STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands The	3820 W Jackson St Muncie, IN 47304

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 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** 40241 Based on observation, interview, and record review, the facility failed to ensure anti-depressant medication and mood stabilizer medication was not started without indication for use for 1 of 3 residents reviewed for abuse (Resident D). Findings include: A Facility Reported Incident indicated, on 5/4/24 at 8:01 p.m., a female resident was discovered on the floor near the area of Resident D. Resident D indicated he had pushed her. They were immediately separated and the female resident was sent to the emergency room due to complaints of pain. On 5/15/24 at 10:40 a.m., Resident D was being propelled in a wheelchair by a staff member to an activity in the main dining room. On 5/15/24 at 1:57 p.m., Resident D was lying in bed and indicated concerns about the pain in his shoulder and how his right hand had not worked right in four years. On 5/16/24 at 1:15 p.m., Resident D was lying in bed. Resident D's clinical record was reviewed on 5/15/24 at 10:14 a.m. Diagnoses included unspecified dementia, unspecified severity, with agitation, anxiety disorder, insomnia, and depression. Resident D's medications included depakote (mood stabilizer) 125 mg (milligram) twice daily for unspecified dementia with unspecified severity with agitation (started on 5/6/24) and Celexa (antidepressant) 10 mg daily for depression (started on 5/7/24). A 4/25/24, quarterly, Minimum Data Set (MDS) indicated Resident D was severely cognitively impaired. He had verbal behavioral symptoms towards others (e.g., threatening others, screaming at others, cursing at others). This behavior occurred one to three days during the assessment period. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's care plan indicated he was in the vicinity where another resident fell on [DATE] (initiated on 5/4/24). His goal was to have no further episodes of verbal and physical aggression (5/4/24). His interventions included he was immediately placed on one on one supervision, psychiatric services was contacted to see him and the table was removed from the lounge area as well (5/4/24), the social worker was to provide psychosocial support (5/4/24). Resident D's care plan indicated he exhibited a tendency to become territorial with his surroundings. He liked to sit in a specific spot in the hall in his wheelchair. He liked to people watch. He may exhibit feelings of being threatened with others close to his vicinity (initiated on 5/6/24). His goal was he would have fewer episodes of voicing out displeasure towards other when he felt another person maybe in the area, daily through next review (5/6/24). His interventions included keep the side of the room he sits in free from any items such as desks, chairs, or tables, let him sit completely alone on his side of the room, always encourage him to join others in group activities, he enjoyed Bingo (5/6/24). Review of Resident D's progress notes indicated the following: A behavior note, dated 2/24/24 at 2:52 p.m., indicated the resident kept yelling at other residents over a table at the front of the unit. He stated the table was his. Resident D kept trying to tell other residents they couldn't sit in the chairs up front, because someone was stealing from him. The table was moved into the lounge and it was explained to Resident D that it was not appropriate to yell and curse at others. Resident D calmed down after the table was removed. A behavior note, dated 2/22/24 at 2:26 p.m., indicated Resident D was agitated and yelled that someone took his four coffee cups from his stand. He was reassured that the cups were picked up and taken to be washed. He calmed down after the explanation. On 5/4/24 at 7:00 p.m., a call was placed to Resident D's family regarding the incident this evening. His family was informed Resident D would be on one on one observations for the next few days. The clinical record lacked indication of what the incident was or what had occurred on 5/4/24. On 5/5/24 at 5:38 a.m., he was on one on one observations due to the incident. He rested throughout the night. He had no worsening aggression or behaviors noted. He would continue to be monitored closely by staff and any changes would be noted. A behavior note, dated 5/5/24 at 1:27 p.m., indicated Resident D was interviewed, and he appeared to be calm with no signs or symptoms of anger. When he was asked what happened he said nothing, she fell on her own and refused to discuss anything else. He was a little agitated by the questions being asked and the writer of the note backed off. A care management note, dated 5/5/24 at 1:47 p.m., indicated his Brief Interview for Mental Status (BIMS) score demonstrated he was severely cognitively impaired. Another BIMS assessment would be administered the next day. The resident was on an antibiotic for an infection. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note, dated 5/5/24 at 7:21 p.m., indicated Resident D had been on one on ones. He had no behavior such as verbal or physical aggression. He stated he was remorseful about the incident that occurred and had stated in several ways that the incident occurred. The table was removed from the lounge and Resident D had no concerns regarding this at this time. Psychiatric services would see him tomorrow and psychosocial support would continue to be offered. A care management note, dated 5/5/24 at 7:27 p.m., indicated the Interdisciplinary Team (IDT) discussed the event and Resident D was immediately placed on one on one supervision. Psychiatric services was contacted to see Resident D, the table was removed from the lounge area, and the social worker would provide psychosocial support. A behavior note, dated 5/6/24 at 12:52 a.m., indicated Resident D continued on one on one supervision. He had not shown any aggression or disruptive behavior today. He had been engaged and conversated with staff. He would continue to be monitored. On 5/6/24 at 10:22 a.m., his family was made aware of a new order for depakote. A behavior note, dated 5/6/24 at 4:02 p.m., indicated Resident D remained on one on ones. He had been polite and agreeable today. He appeared to enjoy the special attention. On 5/6/24 at 6:30 p.m., the psychiatric nurse practitioner saw Resident D and ordered Celexa 10 mg daily. The family was made aware. An Initial Psychiatry Consult note, dated 5/6/24, indicated Resident D was being seen at the request of the facility and primary care provider for dementia with mood disturbance and agitation, depression, anxiety and insomnia. Staff reported the resident was territorial, with increased paranoia that someone will take his things. He was verbally aggressive towards other residents. He pushed a resident down and the resident had fractures from the fall. He reported he was doing well, and could do better if he had his teeth. He felt like people were going to take his belongings. He was pleasant, and not reporting depression. He had anxiety and was aggressive when others were near his belongings. On 5/6/24 at 11:34 p.m., Resident D remained on observations from the resident-to-resident altercation. No adverse effects were noted. He had no emotional distress or mental anguish. He remained on one on one observations from the altercation. On 5/6/24 at 11:39 p.m., Resident D tolerated the start of Celexa and Depakote with no adverse effects thus far. A care management note, dated 5/7/24 at 11:57 a.m., indicated IDT reviewed Resident D's behavior. His current status, diagnoses, and medications were reviewed. His care plan was reviewed and revised as necessary. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A communication note with family, dated 5/8/24 at 7:18 a.m., indicated Resident D's family was spoken to regarding moving him off the memory care unit. He was taken to the room by the one on one staff and he was shown the room. He liked it and liked his new roommate because he recalled him being on the unit before. He thought he used to work with him. Resident D had shown little patience with others who were demented. The move would be better for him emotionally and behavior-wise. The resident's family agreed. A behavior note, dated 5/8/24 at 7:44 a.m., indicated Resident D continued on one on one observations with no behaviors at that time. On 5/8/24 at 7:46 a.m., he was moved off the memory care unit. During an interview with the Social Service Director, on 5/15/24 at 10:46 a.m., she indicated Resident D was on the memory care unit and would get very territorial. There was a table by the exit door that he sat at in his wheelchair. He was territorial over the drawer in the table, so it was removed. He then became territorial over a chair. He had one altercation on the memory care unit where he shoved a female resident down. When the Social Service Director asked Resident D about the incident, he told her that the female resident reached down for the drawer and went to pull it out and she lost her balance and fell backward. He was just a grumpy old man, and he guarded his snacks in that drawer. No one witnessed the incident between Resident D and the female resident. He was not alert and oriented, and she thought he was severely cognitively impaired. During an interview with CNA 7, on 5/15/24 at 11:12 a.m., she indicated Resident D did not normally get up until after breakfast. He used a wheelchair and normally sat by the door to the memory care unit. He could be grumpy at times, and he didn't like people messing with his stuff. There was a little table at the entrance to the unit he would wheel up to and he kept his snacks in the drawer. He was territorial over the table. She hadn't seen him have an altercation with another resident. If anyone walked up to him and the table, he would say stay away from my stuff. She had never seen him be violent. During an interview with LPN 5, on 5/16/24 at 9:28 a.m., she indicated Resident D was a little grumpy and didn't want his things touched. Behaviors were documented in the nurses' notes. During an interview with the SSD, on 5/16/24 at 9:45 a.m., she indicated Resident D was put on depakote because he kept messing with his suprapubic catheter and he kept pulling it out. He liked to wear the catheter on the outside of his pants and indicated that's what the doctor had told him to do. The medication was also started because the resident was being territorial with the desk. If anyone got close to his desk he would yell Get them away. There was a resident who couldn't hear and would come near him, and he would tell her to get away. She would get away and sit in a chair. Then he would take out a cracker out of his drawer and take a bite, as if to taunt her. She would yell at him and tell him not to eat that. The SSD would sit in her office and just laugh at them. The worst thing the facility did was give him that table. During an interview with CNA 13, on 5/16/24 at 9:53 a.m., she indicated Resident D would growl if anyone got close to his coffee/table. She had never seen him be aggressive. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, on 5/16/24 at 10:15 a.m., she indicated they took the table away from Resident D. He had no physical aggression towards others. They were not 100% sure he pushed the female resident down, but he was territorial with his surroundings. She reached for his coffee, and he tried to prevent her from getting it, and she stepped back and fell . His initial response was that he did push her, but they were not sure if he really did. He was seen by psychiatric services on the Monday afterward the incident and his medications were adjusted. He had not had prior physical aggression. He was on one-on-one observations for seven days. He didn't like his stuff messed with, they moved him off the memory care unit because he had no elopements, and the boundaries of other residents were different outside the unit. The Medical Director ordered the depakote on 5/6/24. The DON could not locate notes regarding why the doctor put Resident D on the medication and the psychiatric NP ordered the Celexa. The DON was not sure what the NP's notes indicated as the reason to prescribe the Celexa. Resident D had a diagnosis of depression. During an interview with the Medical Director, 5/16/24 at 10:44 a.m., he indicated he had been in the facility and staff reported Resident D had frequent behaviors. He had an altercation this one time with another resident, when they were trying to get the same item. Resident D grabbed her, pushed her, and she had received broken bones. The Medical Director treated the resident's aggressiveness and prevented him from injuring another resident. If they didn't do anything, they would receive a citation and if they do something like medicate a resident, they would receive a citation, so either way, it would be the same conversation. During an interview with the Psychiatric NP, on 5/16/24 at 11:23 a.m., she indicated this had been the first time she had seen Resident D. There were mixed reports about whether the incident was witnessed or unwitnessed. Resident D said he pushed the female resident and said he felt like people were taking his things. Basically, the resident said to her that he going to do what he could to keep other residents from getting his things. She tried to talk to him about what he would do, and he would change the conversation and she tried to redirect the conversation back. He did not present with agitation and was with a staff member for one on one observation. She had no justification to put him on an antipsychotic or to send him out to psychiatric hospital. She felt she needed to initiate Celexa to keep him from hurting somebody else and felt that was the best course of action to create more of an antianxiety effect. Celexa and Lexapro (antidepressant) were her go-to medications for a resident to be more restful. A current facility policy, titled Unnecessary Medication, provided by the DON on 5/16/24 at 1:42 p.m., indicated the following: . Procedure . 2. The facility will assess the resident's underlying condition, current signs, symptoms, and expressions and preferences and goals for treatment. This will assist the facility in determining if there are any indications for initiating, or withholding medication(s), as well as the use of non-pharmacological approaches. a. A diagnosis alone may not warrant treatment with medication . 3. e. The use of non-pharmacological approaches, unless contraindicated, to minimize the need for medications . 4. The resident's medical record should show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed This citation relates to Complaint IN00433954. 3.1-48(a)(4)