered at this time. (continued on next page)

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Woodland Manor	343 S Nappanee St Elkhart, IN 46514

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A clinical record review was completed on, 7/20/2021 at 3:16 P.M., and indicated Resident 39's diagnoses included, but were not limited to:chronic obstructive pulmonary disease, sleep apnea, obstructive and reflux uropathy, chronic kidney disease and heart failure. A quarterly MDS (Minimum Data Set) assessment, dated 6/16/2021 indicated Resident 39 requires extensive assist of 2 staff for bed mobility, transfers, toilet use and dressing. Uses oxygen continuous and had an indwelling catheter. A current care plan, dated 6/18/2021, indicated Resident 39 had a supra pubic catheter related to obstructive uropathy with lower urinary tract obstruction. Interventions included, but were not limited to: check tubing for kinks each shift/per policy; monitor and document intake and output as per facility policy; observe for/document pain/discomfort due to catheter; observe for/document/report to MD for signs and symptoms of UTI (urinary tract infections): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. A nurse's note, dated 5/12/2021 at 6:12 P.M., indicated Resident 39's supra pubic catheter was leaking. Changed with 16 x 10 cc bulb without difficulty. Resident tolerated well with 30 cc clear yellow urine obtained. A nurse's note, dated 5/15/2021 at 12:53 P.M., indicated Resident 39 was sent to the hospital related to the supra pubic catheter had not been draining properly this am, and the resident did complain of abdominal pain. A nurse's note, dated 5/15/2021 at 4:07 P.M., indicated the resident had returned from the hospital with new suprapubic catheter in place, no further orders received. A physicians progress note, dated 6/1/2021 at 2:02 P.M., indicated Resident 39 was seen today for follow-up after visit to emergency roiagnom on [DATE] for urinary retention, suprapubic catheter not draining. Catheter was replace and draining well, and resident was sent back to facility. The resident denies any concerns or questions regarding catheter. He reports the only time he has discomfort/pain is when his drainage bag is full, symptoms resolve after emptying. A nurse practitioner's note, dated 6/22/2021 at 5:00 P.M. indicated the catheter had been leaking and the resident had been seen today for assessment of blood in catheter bag. Catheter bag is purple and blood is present in urine. The resident reports suprapubic pain and testicular/penile discomfort and a history of UTI (urinary tract infections) before and reports symptom of irritation. A nurse's note, dated 6/22/2021 at 5:10 P.M., indicated Resident 39 had blood in the Foley catheter bag. Urine in bag is a purplish/red with a strong odor. Resident noted to have suprapubic pain. A physicians order, dated 6/22/2021 for Bactrim DS (antibiotic) 800/160 1 tablet two times a day for urinary tract infection. During an observation, on 7/21/2021 at 7:50 A.M., Resident 39's urinary drainage bag was full and expanding with urine noted in the catheter tube and unable to drain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 7/21/2021 at 8:30 A.M., Resident 39's urinary drainage bag was full and expanding with urine noted in the catheter tube and unable to drain. During an observation, on 7/21/2021 at 9:15 A.M., Resident 39's urinary drainage bag was full and expanding with urine noted in the catheter tube and unable to drain. During an interview, on 7/21/2021 at 9:46 A.M., CNA's (certified nursing assistant) 7 indicated she usually tries to empty the drainage bag every 4 hours. CNA 7 emptied the drainage bag, indicated there was more than 1200cc's in the bag and the drainage bag was bulging. CNA 7 indicated the bag should have been covered and emptied sooner. During an observation, on 7/23/2021 at 11:00 A.M., Resident 39's urinary drainage bag was full of urine and bulging. CNA 14 emptied the urine into a urinal and indicated there was more than 1200 cc's in the drainage bag. During an interview, on 7/23/2021 at 11:02 A.M., CNA 14 indicated she usually works the other halls and was not sure how often the catheter drainage bag is emptied. On 7/23/21 at 2:05 P.M., Resident 39 was observed in his wheel chair with the urinary drainage bag not covered with the catheter tube on the floor. On 7/23/2021 at 2:06 P.M., CNA 14 indicated the drainage bag should be covered and the tube should not be on the floor. During an interview, on 7/27/2021 at 1:25 P.M., Resident 39 indicated they do not clean the catheter and never do During an interview, on 7/27/2021 at 1:40 P.M., CNA 19 indicated as far as cleaning the tubing goes, she usually does it 1-2 times per shift and will empty the urinary drainage bag at the end of the shift. On 7/27/2021 at 1:40 P.M., Resident 39's supra pubic catheter tube was observed with a brown substance on it that was close to the ostomy (opening) into the skin. A white piece of padding was observed at the ostomy site with a ring around the outer area and had a urine smell. During an interview, on 7/27/2021 at 1:43 CNA 19 indicated it appears the resident did not get catheter care today. A policy was provided by the Administrator, on 7/27/2021 at 1:13 P.M., titled Urinary/Bowel Incontinence, dated June 2008, and indicated this was the policy currently used by the facility. The policy indicated, .1. The facility staff shall strive to help the residents maintain or maximize urinary/bowel continence as much as possible (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/2021 at 3:37 P.M., the Administrator provided the policy titled, Catheter Care, Urinary, undated, and indicated the policy was the one currently used by the facility. The policy indicated .4. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in th tubing an drainage bag from flowing back into th urinary bladder. 11. Be sure to keep the catheter tubing and drainage bag are kept off thee floor. 12. Empty the collection bag at least every eight (8) hours. 18. Check drainage tubing and bag to ensure that the catheter is draining properly 3.1-41(2) 3.1-41(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44111 Based on observation, interview and record review, the facility failed to ensure that the oxygen tubing and humidifier water was dated, room identifier on door and filter cleaned for 2 of 5 resident's reviewed for respiratory care. (Resident 52 and 58) Findings include: 1. On 7/20/2021 at 9:48 A.M., Resident 58's oxygen tubing was observed undated, no humidifier bottle connected, or oxygen sign on the door and the concentrator filter was covered with thick white/gray colored lint. 2. On 7/20/2021 at 10:01 A.M., Resident 52 was observed to have a humidifier bottle that was empty, and the date on the tubing was dated 7/12/2021 and no oxygen sign on the door. During an interview, on 7/21/2021 at 11:13 A.M., the Assistant Director of Nursing indicated that they have magnets on the door with those on oxygen but none are currently on. She indicated the filter should be cleaned at least monthly, she removed them and cleaned the lint off the filters and took them to bathroom and rinse. The tubing is marked with a date either with a marker by the end of tubing or date placed on piece of tape and indicated there was no date on residents tubing, and it should be humidified. A policy was provided by the Administrator, on 7/21/2021 at 2:53 P.M., titled Oxygen Concentrator, dated 11/1/2019, and indicated this was the policy currently used by the facility. The policy indicated .6. Post No Smoking - Oxygen In Use sign on patient's door. 11. Label, date, and attach pre-filled humidifier bottle, if applicable On 7/23/2021 at 10:31 A.M., the Administrator provided a copy of the operators manual for the concentrator and it indicated . 1. removes each filter and clean at least once a week 2. clean the cabinet filter with a vacuum cleaner or wash with warm soapy water and rinse thoroughly 3, dry the filters thoroughly before reinstallation 3.1-47(a)(6)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 38844 Based on record review and interview, the facility failed to ensure visits from a physician or his designee were completed every 60 days for 2 of 3 residents reviewed for physician's visits. (Resident 20 & 21) Finding Includes: 1. A record review was conducted, on 7/25/21 at 12:29 P.M., for Resident 20. Diagnoses included, but were not limited to, Parkinson's disease, cerebral palsy dementia with behavioral disturbance, depressive disorder, benign intracranial hypertension, atrial fibrillation and convulsions. A Quarterly MDS (Minimum Data Set) assessment, dated 6/2/21, indicated Resident 20 had severe cognitive impairment. Resident 20's record indicated she was seen by her physician on 9/4/2020, on 12/24/2020 and 2/25/21 and was seen by the NP (Nurse Practitioner) on 6/4/2020 and in 5/2021 and on 6/4/2021. During an interview, on 7/25/21 at 1:15 P.M., the ED (Executive Director) indicated the physician or NP should visit the residents at least every 60 days. 35985 2. A clinical record was completed on 7/25/2021 at 12:45 P.M., and indicated Resident 21's diagnoses included but were not limited to: pseudobulbar affect, autistic disorder and Alzheimer's disease. Resident 21's medical record indicated there had not been any physician visits in the last year. A policy was provided by the ED on 7/27/2021 at 1:13 P.M., titled Physician Visits, revised 9/30/2013, and indicated this was the policy currently used by the facility. The policy indicated .Each Resident shall be assessed by a physician no less frequently than as prescribed by current regulatory statues. 1. Residents must be seen by a physician once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter 3.1-22(d)(1) 3.1-22(d)(4)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35985 Based on observation, interview and record reveiw, the facility failed to ensure residents with dementia and aggressive behaviors received appropriate resdient specific programming and ongoing interventions which resulted in multiple injuries, harm to self and harm to others, includeing fear and psychosocial harm to the reasonable person, for 3 of 5 residents reviewed for dementia care. (Resident 41, 21 & 28) The Immediate Jeopardy began on 10/2/2020 when the facility failed to ensure Resident 41 was not provided with specific programming to assist with his dementia. The Administrator was notified of the Immediate Jeopardy at 2:36 P.M. on 7/23/2021. The Immediate Jeopardy was removed on 7/26/2021, 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: 1. During intial tour of the facility, on 7/19/2021 at 10:45 A.M., Resident 41 was observed to have feces on himself, the wall, the air conditioner, his bed, his recliner and his call light. The air conditioner was missing its cover, the outlet was missing from the wall, the outlet was broken for air conditioner, foot board was missing from his bed, leaving metal bars standing up in the air. On 7/19/21 at 11:05 A.M., Resident 41's call light was still covered in feces and stretched across the newly made bed. On 7/19/2021 at 11:53 A.M., Resident 41 was observed standing at the head of his bed bent over with his socks halfway off his feet. Feces was observed running down the air conditioner and a broken electric outlet laying on the ground. On 7/19/2021 at 12:32 P.M., the Administrator acknowledged Resident 41 needed assistance/care to help with his situation. She indicated the staff did not finish cleaning up Resident 41's room. A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. A Nurses Note, dated 10/1/2020, indicated .resident entered nurses station, and upon attempt to redirect resident out of this area, resident physically attacked this nurse . slapping glasses of face, and punching this nurse . the aide arrived and attempted to talk resident down at which time resident picked up the chair from the nurses desk and threw it . both the aide and this nurse attempted to escort the resident back to his room . he began throwing everything he could get his hands on down the hallway .other staff members arrived to this unit and helped to ensure the safety of all other residents on the unit (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurses Note, dated 10/2/2020, indicated .CNA [certified nurses assistant] went into residents room to do a check. Reported to nurse that his BM was spread all over his room. This writer went to room and observed that resident had smeared feces all over his room. All over the walls, bed side table, inside of his box of cookies that family had brought in, all over the floor and bedding that he had previously laid on the floor A Nurses Note, dated 10/26/2020, indicated .Res very restless et exit seeking at present. Up by nurses' station, attempting to open locked unit doors, et to open locked linen room door. Frequently pacing back et forth, opening ice cart, looking inside, then closing lid again. Observed by staff to be studying fire alarm, et at one point, removing face plate. Staff able to replace before res pulled fire alarm. Not able to be redirected. Also standing at med cart, touching et moving objects. Frequently telling staff bye and I've got to be going A Behavior Note, dated 11/13/2020, indicated .Most of shift resident walked up and down hall and at times went into other resident's rooms. Much redirection, but most of time did very little to get resident to do a different activity A Behavior Note, dated 12/5/2020, .Res noted to have urinated x2 [twice] in inappropriate places, such as corner in his room, et [and] in unit dining room. Bathroom door in res' room left open et res shown bathroom several times this am A Behavior Note, dated 12/6/2020, indicated .Res has past behavior of crawling under other res' beds. Res' roommate is currently on O2 [oxygen]. While doing rounds, observed roommate's O2 off, et machine under bed unplugged. This res was the only person in room with roommate at the time. Res has history of destroying electronic devices, such as Tvs, VCRs, computers, phones, and radios. This res also pulls the curtains around his roommate on a constant basis, obstructing staff's view of dying roommate A Behavior Note, dated 12/16/2020, indicated .Res was going in et out of other res' rooms, taking their belongings and refusing to give them back, becoming agitated towards staff when attempting to re-direct res towards his room A Behavior Note, dated 12/17/2020, indicated .Observed urinating into a dresser drawer this am. Was found in an empty room, attempting to pull call-light out of wall, then slamming doors on closets. Redirected into his room, where he only stayed a few seconds, then went back into previous room where behavior continued A Nurses Note, dated 12/27/2020, indicated .writer was in the middle of mid day med pass when he saw resident pushing very aggressively on the ice bucket almost trying to break it, the ledge finally gave in and the resident fell down hitting his nose on the way down. resident then jumped up and down, had a unsteady gait. writer rushed over to help resident . writer called for a cna to get a wheel chair while helping the resident stand up straight. resident assisted back into the wheel chair and pushed back to his room for further assessment. when helped in the bed writer notice that the resident then became unresponsive to his name and was laying there hyperventilating with his eyes close vs assed Bp [blood pressure] 137/73 pulse 103 o2 [oxygen level] was between 78-83% and temp [temperature] was 98. Resident was repositioned and oxygen initiated and 911 was called (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 12/31/2020, indicated .Resident up all morning, wandering into others rooms, touching/taking belongings . when staff attempts to redirect, resident ignores staff or becomes physically aggressive. Resident sleeping at this time, however, has not slept per night shift nurse for the last 2 nights A Behavior Note, dated 1/1/2021, indicated .Resident entered another resident's room and could not be re-directed verbally. Became combative and aggressive. Inside other resident's room resident forcefully closed door An Incident Note, dated 1/11/2021, indicated .This nurse called to resident room per therapy, noted small laceration and raised area to back of head, L of center . resident was crawling around on the floor and bumped his head on the bed, as evidenced by the blood A Behavior Note, dated 1/14/2021, indicated .Resident came out of room upon this nurses arrivial . covered in feces, male aide attempted to take resident to his room to get cleaned up when resident began punching staff member . two more staff came to assist. Resident fighting staff the entire time A Behavior Note, dated 2/12/2021, indicated .Resident noted to be in his room, standing up and having a bowel movement all over the floor . when staff attempted to provide care, resident began to swing with closed fists A Behavior Note, dated 3/8/2021, indicated .Res frequently in other res' [resident] rooms today. Noted res covered up another res' head while they were lying in bed. Also noted to be messing with the heater in another res' room A Behavior Note, dated 3/31/2021, indicated .res attempting to place small balls of bm under his pillow this am. Allowed CNA to clean him et change his clothing. Staff also found a brief that was heavily soiled with urine in res' bedside table A Behavior Note, dated 4/5/2021, indicated .Up in the hall and going into other resident's rooms. Tried to redirect and he started trying to hit the CNA. He had a cup of water in his hand and he tried to throw it on the CNA. I took the water and emptied it. He walked ahead of me and picked a bottle of body wash off the CNA cart and throw it at me A Behavior Note, dated 4/5/2021, indicated .Again in another resident's room. He was making the empty bed. We encourage him to go to his room and he refused. We pulled the curtain to do AM care but he pulled the blanket off the other resident's bed and started to put it on the empty bed. The CNA and I took an arm each and pulled him down the hall and put him in his room and closed the door. The male CNA opened the door and ask this resident [NAME] he was doing. He yelled back Get out A Behavior Note, dated 4/9/2021, indicated .At approx 0820 [8:20 A.M.] this am, staff member was attempting to deliver res' breakfast tray. Res had room door blocked with his bed. Staff able to move bed to allow entrance. Res became very angry et aggressive, Punched CNA in the face with his fist, attempted to spit in staff's faces et kicked a hole in the wall of his room. Unable to calm res. Res had also torn covering on bed in room, as well as fully destroying the heater/ air conditioning unit and .At present, res found standing up in his room completely naked, took 2 staff members to get res dressed, as res was being combative (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 4/9/2021, indicated .Found res in another res' room, attempting to pull apart the call-light system and the remote to other res' bed. Was able to redirect res back into his room, where this nurse found that res had torn off the footboard of his bed, as well as ripped mattress cover on his bed even further than he had previously A Behavior Note, dated 4/27/2021, indicated .Patient was pulling on electrical cord of the bed and the control unit trying to pull them out of the bed. he pushed the bed and table out of the room the tv cable end had been pulled off, on the unit by pulling on the cords he could cause himself or others to trip or possibly be electrocuted from a bare wire contact A Behavior Note, dated 5/12/2021, indicated .During the evening this resident went into multiple rooms and removed personal items of residents in each room. I redirected over and over and returned the items he removed. I gave him a PBJ sandwich and he ate all the sandwich. After about 2200 [10:00 P.M.] we put this resident in his room and stationed a CNA in front of his door. CNA redirected this resident multiple times and did not allow him to leave his room. At this point he has not tried to open his door for about 15mins A Behavior Note, dated 5/14/2021, indicated .Resident remains very restless and unable to stay still. He continues going in and out of rooms and taking items. When this resident is placed in his room with a CNA at the door, he pulls apart anything and everything A Behavior Note, dated 5/14/2021, indicated .Res has been in other res' rooms numerous times this shift, despite numerous staff attempts to redirect. Early in shift found res pushing a bed out into hallway with another res lying on it. Was easily redirected at that time. Continued to attempt to push other beds into hallway, pushed his bed out several times. Observed tinkering with heater in his room numerous times. Has broken cover off of unit. Unable to be redirected. Told staff member to Kiss my a-- when taking dirty dishes out of his room. Continues to ambulate up et down hallway at present A Nurses Note, dated 5/25/2021, indicated .Resident up this am in his room, tearing things up as he does, and this nurse noted swelling and discoloration to R [right] hand this am while giving resident his medications. NP advised, received new orders for XR [x-ray] of R hand . ordered and awaiting tech A Nurse Practitioner Note, dated 5/25/2021, indicated .Nursing staff report right hand bruising to resident. There is no known source of injury and no witnessed falls/injury. Nurse reports noticing swelling and bruising this morning that was not there previously. Staff also report that resident often fixes or works on furniture around the unit. He has a history of encephalopathy and dementia, is a poor historian and .Edema present to right wrist and hand measuring 16cm in length, bruising covering this area is present. Edema and bruising wrap around to radial/ulnar wrist areas with 6cm in diameter from wrist into forearm. Pain response is illicited with palpation to radial area. Pain response is strong and present with right wrist extension and flexion. Mild pain response to adduction and abduction of right wrist. It is hard for resident to make a fist with right hand A Nurses Note, dated 5/25/2021, indicated .XR positive for FX [fracture] to R distal radius [bone in the arm] (continued on next page)

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Woodland Manor	343 S Nappanee St Elkhart, IN 46514

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurses Note, dated 6/2/2021, indicated .Found face down in front of his chair. Noted large lump on right forehead and right eye bruised . and .911 called A Behavior Note, dated 6/6/2021, indicated .Upon entering unit this am , noted res to be in his room with air conditioning/heating unit cover lying on floor, entire unit taken out of wall et lying on the floor, insulation removed from unit, et large hole in place where unit was removed from. Res in his room continuing to tinker with his clothing, his belongings, et the furniture in the room A Nurses Note, dated 6/10/2021, indicated .Told physician that res has had an altered gate today. His reply was We can't fix his dementia A behavior Note, dated 7/10/2021, indicated .Last evening I noted this resident chewing and chewing. I ask him what was in his mouth and was able to remove the item. He was chewing on 2 pieces of rubber that he had pilled off the inside of his shoes A Behavior Note, dated 7/18/2021, indicated .Res has been in et out of other res' rooms most of day- taking other res' small belongings. Not always easily redirected. Raised his fist at CNA as she was redirecting him out of a res' room A review of Resident 41's medical record indicated there were no individualized or nonpharmacological interventions to assist him with his dementia. During an interview, on 7/22/21 at 11:49 A.M., the DON indicated anyone can stub their toe, get stitches to their head or break their wrist. During an interview, on 7/23/2021 at 11:06 A.M., the Administrator indicated there wasn't any programing for the residents in the dementia unit and that there were no individualized interventions for this resident, related to his dementia. 2. On 7/19/2021 at 12:19 P.M., Employee 19 served Resident 21 her lunch. Resident 21's bed sheets were observed with brown/yellow circles dried and wet yellow circles. A soiled brief was observed lying on the opposite bed in her room, also observed to be wet. Five flies were observed crawling around on Resident 21's pillow. Resident 21 was observed sitting in her chair with a strong odor and her pants were observed to be wet. Employee 19 did not mention the wetness or clean anything, only served her her meal tray. During an interview, on 7/19/2021 at 12:32 P.M., the Administrator acknowledged the situation Resident 21 was left in and began assisting her to get cleaned up and change her linens. A clinical record review was completed, on 7/19/2021 at 2:35 P.M., and indicated Resident 21's diagnoses included but were not limited to: vascular dementia with behavioral disturbance, Alzheimer's disease and autistic disorder. A Social Service Note, dated 1/15/2021, indicated Resident .had an accident, and her room smells like uring. I asked [Resident 21's name] if I could help her get on some clean clothes, she said f--- you and f--- no. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A behavior Note, dated 1/23/2021, indicated .During morning ADL [activities of daily living] resident became combative with care and hit door with left hand resulting in bruising and decreased ROM [range of motion]. Nurse applied ice pack and finished ADL resident did not have socks and shoes which nurse applied to feet DON [Director of Nursing] updated on behavior N.O. for STAT order 2 view to left wrist A Nurses Note, dated 1/23/2021, indicated .nurse stayed with resident during xray of wrist - visible fracture of distal radius A Nurses Note, dated 1/23/2021, indicated .IMPRESSION: Acute fracture of the distal radius A Nurses Note, dated 1/24/2021, indicated .Left wrist and hand still swollen and bruised ice applied fingertips warm and moveable A Nurses Note, dated 1/26/2021, indicated .Lt [left] wrist remains edematous. Res [Resident] guarding limb very closely A Nurses Note, dated 1/28/2021, indicated .resident has not eaten a meal for at least the last 48 hrs [hours] . different alternative meals/snacks have been offered, and resident continues to refuse . DON notified . will continue to monitor A Social Services Note, dated 1/28/2021, indicated .Attempted to do interview with [Resident 21's name] she refused. Nurse did say she has refused to eat for the past two days, did try to offer snacks and she still said no. She has had some behaviors with cussing at staff, and refusing care A Nurses Note, dated 2/11/2021, indicated .Resident scheduled for outpatient surgery for fracture to L [left] forearm A Behavior Note, dated 2/19/2021, indicated .Res has flooded her bathroom x2 today by flushing small plastic cups down her toilet. Flooded her bathroom et [and] part of her room A Behavior Note, dated 3/22/2021, indicated .Physically aggressive towards CNA [Certified Nurses Assistant] this am while attempting to get res ready for Dr's [Doctor] appt [appointment]. Attempted to hit with her splinted hand. A Behavior Note, dated 3/24/2021, indicated .This nurse over-heard res yelling, F--- you b----. Upon entering room, observed this res holding up her middle finger and angrily shaking it at her roommate. Roommate removed from room. Went back into room to talk with this res, res threw her water cup et tv remote across the room, while continuing to yell f------ b---- A Behavior Note, dated 3/30/2021, indicated .Res very residtant to care this am. Physically aggressive towerds CNA, also cursed, flipped off staff et threw soiled brief at CNA. Res refused to allow CNA to assist her with dressing, et was found standing in her doorway wearing just a bra et cursing at staff (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 5/10/2021, indicated .resident continues to stand in doorway of her room and scream at staff as they walk past. she occasionally is slamming her door. one of her chairs in room is broken and was removed for safety to which she continued to scream at staff, f--- you, you w----. continual screameing even with staff giving resident her space A Behavior Note, dated 5/10/2021, indicated .resident still upset and slamming the door to her room at times, continues with agitation A Behavior Note, dated 5/10/2021, indicated .resident refusing PO [by mouth] meds at this time. will nto take any snacks or fluids from staff either. continues to yell at times and slammed the door on staff A Behavior Note, dated 5/10/2021, indicated .resident is in room with all clothing off and is refusing to get dddressed. door and curtain closed for privacy. different staff have gone into room to attempt care and resident becomes very aggressive with staff A Social Services Note, dated 5/14/2021, indicated .Called [local psychiatric hospital] to get an update on [Resident 21's name]. The nurse on duty [nurses name] said that she was very pleasant the past few days but this morning she threw a cup at another resident and said f--- you. [nurses name] said she redirected [Resident 21's name] and tried to ask her what happen and what made her throw the drink and she said [Resident 21's name] jsut looked at her A Nurse Practitioner Note, dated 6/2/2021, indicated .[Resident 21's name] has been readmitted to [facilities name] after being transferred to [a psychiatric hospital] on 5/11/2021 after numerous episodes of aggressive behavior, screaming profanities at staff and residents, throwing items, and becoming physical with staff A Nurse Practitioner Note, dated 6/3/2021, indicated .[Resident 21's name] was assessed today after nurse reported new thumb swelling and bruising. [Resident 21's name] has significant neurologic and mental health history and is not able to report how thumb was injured and .Obtain xray of right thumb A Nurse Practitioner Note, dated 6/9/2021, indicated .[Resident 21's name] was seen today for f/u [follow up] s/p right thumb fracture. She reports thumb is not painful. She denies any numbness or tingling to right thumb, hand and wrist. X-ray showed acute nondisplaced fracture of distal phalanx on thumb A Behavior Note, dated 6/20/2021, indicated . Resient was screaming at the top of her lungs, throwing things, swinging to hit staff, threw her urine soiled pants at staff and refused to allow staff to clean her up, change her brief, or make her bed. Resident refused meds and care during the evening and night shift as well. This tantrum topped any that writter had seen her throw. She would not reason with writer either A Behavior Note, dated 6/29/2021, .Accompanied housekeeper into res' room. Found at least 40 used cups in res' bedside table. Also found a bag full of used briefs containing urine et faces in res' closet (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior Note, dated 7/26/2021, indicated .Resistant to care. 2 staff assisted with getting res to change out of soiled clothing, et to change res' bed linen. Res very angry with staff, threw water et all other liquids from her bedside table across the room A Behavior Note, dated 7/19/2021, indicated .resident soaked from being incontinent. gave her a total bed bath and did peri care. clothing changed. resident had refuesed care from 3 different staff members previous to my coming in to offer care. bed linen was soaked with juice. mattress cleaned and new linen placed on bed. resident did refuse to shower, that is why a bed bath was given. refused to brush hair and teeth multiple times. empty gatorade bottles, cups and silverware removed from room. they were found in bottom of her closet A Behavior Note, dated 7/19/2021, indicated .resident physiccally and verbally combative with care, yells profanities and threatens to spit on and hit staff when staff tries to provide care A Behavior Note, dated 7/15/2021, indicated .resident needed cahgned and staff was changing her, she was screaming, swearing, and hit the CNA but did not cause injury. she called them names B---- and was angry, residents room smelled very bad like uring and needed cleaned. Resident wold benefit from a monthly antipsychotic injection as she is so labile and refuses meds [medications] often During an interview, on 7/23/2021 at 3:02 P.M., the DON indicated she did not have an individualized care plan documented to address Resident 21's dementia needs. 37147 3. On 7/24/21 at 12:43 P.M., the clinical record for Resident 28 was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, intellectual disabilities, pressure ulcers to the left and right buttock, left and right heels, right hip and back of right shoulder, protein calorie malnutrition, diabetes, and MRSA infection to buttock wound. The resident was admitted to the facility's memory care unit following hospitalization . A hospital note, dated 6/2/21, indicated the resident had been hospitalized for evaluation of weakness, possible dehydration, and altered mental status and was found to have a urinary tract infection. She had a long history of mental disorder and aggressive behavior. A few weeks ago, she fell and broke her hip. After hip repair, she was discharged to a nursing home. She lasted about a week in the nursing home but would not follow staff directions, refused to eat, and refused to take medication. She was discharged home . She continues to refuse to eat or drink. She is not taking medications . she came back to the hospital for psychiatric evaluation. An admission MDS assessment, dated 6/12/21, indicated a BIMS score of 2-severely impaired cognition. Resident 28 had multiple mood indicators which occurred over 12-14 days of the assessment which were: little interest or pleasure in doing things; feeling down, depressed or hopeless; feeling tired or little energy; and trouble concentrating on things. She had no behaviors. The resident required extensive assistance from 2 staff members for bed mobility and transfers; extensive assistance from 1 staff member for dressing, toileting, and personal hygiene; and supervision from 1 staff for eating. She was incontinent of bowel and bladder and had a total of 5 pressure ulcers. A Psychosocial Care Area Assessment (CAA) triggered due to resident having multiple mood symptoms. She recently moved into the facility with a dx of ID/DD and altered mental state. MD/NP to assess for psych (psychological) services. Will encourage her to participate in activities of choice. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/24/21 at 11:56 A.M., Resident 28 was observed in her room with the door open. She was lying in bed on her right side facing the wall and was covered with a sheet up to her chin. There was a sign outside her room on the wall that indicated she was in contact precautions and staff were to don a gown and gloves prior to entering her room. -At 12:53 P.M., the resident was observed still lying on her right side, towards the wall. Her sheet had slipped down below her shoulders to her waist and a large dried brown stain was observed on the bottom sheet. Her feet were uncovered by the sheet and her left heel had a large black necrotic ulcer that had separated at the edges of the wound and was red in color. A staff member was observed to go in the room and ask the resident if she wanted to eat. There was no tray observed in the room. The resident was heard to say no and the staff member left the room. -At 1:09 P.M., CNA 29 was observed in resident's room with clean linens and gown. The CNA asked the resident if she wanted to get up or allow the aid to change her bed sheets because she had spilled coffee on the bottom sheet. Resident 28 stated no. The CNA got all her supplies ready and placed on the bedside table while she continued to talk to the resident and tried to engage her in conversation but the resident said nothing. CNA 29 indicated the resident had lain on her right side, in the same position, all day since she had arrived for her shift, and she wasn't sure what to do. Her shift was getting ready to end and she indicated she needed to get the resident cleaned up and off her right side because she had a sore on her hip. The CNA indicated she had asked the resident throughout the day if she could help her get cleaned up but each time the resident had refused. The resident's TV was on which was located on the bedside stand across the room from the resident's bed. Behind the TV, sat the residents lunch plate with a cover over it, an uncovered bowl of chocolate pudding and a full glass of uncovered red juice. The cover on the plate was lifted off and the food appeared to be untouched and was a congealed mass of green vegetable, unidentified meat and gravy. The CNA indicated another staff member had come in and asked the resident if she wanted to eat and the resident had said no. CNA 29 started to change the resident's bedding while calmly speaking to her and telling her what she was doing but the resident continued to say no and I don't want to move. She had the soiled linen rolled under the resident and new bedding on when she told the resident she needed to remove her brief. The brief was dry, and the resident had not voided all shift. The aid kept explaining to Resident 28 that she would need to help her turn over and go over a large bump. LPN 27 then entered the room to assist the CNA to complete care to the resident who was gripping the right side of the bed frame and stated, leave me alone and why do you have to do that. After much coaxing, the CNA and LPN were able to roll the resident over and finish making her bed. Care Plans indicated the following: -Actual behaviors related to refuses ADL care, changing of wound treatments, refuses meals at times (initiated 6/15/21) and exhibits behaviors of anger/yelling/cursing at staff when trying to give care, change wound dressing, giving incontinent care. When meals are brought, will refuse meal, and yell I want my mother or will state I want my mom's food (initiated 6/22/21). Interventions, dated 6/15/21, were: approach in a quiet calm manner; ask another staff member to assist; introduce self and tasks needing attention; explain task before beginning; play music to resident's liking; return at later time when refusing, yelling, or physically aggressive; and IDT to review behavior management program quarterly and as needed. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Makes racial comments to staff when non-white staff try to give care (initiated 6/22/21). The goal was for the resident to be accepting of care at least once daily. Interventions, all dated 6/22/21, were to approach at later time; ask other staff to assist as needed; introduce self and explain task before beginning; and notify doctor and family of behavior. A Resident Care Sheet, dated 7/23/21, indicated Resident 28 was on a regular, diabetic diet and required cueing when eating; was an elopement risk; was incontinent and required 1-2 staff members to assist with transfers and bed mobility; and she had unspecified behaviors. Behavior and Nurse notes indicated the following: 6/5/21 at 2:31 p.m., very resistant to care this a.m . incontinent of bladder and bowel and resisting care from CNA . During care, resident cursed, screamed, and resisted allowing clothes to be changed. Continues to refuse all food and fluids offered. Yells out frequently . Spoke with brother and wife this a.m . resident has IQ of an 8 year old. fell at home 3 weeks ago and had to have hip surgery. Ever since fall, resident has refused to eat or drink . personality has changed . is now mean, verbally and physically aggressive towards care givers . Resident has small stuffed lion that she likes to hold during care. 6/6/21 at 1:35 p.m., .Yells and screams out, resistant to care, refuses all food and fluid offered. Different staff have attempted care, explained everything before doing any tasks. Symptoms interfere with ADL's and care. -At 2:52 p.m., [family members] came to window for window visit. Resident refused to look at them or speak to them, just continued to scream 'I wanna go home!' over and over. Continues to refuse all food and fluids offered. Verbally aggressive towards staff. 6/8/21 at 3:31 p.m., Resident verbally combative with CNA this shift, swatting at her while she is trying to change her, calling her names such as 'N-----' and 'Blackie' . Resident asked not to speak to staff that way, and the verbal assaults just kept coming out of resident's mouth . 6/9/21 at 3:23 p.m., therapy in with resident this am, they reported to this nurse that resident was physically and verbally combative with them, resident also stated 'I won't be happy until I kill somebody with my gun' . resident resists care. 6/13/21 at 4:31 p.m., Resident combative with care requiring 3 staff to change resident, attempts to hit, bite staff. Yelled all shift for her mother, refused fluids and food, attempted to redirect resident in calming, reassuring manner, all attempts failed. 6/14/21 at 2:13 p.m., Refused all food and fluids, multivitamin, and have temperature taken. Refused to allow staff to change her clothing or line [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38845 Based on record review, observation and interview the facility failed to follow standards of care of visually observing a resident take their medications for 1 of 1 randomly observed residents. (Resident 11). Finding includes: During an random observation, on 7/19/2021 at 10:43 A,M. a medication cup with chocolate pudding and medications was observed sitting on Resident 11 bed side table. During an interview, on 7/19/2021 at 10:49 A.M., LPN (licensed practical nurse) 27 indicated the pills should not be left in the room. On 7/26/2021 at 3:37 P.M., the Administrator provided the policy titled, Medication Administration-General Guidelines, undated, and indicated the policy was the one currently used by the facility. The policy indicated . 4). Medications are administered at the time they are prepared. 6.) The person who prepares the dose for administration is the person who administers the dose. 15). The resident is always observed after administration to ensure that the dose was completely ingested 3.1-25(b)(4)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on record review and interview, the facility failed to ensure a resident had an appropriate diagnosis for the use of an antipsychotic medication and failed to try non pharmacological interventions prior to the initating of and the increase of an antipsychotic medication in 3 of 5 residents reviewed for unnecessary medications. (Resident 1, 41 & 21) Findings include: 1. A clinical record review was completed on 7/23/2021 at 4:13 P.M., and indicated Resident 1's diagnoses included, but were not limited to: dementia, diabetes, gastroparesis, chronic kidney disease and depression. A quarterly MDS (Minimum Data Set) assessment, dated 7/9/2021, indicated Resident 1 had a BIMS (Brief interview for Mental Status) score of 15, intact cognition. Had no behaviors and received an antipsychotic medication 7 days during the assessment period. Resident 1's current medications included Quetiapine (antipsychotic) 100 mg (milligrams) every night for behavioral symptoms of dementia, which started on 12/3/2020. A current care plan, dated 12/23/2020, indicated Resident 1 was receiving an antipsychotic medication. Interventions included, but were not limited to: Observe/record occurrence of target behavior symptoms and document per facility protocol. The care plan lacked any behaviors to monitor. A Psychology Diagnostic Assessment, dated 6/10/2021, indicated Resident 1 was not a danger to himself and or others, received quetiapine medication for behavioral symptoms of dementia and had a diagnosis of Dementia in other disease classified elsewhere with behavioral disturbances. A psychology progress note, dated 7/8/2021, indicated Resident 1 was not currently a danger to self/others and staff report no new or worsening behaviors. The antipsychotic medication Quetiapine was for dementia with behavior disturbances. During an interview, on 7/26/20/21 at 12:02 P.M., CNA (certified nursing assistant) 7 indicated Resident 1 did not have any behaviors. During an interview, on 7/26/2021 at 12:03 P.M., LPN (licensed practical nurse) 5 indicated Resident 1 did not have any behaviors. During an interview, on 7/26/2021 at 12:10 P.M., Social Service director indicated the diagnoses of dementia was not an appropriate diagnosis and the resident did not have any behaviors. 35985 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A clinical record review was conducted, on 7/19/2021 at 3:54 P.M., and indicated Resident 41 was admitted on [DATE] and his diagnoses included, but were not limited to: Wernicke's encephalopathy, psychotic disorder with delusions and dementia with behavioral disturbance. Resident 41's medical record indicated he had received Ativan (an antianxiety medication) on December 10, 11, 15, 16 and 17, 2020 and on April 9, 2021. Resident 41's medical record indicated there were no individualized or nonpharmacolgical interventions prior to administering Ativan. Resident 41's medical record indicated he had received an increase of Seroquil (an antipsychotic medication) from 75 mg to 100 mg a day, with no individualized or nonpharmacological interventions attempted prior to the increase of the medication. 3. A clinical record review was completed, on 7/19/2021 at 2:35 P.M., and indicated Resident 21's diagnoses included but were not limited to: vascular dementia with behavioral disturbance, Alzheimer's disease and autistic disorder. A Physician order, dated 10/13/2020, indicated Resident was ordered quetipine for .antipsychotic On 7/26/2021 at 2:31 P.M., the Administrator indicated she would expect nonpharmalogical interventions to be attempted prior to the initiation or the increase of a psych/[NAME] medication. She further indicated she would expect it to be appropriate, individualized to the resident and that medications should have a proper diagnoses for Residents 21 & 41. On 7/27/21 at 9:50 A.M., the Administrator provided the policy, titled, Unnecessary Drugs-Monitoring, undated, and indicated the policy was the one currently used by the facility. The policy indicated .An unnecessary drug is any drug when used in excessive dose, for excessive duration, or without adequate monitoring. It also includes drug without adequate indications for the use or in the presence of adverse consequences On 7/27/21 at 9:51 A.M., the Administrator provided the policy, titled, Behavioral Assessment, Intervention and Monitoring, dated 11/2019, and indicated the policy was the one currently used by the facility. The policy indicated .3. Behavioral or Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. 5. Current guidelines recommend the use of non-pharmacological interventions for BPSD. Management 8. Non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of psychotropic medications to manage behavioral symptoms. These may include individualized activities, redirection, diversion, sitting with resident in a quiet area, and other interventions that may break the cycle of the behavior 3.1-48(b)(1) 3.1-48(b)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38845 Based on observation and interview, the facility failed to ensure medications were kept in a locked cart when unattended; failed to ensure medication storage areas were clean and free from loose medications and medications with no resident identifiers; failed to ensure medications were labeled and dated when opened, during medication storage review in 2 of 2 medication carts reviewed and 1 of 2 medication rooms. (100 hall medication cart, 400 medication cart and storage room) Findings include: 1. During a random observation, on 7/21/2021 at 4:50 A.M., the medication cart on the 100 hall was observed unlocked with no licensed nursing staff nearby. During an interview, on 7/21/2021 at 4:54 A.M., QMA (qualified medication aide) 9 indicated the medication cart should have been locked when unattended. 2. During a medication storage observation on hall 100 medication cart, on 7/21/2021 from 7:15 A.M. to 7:35 A.M., the following were observed: total of 13 loose pills were in 3 of 4 drawers and had debris in the drawer corners. Two (2) opened bottles of Miralax powder with no date opened for Resident 30. Two (2) opened bottles of Risperdal liquid with no date opened, an opened bottle of Zoloft not dated and 3 opened bottles of Calcium Carbonate tablets with no date opened for Resident 14. Opened bottle of Roxinal with no date opened, opened bottle of liquid Ativan with no date opened and on the label was refrigerate the medication for Resident 34. An opened bottle of Roxinal with no date opened for Resident 49. An opened bottle of Miralax for a resident who no longer resides in the facility. An opened bottle of Roxinal and Risperdal with no dates opened for Resident 56, and a lorazepam (antianxiety) count sheet for Resident 56 indicated 30 tablets were present on 9/22/2020. The current physician's orders for Resident 56 Lorazepam indicated the medication was discontinued on 10/3/2020. During an interview, on 7/21/2021 at 7:38 A.M., LPN (licensed practical nurse) 5 indicated the medications should be dated when opened and the medication for the discharged resident should have been destroyed. 3. On 7/21/2021 at 10:04 A.M. a medication storage observation was completed on the 400 hall medication room. The following was observed; An unopened box of lancets for a resident no longer in the facility. 4. During a medication storage observation on the 400 hall medication cart, on 7/22/2021 at 3:47 P.M., the following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 bottle of opened antacid tablets with no resident label. 4 opened and undated bottles of Miralax for Residents 6, 19, 32 and 45. 2 bottles of Enulose opened and undated for Resident 20 and 41. 1 unopened bottle of Novolog with no label or name and a total of 13 loose pills in 4 of 4 drawers. On 7/22/21 at 4:00 PM during an interview LPN (licensed practical nurse) 15 indicated there should be dates on the opened bottles, no loose pills in the drawers and the antacid tablets and insulin should have a label on them. On 7/21/2021 at 12:05 P.M., the ADON (Assistant Director of Nursing) provided the policy titled, Specific Procedures for All Medications, dated 5/20/2020, and indicated the policy was the one currently use by the facility. The policy indicated .1. Medication cart is locked at all times unless in use and under the direct observation of the medication nurse/aide. 5. When opening multi dose container, place the dated on the container. On 7/21/2021 at 12:05 P.M., the ADON provided the policy titled, Destruction of Medications By Facility, dated 5/13/215, and indicated the policy was the one currently used by the facility. The policy indicated .All discontinued and expired medications shall be disposed of and documented appropriately by th facility nursing staff. A. All discontinued medications sill be immediately located and removed from the resident;s active medication storage area and stored is a separate locked area for up to 90 days or as required by applicable law, and then destroyed by a manner in accordance with applicable state and federal laws. G. Discontinued medications and /or out dated medications will be disposed of by th facility within 90 days of the date the medication was discontinued, or by applicable law 3.1-25(j) 3.1-25(m) 3.1-25(r)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44111 Based on observation, interview and record review, the facility failed to ensure that resident food was served at a safe temperature for 1 of 1 hall cart reviewed for food temperatures. (400 hall tray cart) Finding includes: On 7/19/2021 at 11:47 A.M., the tray cart on 400 hall was delivered to the unit and the staff started passing out trays at 11:57 A.M. On 7/19/2021 at 12:24 P.M., Resident 29 indicated his food was cold when he received it. On 7/19/2021 at 12:25 P.M., Resident 17 and Resident 25 indicated their food was not warm enough when it was delivered. On 7/19/2021 at 12:28 P.M., the Dietary Manager took the temperature of the last tray in the tray cart. The turkey's temperature was 101 degrees F (Fahrenheit), mashed potatoes 104 degrees F, carrots 101 degrees F. During an interview, on 7/19/2021 at 12:30 P.M., the dietary manager indicated that the food should be reheated to bring the turkey back to 165 degrees and indicated the food should not have sat for an hour. On 7/20/2021 at 11:05 A.M. the Administrator provided a policy titled, Serving of Food (Point of Service), no date, and indicated the policy was the one currently used by the facility. The policy indicated .1. All hot food shall be held during service at or above a temperature of 135 degrees F On 7/20/2021 at 12:18 P.M., CNA (certified nurses assistant) 2 entered Resident 30's room with her lunch. The resident indicated the tomato soup was cold as well as the grilled cheese and that every time she eats in her room, her food is always cold. 3.1-21(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44111 Based on observation and interview, the facility failed to ensure that the nourishment refrigerator on 100 hall, food is labeled and dated for 1 of 1 refrigerators reviewed. Finding includes: On 7/21/2021 at 10:20 A.M., the Administrator was present during observation of the nourishment kitchen on 100 hall. There were three zip lock bags with three hotdog's in each bag, celery and carrot in the third bag, a grocery bag with a rubber maid container with food, a grocery bag with two Styrofoam containers with sweet corn, 16 ounce bottle of coke half emptied, McDonald's cup half full with a brown liquid all without a label with a name and date. On 7/21/2021 at 10:25 A.M. the Administrator indicated that she had no idea whose food it was in the refrigerator. She indicated the food should have been labeled with a name and date. A policy was requested on 7/21/2021 at 11:30 A.M., and one was not provided. 3.1-21(i)(3)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38845 Based on record review, interview and observation, the facility failed to evaluate the increasing population of residents requiring more behavioral care and failed to provide the services to meet those residents needs. This deficient practice had the potential to affect 19 of 61 residents residing in the facility who had mental health and/or behavioral concerns. Finding includes: On 7/24/2021 at 11:00 A.M., the Administrator provided the Facility Assessment Tool. The Facility Assessment was initiated on 5/31/2019, updated on 8/10/2019, 4/5/2020 and on 4/1/2021. The document indicated, IDT Team to Make Admission Decisions Based Upon Diagnosis/Services Required: The IDT team shall review prospective Resident related to their diagnoses and needs to assure that facility has adequate training staff, and resources to provide care and support all needs for the potential resident. If needed, a representative of nursing will provide a bedside assessment prior to determination of admission. If a potential new admission had a diagnosis or requires a service that is unfamiliar or additional resources, the facility will obtain proper training/resources prior to the acceptance of any such admission. The facility will not accept admissions for those residents the IDT team has determined his/her needs cannot be met. PART 2: Services and Care We offer Based on our Residents' Needs: Mental Health and Behavior: Manage medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of some one with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. Provide person -centered/directed care: Psycho/social/spiritual support: what upsets him/her and incorporate this information into the care planning process. Makes sure staff caring for the resident have this information. Record and discuss treatment and care preferences. Prevent abuse and neglect. Identify hazards and risk for residents. Individual staff assignments: The IDT reviews assignments to assure that all Resident needs are met and determines if changes to staff assignments need adjusted. Competencies included: Person centered Care planning done annually. Care for residents with mental and psychosocial disorders --ongoing. Alzheimer's/ Dementia--(understanding caring for)--ongoing The assessment was updated with the following info: Average number of resident with behavioral health needs went from 20-30 to 20-40 during a typical month. During an interview,on 7/24/2021 at 1:59 P.M., the Administrator indicated the admissions are not assessed prior to coming to the facility. She indicated they would go and assess prior to Covid and when that happened they were not allowed in the hospitals to do an assessment. During an interview on 7/27/2021 at 3:54 P.M., the Administrator indicated the facility should be following the assessment tool in regards to admissions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38845 Based on record review and interview, the facility failed to maintain accurate and complete narcotic sheet for 1 or 8 residents whose narcotic count sheets were reviewed. (Resident 56) Finding includes: On 7/21/2021 at 7:35 A.M., a medication storage audit was completed on the 100 hall medication cart. Resident 56's lorazepam (antianxiety) count sheet indicated 30 tablets were present on 9/22/2020. The last date of Resident 56 receiving the lorazepam was documented 9/27/2020. The current physician's orders for Resident 56 indicated an order for Lorazepam 0.5 mg (milligrams) every 6 hours as needed for anxiety ordered 9/20/2020 and discontinued on 10/3/2020. The narcotic count sheet was observed with numbers randomly documented, with circles drawn around the numbers, and lines drawn through the numbers that were written. The signatures documented were illegible and had lines drawn through 4 of the 5 signatures. The narcotic sheet lacked dates and times of administration for 5 of the signature lines. During an interview, on 7/21/2021 at 9:15 A.M., the Director of Nursing indicated the staff might have pulled the first doses of medication from the EDK (emergency drug kit). The September 2020 MAR (medication administration record) indicated the Lorazepam medication was signed as administered 13 times from 9/20/20 to 9/27/2020 on 9/20, 9/21 x 2, 9/22 x 2, 9/23, 9/24 x 2, 9/25 x 2, 9/26 x 2 and 9/27 x 1. During an interview, on 7/21/2021 at 10:21 A.M., the Assistant Director of Nursing (ADON) indicated 1 lorazepam tablet was removed from the EDK on 9/20/2021 but was unable to provide any further documentation of other lorazepam tablets removed from the EDK prior to starting the narcotic count sheet on 9/22/2020. The ADON indicated the number (14) on the medication card was correct with the number listed on the narcotic count sheet (14), but the medication administration record was missing documentation. She indicated the narcotic count sheet had the word wasted' written by 2 of the nurses' signatures, but was unable to provide further information of the 5 pills that had no documentation of being wasted and or administered to the resident. The ADON indicated the medication should have been pulled out of the cart when it was discontinued. On 7/27/2021 at 1:13 P.M., the Administrator provided the policy titled, Medication Ordering and receiving from Pharmacy, undated, and indicated the policy was the one currently used by the facility. The policy indicated .F. The emergency supply is maintained at a designated area, along with a list of supply contents as follows: 4) emergency controlled substances are kept in a sealed, portable container, under double lock. H. As soon as possible, the nurse records the medication use on the medication order form and faxes the pharmacy for replacement of the kit. I. Use of the emergency medication is noted on the resident's medications administration record (MAR) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/27/2021 at 12:05 P.M., the Administrator provided the policy titled,Controlled Medication Destruction Policy and Procedure, undated, and indicated the policy was the one currently used by the facility. The policy indicated .3. All controlled substances remaining in the facility after a resident has been discharged or expires, or the order discontinued are disposed of (as directed by state and federal laws and/or the DEA) by either the director of nursing and another licensed nurse, the director of nursing and consultant pharmacist, or by two licensed nurses. Facility must keep detailed record of any/all medications destroyed 3.1-50(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38845 Based on record review, observation, and interview the facility failed to ensure oxygen tubing was not lying on the floor, failed to have oxygen concentrators filters free of dust, failed to not reuse a dirty nasal cannula for 3 of 6 residents reviewed for oxygen therapy; failed to ensure urinary catheter tubing and drainage bags were not touching the floor for 1 of 3 residents reviewed for catheters; failed to initiate precautions timely for shingles for 1 of 1 resident reviewed for infections; and failed to remove gloves prior to leaving a residents room after obtaining a blood sugar and failed to dispose of a lancet (finger stick device) in a proper receptacle in 2 of 4 medication pass observations. (Residents 49, 39, 48, 47, 43 and 12) Findings include: 1. During an observation, on 7/19/2021 at 10:19 A.M., Resident 49's oxygen tubing was observed on the floor. During an observation, on 7/20/2021 at 11:09 A.M., Resident 49's oxygen concentrator was observed with the filter covered in gray dust and the oxygen tubing was on the floor. During an observation, on 7/20/20/21 at 11:20 A.M., Resident 49's oxygen tubing was on the floor, a nebulizer mask on the over the bed table was not bagged and the concentrator filter on the front of the machine was covered with dust. A clinical record review was completed on 7/20/2021 at 3:05 P.M., and indicated Resident 49's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, compression fractures T 5-T 6, dependence on supplemental 02, lymphoma and intercostal pain. Physician orders, dated July 2021, indicated Resident 49 was receiving 02 at 2 liters via NC (nasal cannula) continuous and to change to oxygen tubing and humidity bottle every week on Wednesday and as needed. During an interview. on 7/21/2021 at 11:20 A.M., LPN (licensed practical nurse) 1 indicated the 02 tubing should not be on the floor, and the nebulizer should be in a bag. 2. A clinical record review was completed on 7/20/2021 at 3:16 P.M., and indicated Resident 39's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, sleep apnea, obstructive and reflux uropathy, chronic kidney disease and heart failure. Physician orders, dated July 2021, indicated Resident 39 was receiving oxygen via nasal cannula and lack any orders to change the oxygen tubing and or nasal cannula. During an observation, on 7/21/2021 at 9:49 A.M., Resident 39's oxygen concentrator filter was covered in dust. During an interview, on 7/21/2021 at 11:59 A.M., Resident 39's oxygen concentrator filter was observed to be covered in a gray dust (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 7/23/2021 at 2:05 P.M., Resident 39 was observed in his wheel chair with the Foley drainage tubing on the floor, the drainage bag not covered and dirty linens lying on the floor. During an interview, on 7/23/2021 at 2:06 P.M., CNA (certified nursing assistant) 14 indicated the linens and the catheter tubing/bag should not be on the floor and the bag should be covered. 3. During an interview, on 7/19/2021 at 11:50 A.M., Resident 47 indicated he thought he had shingles to his right upper arm and indicated he had informed a nurse. Observed an area to the right upper arm of a cluster of small fluid filled blisters. During an interview, on 7/21/2021 at 4:36 P.M., LPN (licensed practical nurse) 5 indicated she knew about the area and they thought it might be shingles, the physician had been notified and he ordered Valtrex for 7 days. During an interview, on 7/21/2021 at 4:45 P.M., the Administrator indicated if they believe the resident or someone had shingles they should be put into isolation immediately. A clinical record review was completed on 7/22/2021 at 3:09 P.M., and indicated Resident 47's diagnoses included, but were not limited to: respiratory failure, obesity, depression and gout. A physicians' order, dated 7/22/2021,indicated Resident 47 was receiving Valtrex (anti viral) 1 GM (gram) 1 tablet three times a day for prevention for 7 days. During a observation, on 7/22/2021 at 11:52 A.M., there was no PPE (personal protective equipotent) out side the door to enter Resident 47's room and no signage on the door to indicate the resident was in isolation. The room mate had been moved out on 7/21/2021. During an observation, on 7/22/2021 at 3:01 P.M.,there was no PPE (personal protective equipotent) out side the door to enter Resident 47's room and no signage on the door to indicate the resident was in isolation. During an interview, on 7/22/2021 at 3:03 P.M., LPN (licensed practical nurse) 1 indicated there should be PPE available and a sign on the door. 4. During a medication pass observation, on 7/21/2021 at 5:20 A.M., LPN (licensed practical nurse) 6 was observed to wash hands and apply gloves to obtain a blood sugar sample from Resident 43. After obtaining the blood sample and completing the test, LPN 6 exited Resident 43's room without removing her gloves and or washing her hands. During an interview, on 7/21/2021 at 5:24 A.M., LPN 6 indicated she should have removed her gloves and washed her hands before leaving the room. 5. During a medication pass observation, on 7/21/2021 at 5:30 A.M., QMA (qualified medication aide) 11 was observed to wash her hands and apply gloves to obtain a blood sugar sample on Resident 12. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	QMA 11 disinfected Resident 12's finger with an alcohol pad then with her other hand fanned the area to dry it. QMA 11 obtained the sample and completed the test, then threw the lancet that was used to obtain the blood sample in the residents trash container. During an interview, on 7/21/2021 at 5:35 A.M., QMA 11 indicated she had just started and was unaware the lancet should not be thrown away in the trash. 38844 7. During an observation, on 7/20/21 at 11:40 A.M., oxygen tubing was laying coiled up on the floor next to Resident 48's oxygen concentrator. During an observation, on 7/21/21 at 9:17 A.M., oxygen tubing was laying coiled up on the floor next to Resident 48's oxygen concentrator. A record review was conducted, on 07/21/21 at 12:53 P.M., for Resident 48. Diagnoses included, but were not limited to, cardiomegaly, chroinc diastolic congestive heart failure, anemia, cardiomyopathy, hypertensive heart disease with heart failure, Parkinson's disease, schizoaffective disorder and atherosclerotic heart disease. A Quarterly MDS (Minimum Data Set) assessment, dated 6/29/21, indicated Resident 48 was cognitively intact and received oxygen therapy. During an interview, on 7/21/21 at 10:27 A.M., the DON (Director of Nursing) indicated the oxygen tubing should not be on the floor. During a random observation, on 7/24/2021 at 12:53 P.M., Resident 48 was observed being pushed in her wheelchair in the hallway. The nasal cannula was dragging the floor. TNA (training nurses aide) 31 stopped and placed the nasal cannula back into the residents nose. During an interview, on 7/24/2021 at 12:54 P.M., TNA (training nurses aide) 31 indicated she should not have put it back in the residents nose. A policy was provided by the ADON (Assistant Director of Nursing), titiled, INFECTION CONTROL CLEANING AND DISINFECTING POLICY AND PROCEDURE, dated November 28th, 2016, and indicated this was the policy currently used by the facility. The policy indicated .2. Semi-Critical Objects .e This category includes respiratory therapy equipment These items are not to be shared and are to be covered when not in use On 7/23/2021 at 10:31 A.M., the Administrator provided the Operator's Manual , undated for the concentrators used in the facility and indicated the manual was what the facility currently uses. The manual indicated Cleaning the cabinet filter. Note: There are two(2) cabinet filters one (1) located on each side of the cabinet. 1. Remove each filter and clean at least once a week, depending on environmental conditions. NOTE: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to: high dust,smoking, air pollutants, etc. 2 Clean the cabinet filters with a vacuum cleaner or wash in warm soapy water and rinse thoroughly (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/2021 at 3:37 P.M., the Administrator provided the policy titled, Oxygen Delivery/Handling Policy and Procedure, dated 11/28/2017, and indicated the policy was the one currently used by the facility. The policy indicated . 9). Oxygen and nebulizer tubing/masks will be changed weekly. 10). Tubing and masks that are not currently in use will be stored in a sanitary manner On 7/26/2021 at 3:37 P.M., the Administrator provided the policy titled, Catheter Care, Urinary, undated, and indicated the policy was the one currently used by the facility. The policy indicated .11. Be sure the catheter tubing and drainage bag are kept off the floor On 7/26/2012 at 3:37 P.M., the Administrator provided the policy titled, Shingles, undated, and indicated the policy was the one currently used by the facility. The policy indicated . 1. Implement Transmission Based Precautions according to resident's immune status and extent of disease. 1.1 Localized infection with normal immune system requires Standard Precautions. 1.1.1 Maintain precautions for duration of illness/until vesicles have crusted. 1.1.2. Limit staff contact to those who are immune. Susceptible individuals (those who have never had chicken pox or vaccine and those who are in first trimester of pregnancy) should not enter the room On 7/27/2021 at 1:13 P.M., the Administrator provided the policy titled, Obtaining a FIngerstick Glucose Level, revised date of 11/2011, and indicated the policy was the one currently used by the facility. The policy indicated .7. Wash the selected fingertip, especially the side of the finger, with warm and soap. (Note: If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Repeated use of alcohol may toughen the skin. 16. Dispose of the lancet in the sharps disposal container. 19. Remove gloves and discard into designated container. 20 Wash hands 3.1-18(b)(1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845 Based on record review, observation and interview, the facility failed to ensure clean/comfortable/homelike environment was maintained, related to missing wall tiles in bathrooms and a shower room, missing closet door, gouged walls, unpainted hole repairs, missing paint on walls, missing baseboards, strong urine odor, black rings on the floor around toilets, broken electrical outlet, television cable not connected to secure outlet, resident floors with black scuffed marks, visible light coming in from under the courtyard door in the activity room, in 2 of 4 halls observed for environment. (100 hall & 400 hall) Finding includes: 1. During an environmental tour, on 7/22/2021 at 10:45 A.M., the following was observed on the 100 hall. On a wall in the 100 hall was a brown stain running down the wall above the thermostat. room [ROOM NUMBER] the walls were beside the second bed were gouged and had missing paint. room [ROOM NUMBER] had a rusty colored floor in the bathroom and dirty privacy curtains. room [ROOM NUMBER] had numerous black skid marks on the floor by the bed by the window. The ice cart had sharp/broken edges on the shelve that pulls out. The activity door leading to the outside courtyard had a gap at the floor where the door was not preventing light from coming in. During an interview, on 7/22/2021 at 10:59 A.M., the Maintenance Director indicated the walls, privacy curtains and floors should have been cleaned, the walls need to be repaired and the door needs to be replaced. 2. During an environmental tour, on 7/22/2021 at 11:02 A.M., the following was observed on the 400 hall: room [ROOM NUMBER] the walls were marred and had missing paint by the window; missing floor tiles in the closet; a closet door was missing; baseboard was missing along 1 wall; missing wall tiles in the bathroom; closet floor had brown substance all over it; the bathroom radiator was rusted and had chipped paint; the elbow of the sink drain was rusty and was leaking with a bucket sitting on the floor under the drain; and the sink was leaking. room [ROOM NUMBER] had ceiling tiles that had bubbled areas where it was not attached firmly to the ceiling; brown ring (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	07/27/2021

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at the bottom of the toilet on the tiles; toilet riser very loose not attached to the toilet securely and the toilet seat was loose. room [ROOM NUMBER] a wall had cracks and bubbled paint; missing spackling to an area on the wall with the air-conditioner. room [ROOM NUMBER] and 406 were missing the door threshold. room [ROOM NUMBER] the bathroom door frame and the door had areas of chipped paint. room [ROOM NUMBER] had a television sitting in a night stand drawer leaning back against the stand with the television cable not attached to the wall --outlet was missing the cover the cables could be moved freely. The 400 hall shower room had 2-3 missing tiles in the shower stall; the bathroom area had a small pipe end extending out of the wall about 1, with an area from the pipe going down the wall all the way to the floor with rust colored drippings. The small dining room had a broken window blind. A black substance covering the wall vent outside of the large dining room. Numerous ceiling tiles with brown stains. A hard brown substance was noted on the hand rail by the door going to the outside. The ice cart had sharp/ broken edges to the pull out shelf. During an interview, on 7/22/2021 11:39 A.M. the Maintenance staff indicated the procedure for repairs is the staff can put in a work order in tells (program in computer) and then it would come to him immediately. He indicated he did not know or was not notified of any of these things that needed repaired, and indicated they all needed to be fixed. On 7/26/2021 at 3:37 P.M., the Administrator provided the policy titled, Housekeeping -Cleaning Schedule, dated 1/1999, and indicated the policy was the one currently used by the facility. The policy indicated .Daily: ii. Wet mop all tile (hard surface) floors. iv. Clean all resident, public and staff lavatories. v. Clean all tub, shower and utility rooms. viii. Note and report any defective equipment to maintenance department for action. xvii. Clean all IV poles, ,internal feeding poles, suction machines, commodes, and any equipment in use in patient rooms. Quarterly or Upon Resident Discharge: iii. Clean closets and /or wardrobes in patient rooms. v. Clean dressers and bedside cabinets. vi. Clean baseboards. vii. Clean blinds A policy for preventative maintenance was requested but on was not provided. 3.1-19(f)

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	07/27/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. 38845 Based on observation and interview, the facility failed to have adequate ventilation for 1 of 4 halls observed. (400 hall Dementia Unit) Finding includes: On 7/27/2021 at 10:48 A.M., an observation of the 400 hall was completed and a strong urine odor was noted in the hallways. During an interview, on 7/27/2021 at 11:00 A.M., Maintenance director indicated there was a strong urine odor in the dementia unit because there was a problem with the ventilation system. He indicated they are old and don't work properly, and the ventilation system is inadequate. A policy for ventilation was requested, but one was not provided. 3.1-19(f)(2)