

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Woodlands The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interview, the facility failed to implement their facility abuse policy when a staff member failed to report a suspicion of abuse of a cognitively impaired resident, which delayed the initiation of the facility investigation and reporting to the appropriate agencies, for 1 of 3 residents reviewed for abuse. (Resident B, RN 3 and QMA 1)</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 5/6/25 at 10:00 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease-stage 4, type 2 diabetes, obstructive and reflux uropathy, and depression.</p> <p>The most recent significant change Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident was severely cognitively impaired.</p> <p>During an interview on, 5/7/25 at 1:08 p.m., LPN 2 indicated, on 4/8/25, she was having difficulty administering medications to Resident B. The resident was combative and repeatedly refused medication. RN 3 arrived and was appraised of the situation. RN 3 indicated the resident had to take the medication due to terminal restlessness. LPN 2 told her she refused to make the resident take the medication and handed her the keys to the medication cart. RN 3 and QMA 1 took the medication cart keys. QMA 1 prepared the medication and entered the resident's room with RN 3 and shut the door. LPN 2 did not see staff interaction with the resident, but heard the resident yelling that she did not want the medication. QMA 1 came out of the resident's room and indicated they were able to get what they could inside her and the resident had been fighting and spitting out the medication. LPN 2 indicated the incident occurred approximately one month ago and she had not reported it to anyone. The Regional [NAME] President, Regional Clinical Director, and DON were present during the interview and indicated they had not been made aware of this incident.</p> <p>During an interview on 5/7/25 at 1:13 p.m., the Regional [NAME] President indicated anyone with a suspicion of abuse or mistreatment should report it to the Executive Director immediately.</p> <p>A current policy, dated 6/27/24, titled Abuse-Reporting and Response- Suspicion of a Crime was provided by Regional Clinical Director on 5/7/25 at 10:44 a.m. The policy indicated the following:</p> <p>Reporting Procedures 1. Once an associate or other covered individual at the facility (e.g., medical director) forms a reasonable suspicion that a crime has been committed against a resident or other individual receiving services at the facility, he or she must immediately notify the Executive Director of their suspicion.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This citation relates to complaint IN00457345.</p> <p>3.1-28(c)</p>		