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	06/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 2 and 3, 2025. Facility number: 014518 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 5, 2025.	R 0000		
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview, and record review, the facility failed to ensure a resident was assessed for self-administrating medications for 1 of 5 residents reviewed for medication self-administration evaluations (Resident 3). Findings include: On 6/2/25 at 11:00 a.m., Resident 3 was observed as she washed dishes in her apartment. She indicated her husband had recently passed away, so she was trying to adjust to a new normal. Resident 3 indicated she took care of most of her husband's needs when he was alive. On 6/2/25 at 12:00 p.m. Resident 3's medical record was reviewed. She was a Resident who resided in an assisted living apartment whose diagnoses included but were not limited to multiple sclerosis (a neurological disease where the body's immune	R 0216	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 3 – suffered no adverse effect r/t this deficient practice. A self medication administration evaluation to accompany the order was completed. Resident's physician agrees that resident may self-manage, administer and store all her medications and treatments. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; To identify other residents who could be affected by this practice, all residents that self-medicate were	06/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Breann Higgins	Executive Director	06/20/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	system mistakenly attacks the protective coating of nerve fibers in the brain and spinal cord) and supraventricular tachycardia (a rapid heart rhythm that originates in the heart's upper chambers). A medication self-administration evaluation, dated 6/25/24, indicated Resident 3 could safely self-administer medications. A progress note, dated 6/25/24 indicated Resident 3 was being assessed to administer her husband's medications. Upon review there were no other medication self-administration evaluations in the Residents medical record. On 6/3/25 at 1:30 p.m. the Executive Director provided a copy of a current facility policy titled "Medication Administration, Supervision of Resident Self-Administration" dated 11/21/24. This policy indicated, " ...Residents who self-administer medication must be assessed annually or after a significant change in status to verify that they are able to continue self-administering medication ...". Regulation 410 IAC 16.2-5-2(a) indicated, "...An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request ...."		audited for semi- completion and by physician order. Corrections were made immediately. Biannual tracking completed for all other self-medication administration evaluation through community's EMR system and external auditing tool. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. A Policy update for the Community was changing to semi-annual and upon change in condition from annually for administration evaluations. HWD and all licensed educated on the company's medication administration policy and procedure, with special emphasis on evaluating residents for medication . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and HWD and all licensed nurse educated on the company's medication administration policy and procedure, with special emphasis on evaluating residents for medication self-administration .Community's EMR system identifies due dates of evaluations and is correct following the policy update. An auditing and tracking tool has been put into place as well to be completed by and designated personnel. This will be reviewed weekly by the Regional	

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			Director of Health Services for a period of 3 months. Then bi-weekly for a period of 3 months. By what date be completed. All evaluations accompanied by a order will be completed by June 30, 2025.	
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to date bottles and eye drops when opened for 1 of 1 medication carts observed and 1 of 1 medication rooms. Findings include: 1. Resident 9 had a bottle of lorazepam (used to treat anxiety) in the refrigerator with no date to indicate when it was opened. It was sent 8/3/24. 2. Resident 10 had a bottle of lorazepam in the refrigerator with no date to indicate when it was opened. It was sent 2/9/24. 3. Resident 11 had a bottle of atropine (used to dilate the pupils) with no date to indicate when it was opened. 4. Resident 12 had a bottle of tobramycin 0.3% eye drops (used to treat bacterial infections) with no date to indicate when it was opened. 5. Resident 13 had a bottle of latanoprost 0.005% eye drops with no date to indicate when it was opened. 6. Resident 14 had a bottle of latanoprost unopened in the medication cart instead of being	R 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication with expired or unidentified open dates according to company policy compliance. All medication storage and refrigeration storage areas have been assessed and organized with open labels audited for ease of identification and separation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All unlabeled medications were disposed of. Medication storage areas will be audited and organized with proper labeling and designated areas for each type of medication per company policy. What measures will be put into place or what systemic changes the facility will make to ensure	06/30/2025

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	left in the refrigerator until opened and an opened bottle of latanoprost with no date to indicate when it was opened. 7. Resident 2 had a bottle of Systane (lubricant) with no date to indicate when it was opened. On 6/3/25 at 1:59 p.m., during an interview, the Executive Director (ED) indicated they would be working on dating medications. . A policy titled, "Medication Storage," was provided by the ED on 6/3/25 at 10:13 a.m. It indicated, "...Medications will be stored in accordance with pharmacy label instructions ...."		that the deficient practice does not recur; Daily audit of all storage and refrigeration areas by designated personnel to maintain designated medication areas with label with open date and appropriate identification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; HWD and unit audit daily for assurance of completion and monitoring storage areas for 3 months and then bi-weekly for 3 months. By what date be completed. All medication storage areas will be audited with proper labeling and designated areas by June 30, 2025	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to provide documentation of drug disposal/disposition for 2 of 2 residents reviewed (Residents 5 and 6). Findings include:	R 0306	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Medication storage areas audited with no findings of identified discharged	06/30/2025

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	1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart failure and multiple fractures of the ribs. Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: alendronate (a medication for rheumatoid arthritis), atorvastatin (a medication for high cholesterol), calcium (a supplement), folic acid (a supplement), methotrexate (for arthritis), multivitamins (a supplement), prednisone (for arthritis), vitamin C (a supplement), aspirin (for heart health), antidiarrheal capsules, and hydrocodone (a narcotic pain reliever). 2. On 6/2/25 at 12:23 p.m., a record review was completed for Resident 6. She had the following diagnoses which included but were not limited to hypertension, Alzheimer's disease, high cholesterol, chronic kidney disease, and diabetes type 2. Her record lacked documentation of the disposition of her medications at the time of discharge from the facility. The medications included: aspirin (for heart health), carvedilol (for hypertension), centrum silver (a supplement), clopidogrel (for blood clots), donepezil (used to treat dementia), doxycycline (used to treat infections), famotidine (used to treat stomach ulcers), Januvia (for diabetes), losartan potassium (for hypertension), memantine (used to treat dementia), multivitamin (a supplement), pioglitazone (used to treat diabetes), probiotic (a supplement), quetiapine (used for insomnia), raloxifene (used for arthritis), rosuvastatin (used for high cholesterol), timilol (used to treat high		residents' medications. Reviewed medication deposition policy and log tool with HWD and nursing staff. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; all medications will be disposed of according to company policies and logged according to 410 IAC 16.2-5-6 with audits and tracking completed by HWD and designated personnel biweekly for 3 months and once per month thereafter, or at resident discharge from community. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; an audit of all medication and storage areas completed with appropriate dispositions and documentation according to company policies and 410 IAC 16.2-5-6. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Initial audit of medication storage areas to be completed by Community's contracted Pharmacist then thereafter Regional Director of Clinician Services monthly for 2 months and HWD monthly. Discharged tracking through Community's EMR system for residents'	

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	blood pressure), and acetaminophen (used to treat pain). On 6/3/25 at 1:59 p.m., the Executive Director (ED) provided dispositions for controlled substances for Resident 6 but was unable to locate disposition for the rest of her medications. A policy titled, "Medication Management/Medication Disposition," was provided by the ED on 6/3/25 at 1:59 p.m. It indicated, " ...As part of the Medication Management Program, the health and wellness director (HWD) or licensed nurse designee will conduct medication disposition (e.g. destroyed, returned to pharmacy, returned to family, etc ...."		medication disposition within 30 days of discharge date. HWD will audit every new admission. By what date be completed. Medication storage areas to be audited, organized and medication disposition if deemed necessary will be completed by June 30, 2025.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to provide a first and second step PPD (tuberculosis testing) for 2 of 3 residents reviewed for TB test (Resident 5 and 7). Findings include: 1. On 6/2/25 at 12:04 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to heart disease, and multiple fractures of the ribs. Her record lacked documentation of a first or second step PPD. On 6/3/25 at 1:05 p.m., an interview was conducted with the Executive Director (ED), he indicated most of their records were stored electronically. He would find and send the results via email.	R 0410	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice residents with expired or past due TB assessments and test PCP notified and orders received for assessment and test completion done by local laboratory services company with negative . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Community EMR system tracked for due dates of TB and communicable diseases	06/30/2025

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	On 6/4/25 at 10:46 a.m., the email was received and did not contain PPDs or other acceptable testing as proof of TB testing for Resident 5. 2. On 6/2/25 at 12:17 p.m., Resident 7's medical record was reviewed. She was admitted to the facility on 3/25/25 with diagnoses which included, but were not limited to, vascular dementia and a history of urinary tract infections. The record lacked documentation of an initial TB skin test, and no chest x-ray was on file. At the time of exit on 6/3/26 at 2:10 p.m., the facility was unable to provide documentation for an initial first and second step TB skin test. After the survey exit, the ED provided an e-mail on 6/3/25 at 3:13 p.m. with a copy of a chest x-ray for Resident 7. The x-ray was dated 5/2/25 but not provide a statement that Resident 7 was free from evidence of TB. At the time of exit on 6/3/25 at 2:10 p.m., the Executive Director, (ED) provided a copy of current facility policy titled, "Communicable Disease - Tuberculosis," reviewed 10/16/23. The policy indicated, "The Community will establish and maintain a Tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the state health department ... prior to moving into a community, and annually thereafter, each resident is required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of TB in an infectious stage ... each prospective resident has a TB skin rest completed within three (3) months prior to moving in or upon moving in and read at 48-72 hours ...."		assessments. External tracking tool updated and audited by HWD and designated personnel for further monitoring of due dates and completion weekly for 6 months. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; monitoring Community's EMR system to identify due dates for assessments and completion. Editing external tracking tool by HWD and designated personnel for information. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place HWD and designated personnel will monitor due dates in tracking log and rectify with PCC EMR system for the most up to date information completed weekly for 6 months. HWD or designated personnel will audit every new admission to policy is followed. By what date be completed. TB tests, assessments and orders will be current and up to date according to policies and guidelines by June 30, 2025.	

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