STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. Building B. Wing	09/15/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure behaviors were care planned, monitored and evaluated for 1 of 2 residents reviewed. (Resident A)During an observation on 9/15/25 at 10:09 AM the following was observed:Resident A was resting on his bed with the head of the bed elevated. The colostomy bag on the resident's left side of the abdomen was bent at an angel more than 90 degrees and ballooning to the shape of the colostomy bag.In an interview, on 9/15/25 at 10:10 AM, Resident A indicated his colostomy bag had opened unexpectedly in the past. He indicated staff only emptied the bag every couple of days and only when he would tell the staff it needed emptied. He indicated he would take care of the bag himself and hand the bag to the nurses. Resident A indicated caring for the colostomy made him anxious. A record review for Resident A began on 9/15/25 at 11:10 AM. Diagnoses included depression, attention-deficit hyperactivity disorder (ADHD), and hemiplegia and hemiparesis following a cerebral infarction affecting the left, non-dominant side.A review of Resident A's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated that the resident needed extensive assistance to use the toilet and was diagnosed with hemiplegia or hemiparesis (the inability to use one side of the body). A review of Resident A's current care plan, dated 8/11/25, titled Colostomy Status Post Bowel Surgery indicated the resident preformed their own colostomy care. Interventions included to change the colostomy bag after each bowel episode or when full, educate Resident A on proper care of the ostomy and how to change the bag, Education Resident A when to alert the nurse to change the bag. A review of Resident A's current care plan, dated 8/11/25, titled Colostomy Phalange indicated Resident A would unseal his colostomy at various times throughout the day. Interventions included a reminder to resident A, not unseal the colostomy (phalange) daily. Observe if resident had unsealed the colostomy, assist the resident with the colostomy seal as needed.A review of Resident A's current care plan, dated 8/11/25, titled depression indicated Resident A had depression after getting a colostomy. Interventions included administration of medications as ordered, psychiatry consultation, and observation of signs and symptoms of depression, including hopelessness, anxiety, sadness, insomnia, negative statements, repetitive anxious or health-related complaints, or tearfulness. There was no intervention related to Resident A's colostomy. A review of Resident A's current care plan, dated 8/11/25, titled Psychosocial well-being related to anxiety, depression, inability to meet role expectations, lack of acceptance to current condition, recent social isolation. One goal indicated the resident would identify coping mechanisms including keep busy, work with hands, and feeling useful. Interventions included allowing time for the resident to answer questions and verbalize feelings, perceptions, and fears, assist/encourage/support the resident to set realistic goals to promote emotional and physical safety. Initiate referrals as needed or increase social relationships. Observe for and document resident's feelings relative to isolation, unhappiness, anger, and loss. Provide opportunities for the resident and family to participate in care, assist, encourage, and support about identified problems that cannot be controlled. There were no interventions related Resident A's colostomy behaviors. A review of Resident A's current care plan, dated 8/11/25, failed to address Resident A's ADHD diagnosis and behaviors. There were no care plans to address Resident A's colostomy behaviors. A review of physician orders, dated 3/10/25 at 18:00, indicated colostomy care was to be completed by staff every shift and emptied as needed.A review of the Task Administration Record for August 2025 indicated the colostomy bag was emptied as needed on 8/3/25 at 11:05 PM. Routine colostomy care was documented as completed.A review of the Task Administration Record for September 2025 indicated routine colostomy care was not documented as completed on 9/2/25 during day shift.A review of the Bowel Elimination Task dated 9/2/25 to 9/15/25 indicated stool output was recorded only one time on 9/4/25 and 9/12/25.A review of psychiatry progress notes, dated 9/11/25, indicated the physician was not aware of Resident A's most recent depression scale score of 20, indicating severe depression, completed on 8/21/25. There was no mention in the notes of Resident A taking off his colostomy bag, or taking off the bag and flange. A review of progress notes from 8/19/25 to 8/25/25 indicated staff had not notified the physician of the depression scale score result of severe depression. There were no notes related to Resident A taking off his colostomy bag, with or without the flange intact and no notes to indicate Resident A had been educated regarding colostomy care or addressing colostomy behavior. A review of progress notes from 8/19/25 to 8/25/25 indicated staff had not documented when the resident was reminded not to unseal the colostomy (phalange) daily.In an interview