STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE OF DANVILLE	200 S ARBOR LANE DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: April 20 and 21, 2022 Facility number: 014518 Residential Census: 5 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 2, 2022.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member with cardiopulmonary resuscitation (CPR) and first aid certifications were on every shift for 10 of 21 observations. This deficient practice had the potential to effect 5 of 5 residents who resided at the facility. Findings include: On 4/21/22 following the entrance conference the Health Wellness Director provided a two week schedule of nursing coverage for the facility dated April 10, 2022, through April 23, 2022. On 4/22/22 at 11:30 a.m., the nursing schedule was reviewed for the week of April 17, through April 23, 2022. On 4/17/22 there was no first aid certified nursing employee scheduled for night shift (11:00 p.m. to 7:00 a.m.). On 4/19/22 there was no first aid certified nursing employee scheduled for night shift (11:00 p.m. to 7:00 a.m.). On 4/20/22 there was no first aid or CPR certified nursing employee scheduled for the evening shift (3:00 p.m. to 11:00 p.m.). On 4/21/22 there was no first aid or CPR certified nursing employee scheduled for	R 0117	What corrective action(s) will be accomplished for those residents found to have been affected by the deficit practice? · ***Community immediately had all RN/LPN/Q.M.A. update their CPR/First Aid certifications and appropriate documentations obtained for records.*** · ***Community leadership will verify each shift has a CPR/First Aid certified team member working onsite.*** How will you identify other residents having the potential to be affective by the same deficit practice and what corrective action will be taken? · ***All residents were identified as potentially affected by this deficiency. The corrective action was immediately initiated.*** What measures will be put into place or what systemic changes will you make to ensure that the deficit practice doesn't reoccur? · ***Health and Wellness Director (or designee) and Business Office Manager will monitor staff CPR/First Aid certification expirations to support scheduling of CPR/First***	04/22/2022

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	evening shift (3:00 p.m. to 11:00 p.m.), and no first aid coverage for night shift (11:00 p.m. to 7:00 a.m.). On 4/22/22 there was no first aid certified nursing employee scheduled for night shift (11:00 p.m. to 7:00 a.m.). On 4/23/22 there was no first aid or CPR certified nursing employee scheduled for the evening shift (3:00 p.m. to 11:00 p.m.). On 4/21/22 during an interview, the Health Wellness Director indicated there were several first aid and CPR certification cards/documentation that were not on campus and available at that time. During evening shifts, during the week, she was still in the building for the first part of the shift and her certifications would cover part of them. The facility followed the State Regulation which always required at least 1 awake person with CPR and first aid certification on each shift.		***Aid certified staff for 24/7 onsite coverage.*** How the corrective action will be monitored to ensure the deficit practice will not reoccur, i.e., what quality assurance program will be put into place? · ***All clinical employee files were reviewed, and certifications obtained from staff certified in CPR/First Aid.*** · ***The Executive Director and/or Health and Wellness Director (or designee) will monitor that all staff CPR/First Aid certifications are current.*** ***Compliant Date: Friday, April 22, 2022***	
R 0193 Bldg. 00	410 IAC 16.2-5-1.6(q)(1-2) Physical Plant Standards - Deficiency (q) The facility shall have laundry services either in-house or with a commercial laundry by contract as follows: (1) If a facility operates its own laundry, the laundry shall be designed and operated to promote a flow of laundry from the soiled utility area toward the clean utility area to prevent contamination. (2) Written procedures for handling, storage, transportation, and processing of linens shall be posted in the laundry and shall be implemented. Based on observation, interview, and record	R 0193	What corrective action(s) will be accomplished for those residents	04/21/2022

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	review, the facility failed to post and implement written procedures for handling, storage, transportation, and processing of linens in the laundry room. This deficient practice had the potential to effect 5 of 5 residents who resided in the facility. Findings include: On 4/20/22 at 12:38 p.m., during a tour of the facility with the Health Wellness Director, 2 facility laundry rooms were observed. The Health Wellness Director indicated these were the 2 laundry rooms used by staff to do resident clothing and linens. The first laundry room, on the Memory Care Unit contained 1 large commercial top loading washing machine and a commercial dryer. There were no instructions for infection control or handling of laundry posted in the laundry room. The Health Wellness Director indicated there were no instructions, protocols, or education materials in the laundry for staff who did laundry. The second laundry room was on the service hall. It was a large double-sided room and contained an industrial sized commercial front-loading washer and industrial sized dryer. There were no instructions for infection control or handling of laundry posted in the laundry room. On 4/21/22 at 12:09 p.m., the Executive Director provided a policy, dated 9/20/21, titled, "Dryer Lint Traps." She indicated this was the only laundry policy they had, and she had never been aware of a regulation that required any signs or instructions in the laundry room. This current policy indicated " ...Store soiled laundry in separate covered container. When taking soiled		found to have been affected by the deficit practice? · ***Community immediately posted written procedures for handling, storage, transportation, and processing of linens in community laundry rooms on 4.21.2022 at 4:30 p.m.*** How will you identify other residents having the potential to be affective by the same deficit practice and what corrective action will be taken? · ***All residents were identified as potentially affect by this deficiency. The corrective action was immediately initiated.*** What measures will be put into place or what systemic changes will you make to ensure that the deficit practice doesn't reoccur? · ***The Environmental Services Director (or designee) and Executive Director will review and verify preventative maintenance was performed for this deficiency.*** How the corrective action will be monitored to ensure the deficit practice will not reoccur, ie, what quality assurance program will be put into place? · ***Weekly QAIP Smart Goal for first three months in preventative maintenance to verify that postings are posted, current, and do not require***	

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	laundry from bags, put it into a washing machine immediately (or as soon as possible), separate from all other laundry. Use a disinfecting agent and the hottest water setting for washing ...See Proctor and Gamble manual for more information ...."		***updating.*** ***Compliant Date:*** ***Thursday, April 21, 2022***	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on observation, interview, and record review, the facility physician orders failed to identify diet orders for 3 of 5 residents who resided on the Memory Care unit (Residents 3, 4, and 6). Findings include: On 4/20/21 at 2:00 p.m., the medical record was reviewed for Resident 3. The physician's order set contained no diet orders. The Resident profile header was blank in the section that indicated "Diet." On 4/20/21 at 2:30 p.m., the medical record was revived for Resident 4. The physician's order set contained no diet orders. The Resident profile header was blank in the section that indicated "Diet." On 4/20/21 at 2:45 p.m., the medical record was revived for Resident 6. The physician's order set contained no diet orders. The Resident profile header was blank in the section that indicated "Diet." On 4/20/22 at 10:25 a.m., during the initial tour	R 0275	What corrective action(s) will be accomplished for those residents found to have been affected by the deficit practice? · ***Health and Wellness Director immediately reviewed all residents' written physician orders and confirmed or added diet orders in the electronic medical record.*** How will you identify other residents having the potential to be affective by the same deficit practice and what corrective action will be taken? · ***All residents were identified as potentially affected by this deficiency. The corrective action was immediately initiated.*** What measures will be put into place or what systemic changes will you make to ensure that the deficit practice doesn't reoccur? · ***Health and Wellness Director (or designee) and***	04/22/2022

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	of the kitchen with the Culinary Director (CD), she indicated there were 5 residents in the facility. All of the residents were on a regular diet at that time. They could do specialized diets, such as mechanical soft or puree, but there were no specialized orders at that time. On 4/21/22 at 8:00 a.m., Licensed Practical Nurse (LPN) 4 was observed as she sat at a computer in the nurses' station. She selected items from the breakfast menu and entered orders for each resident. The residents were not present at the time of selection. She ordered French toast for all 5 residents. On 4/21/22 at 12:09 p.m., the Executive Director provided a policy, dated 11/5/21, titled, "Diet and Nutrition." This current policy indicated " ...It is the policy of the Community to meet the dietary needs of the residents...Resident specialty diets are documented in the point-of-sale (POS) system for reference by the Culinary Service Department...."		***Culinary Manager will review at morning clinical meeting the electronic medical record for all new move-ins and existing residents to ensure dietary orders have been entered in EHR.*** How the corrective action will be monitored to ensure the deficit practice will not reoccur, ie, what quality assurance program will be put into place? · ***QAIP Smart Goal for the first three months the Executive Director, Health and Wellness Director (or designee) and Culinary Manager will review all new move-ins to ensure dietary orders have been entered into the EHR.*** ***Compliant Date: Friday, April 22, 2022***	