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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	343 S Nappanee St Elkhart, IN 46514

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, the facility failed to notify the physician of a resident's change in condition related to blood pressure, missed doses of medication and blood sugar for 2 of 3 residents review for physician notification. (Residents 71 and 34)Findings include: The clinical record of Resident 71 was reviewed on 11/19/2025 at 2:32 P.M. The resident's diagnoses included, but were not limited to: acute and chronic respiratory failure, chronic heart failure, diabetes mellitus, cirrhosis of the liver, cerebral infarction, morbid obesity, depression, anxiety, hypertension and cardiac murmur. An admission Minimum Data Set (MDS) assessment, completed on 8/16/25, indicated Resident 71 was cognitively intact. Current Physician orders included, but were not limited to: -Amlodipine Besylate oral tablet 10 mg (milligrams), one tablet by mouth one time a day for hypertension. -Carvedilol oral tablet 12.5 mg, two tablets by mouth two times a day for hypertension. -Hydralazine Hydrochloride oral tablet 25 mg, two tablets every 8 hours for hypertension. A Care Plan, initiated on 8/12/2025, indicated Resident 71 had a diagnosis of hypertension with interventions included, but not limited to: administer anti-hypertensive medications as ordered and observe for side effects such as orthostatic hypotension and observe for/record medication side effects and report to the physician as necessary. The August 2025 Medication Administration Record (MAR) indicated Resident 71 had not received Amlodipine Besylate on the following dates: 8/16/2025 and 8/24/2025. The August 2025 MAR indicated the resident had not received Carvedilol on the following dates/times: 8/16/2025 morning and 8/24/2025 morning. The August 2025 MAR indicated the resident had not received Hydralazine Hydrochloride on the following dates/times: 8/15/2025 6:00 A.M., 8/16/2025 6:00 A.M. and 8/21/2025 10:00 P.M. A Nurses' Note, dated 8/16/2025 at 9:18 A.M., indicated Resident 71's anti-hypertensive medications were held due to the resident's blood pressure being low. There was no documentation the physician (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been notified of the low blood pressure assessments or the missed medications. During an interview, on 11/20/2025 at 9:08 A.M., the Quality Assurance Administrator provided text messages via Tiger Text (a secure messaging application for personal or business use) and indicated the provided texts contained notifications to the physician regarding Resident 71's low blood pressure and missing medications. The Quality Assurance Administrator indicated the texts used to be documented in the progress notes but were no longer being put in the resident's clinical record/chart. However, review of the provided Tiger Texts indicated there was no specific information regarding the resident's low blood pressure assessments or help medications. During an interview, on 11/20/2025 at 3:15 P.M., the Quality Assurance Administrator indicated the Tiger Text messages had not contained any physician notification for either low blood pressure assessments or the missing medications. On 11/20/2025 at 12:05 P.M., the Quality Assurance Administrator provided a policy titled, Medication Administration General Guidelines, dated 5/20/2020 and indicated the policy was the one currently used by the facility. The policy indicated .any vital medication(s) refused or more than one dose of a medication refused should be reported to the DON/designee and/or physician according to facility policy. On 11/20/2025 at 12:05 P.M., the Quality Assurance Administrator provided a policy titled, Acute Condition Changes – Clinical Protocol, dated 3/2018 and indicated the policy was the one currently used by the facility. The policy indicated .the nursing staff will contact the physician based on the urgency of the situation. 2. A record review for Resident 34 was completed on 11/19/2025 at 10:28 AM. Diagnoses included, but were not limited to: Parkinson's disease, anxiety disorder, major depressive disorder and diabetes mellitus type 2. A Quarterly Minimum Data Set (MDS) assessment, completed on 11/5/2025, indicated Resident 34 was cognitively intact and had received insulin injections for 7 days of the 7-day look back period. A current Physician's Order, initiated on 10/26/2025, indicated staff were to notify the physician or nurse practitioner for blood sugar results greater than 401 milligrams per deciliter (mg/dL) Blood sugar results, documented on 10/30/2025 at 5:05 P.M., were 487 mg/dL and, on 10/31/2025 at 5:47 P.M., the blood sugar results were 401 mg/dL for Resident 34. A Care Plan, initiated on 10/15/2024 and revised on 6/24/2025, indicated Resident 34 had diabetes mellitus. Interventions included, but were not limited to: administer diabetes medication as ordered by the physician and observe for/document side effects and effectiveness. During an interview, on 11/21/2025 at 12:05 P.M., the Quality Assurance Administrator indicated no documentation could be located for the notification of the high blood sugars on 10/30/2025 and 10/31/2025. A policy was provided by the Quality Assurance Administrator, on 11/20/2025 at 2:18 P.M. The policy titled, Diabetes-Clinical Protocols, indicated, .Monitoring and Follow-Up 1. The provider will order desired glucose targets and monitoring regimens, as well as parameters for reporting information (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to blood glucose monitoring. 2. The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan. 3.1-5(a)(1)3.1-5(a)(2)3.1-5(a)(3)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, record review and interview, the facility failed to ensure the correct dosage of an antipsychotic was ordered after a failed gradual dose reduction for 1 of 5 residents reviewed for unnecessary medications. (Resident 22)Finding includes: A record review for Resident 22 was completed on 11/18/2025 at 1:08 P.M. Diagnoses included, but were not limited to: brain damage related to a birth injury, epilepsy, unspecified psychosis, generalized anxiety, dementia and pseudobulbar affect.A Quarterly Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated Resident 22 had moderate cognitive impairment, received an antipsychotic medication and the last gradual dose reduction had been attempted on 9/25/2025 with no clinical contraindications for the previous reductions.A Physician's Order, dated 3/10/2025 and discontinued on 9/25/2025, indicated Resident 22 was to receive Abilify 15 milligrams 0.5 tablet (7.5 milligrams) daily at bedtime for psychosis.A Physician's Order, dated 9/25/2025 and discontinued on 10/7/2025, indicated Resident 22 was to receive Abilify 5 milligrams one tablet at bedtime for psychosis.A Physician's Order, dated 10/7/2025, indicated Resident 22 was to receive Abilify 15 milligrams daily at bedtime for psychosis. The pharmacist, psychiatric nurse practitioner and director of nursing were aware.A Nursing Progress Note, on 9/25/2025 at 11:28 A.M., indicated a GDR (Gradual Dose Reduction) meeting had occurred and Resident 22's Abilify dosage was decreased from 15 milligrams to 5 milligrams daily. A Nursing Progress Note, on 9/28/2028 at 2:34 P.M., indicated Resident 22 had been shouting Get out of here, You're evil, and Don't touch my stuff. There were no staff members in Resident 22's room and Resident 22 appeared to have hallucinated.A Nursing Progress Note, on 10/1/2025 at 5:26 A.M., Resident 22 was observed agitated and yelling loudly in her room during the night shift. Resident 22 was calling out that she needed supplies with her on the bed. The facility staff attempted verbal redirection, but Resident 22 continued to yell, but eventually stopped banging the bed and yelling. A Progress Note, on 10/3/2025 at 10:27 A.M., the Social Services Designee spoke with the insurance company nurse practitioner, the psychiatric nurse practitioner, the interdisciplinary team and the floor staff regarding Resident 22's behaviors. Together the team decided decreasing the Abilify was a failed gradual dose reduction. The Psychiatric nurse practitioner indicated she would reinstate the Ability dose.A Progress Note, on 10/7/2025 at 11:35 A.M., indicated the Social Service Designee spoke with insurance company nurse practitioner and the psychiatric nurse practitioner and Resident 22 had failed a gradual dose reduction of Abilify. The new order indicated the Abilify was being restored to the previous dosage of 15 milligrams every day. However, the previous dose from 3/10/2025 through 9/25/2025 was 7.5 milligrams, with a dose reduction to 5 milligrams on 9/25/2025.A Care Plan, initiated on 2/3/2016 and revised on 2/6/2024, indicated Resident 22 took an antipsychotic medication for a diagnosis of psychosis and agitation. The care plan goal included Resident 22 to receive the lowest therapeutic dosage of medication. The interventions included, but were not limited to: administering medications as ordered, remain free of side effects/adverse reactions to medications, IDT (Interdisciplinary Team) to review medication for use and consideration for gradual dosage reduction. During an interview, on 11/21/2025 at 9:41 A.M., the Quality Assurance Administrator indicated she was not sure why the 7.5 milligrams of Abilify was skipped after a successful gradual dose reduction and the 15 milligrams of Abilify was ordered.An attempt was made to contact the psychiatric nurse practitioner, on 11/21/2025 at 10:05 A.M. The phone call was not returned. A current policy, revised on February 2025, was provided by the Quality Assurance Administrator, on 11/20/2025 at 2:18 P.M. The policy titled, Tapering Medications and Gradual Dose Reduction, indicated, .Policy Statement.2. Residents who use psychotropic medications receive gradual dose reductions, unless clinically contraindicated, in an (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effect to discontinue these medications.Policy Interpretation and Implementation 1. Gradual Dose Reduction [GDR] refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed at a lower dose or if a medication can be discontinued. 3.1-3(w)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on Interview and record review, the facility failed to hold quarterly care plan conferences and include the resident, or resident representative for 1 of 19 residents whose care plans were reviewed. (Resident 3)Finding includes:During an interview on 11/17/2025 at 10:57 A.M. Resident 3 indicated she had not been invited to any care planning conferences.A record review was completed on 11/18/2025 at 1:40 P.M. for Resident 3. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic pulmonary obstructive disease, and bipolar disorder. The record indicated a care plan meeting was held on 1/8/2025 and the resident was in attendance. No further care plan meetings were found in the record.During an interview on 11/20/2025 at 11:23 A.M. the Social Worker indicated care plan meetings should have been done quarterly but had not been held.On 11/20/2025 at 12:12 A.M. a current policy, dated 9/2022 and titled, Care Plans, Comprehensive Person-Centered, was provided by the Corporate Quality Assurance Administrator. The policy indicated, .Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: Participate in the planning process; see the care plan and sign it after significant changes are made and .The Interdisciplinary Team must review and update the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set assessment 3.1-35(c)(2)(C)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review and interview, the facility failed to identify skin conditions for 1 of 2 residents reviewed for skin conditions (Resident 8) and failed to administer blood pressure medications according to the ordered parameters for 1 of 5 residents reviewed for unnecessary medications (Resident 44).Findings include:1. During an interview on 11/17/2025 at 2:18 P.M., Resident 8 was not able to identify how he obtained a large dark bruise on the top of his right hand or why he had two scabs on his right temple and one scab under his right eye.Resident 8's record review was completed on 11/19/2025 at 2:15 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia and type 2 diabetes mellitus. A current Physician's order, initiated on 3/15/2025, indicated Resident was to receive a complete Weekly Skin Review assessment and staff were to report any new skin problem to the Director of Nursing and the Medical Director. Resident 8's current Care Plan, initiated on 8/5/2025, indicated Resident 8 was at risk of skin breakdown related to dementia, impaired nutrition and bowel and bladder incontinence. A Care Plan intervention, initiated on 3/13/2025, indicated Resident 8 was to have Weekly Skin Reviews by a licensed nurse.Resident 8's Weekly Skin Review assessment, completed on 11/17/2025 at 4:41 P.M., had not indicated the resident had a bruise on his right arm or scabs on the right side of his face. During an interview, on 11/19/2025 at 2:58 P.M., LPN 2 indicated any skin issue, including bruises and scabs, should be documented on the Weekly Skin Review assessment. If any new skin problems occurred after the skin assessment had been completed for the week, another Weekly Skin Review assessment should have been completed. LPN 2 was nor able to identify how Resident 8 had acquired the bruise on his left hand but believed the scabs on his face had been acquired from the resident scratching himself. LPN 2 indicated Resident 8's Electronic Medical Record (EMR) lacked the documentation regarding the bruise on his right hand and the scabs on the right side of his face. Both areas had not been added to the resident's Weekly Skin Review assessment and the Medical Provider and the DON had not been notified of the resident's new skin problems. 2. A record review was completed on 11/19/2025 at 2:58 P.M. for Resident 44. Diagnoses included. but were not limited to: essential hypertension.Physician Orders for Resident 44 included, but were not limited to, atenolol 25 milligrams (mg) give 0.5 tablet by mouth one time a day for essential hypertension, hold if systolic blood pressure (SBP) <110 or for heart rate <60.During the month of November 2025, the atenolol was administered outside of the blood pressure parameters. On the following dates Resident 44's systolic blood pressure was less than 110 (<110) and the atenolol was administered:11/1/2025 the SBP was 107.11/10/2025 the SBP was 101.11/12/2025 the SBP was 109.11/17/2025 the SBP was 104.11/19/2025 the SBP was 100.During an interview, on 11/20/2025 at 2:16 P.M., the Quality Assurance Administrator indicated the atenolol should not have been administered when Resident 44's SBP was less than 110.On 11/20/2025 at 11:42 A.M. an undated policy was provided by the Quality Assurance Administrator (QAA) who indicated it was the policy currently used by the facility. The policy titled, Skin and Wound Management System. The policy indicated, . 3. Ongoing weekly evaluations of resident's skin will be completed and documented on the Weekly Skin Evaluation form.On 11/20/2025 at 1:12 P.M. the Corporate Quality Assurance Administrator provided a current policy dated 3/17/2022 and titled, Physician Orders. The policy indicated, .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on observation, record review and interview, the facility failed to obtain ordered laboratory tests for 1 of 5 residents reviewed for unnecessary medications. (Resident 22)Finding includes:A record review for Resident 22 was completed on 11/18/2025 at 1:08 P.M. Diagnoses included, but were not limited to: brain damage related to a birth injury, epilepsy, unspecified psychosis, generalized anxiety, dementia and pseudobulbar affect.A Quarterly Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated Resident 22 had moderate cognitive impairment and received an anticonvulsant.A Physician's Order, dated 3/10/2025, indicated a phenobarbital and valproic acid blood level every six months and was scheduled on 6/13/2025. However, these laboratory tests had not been obtained.A Physician's Order, dated 9/25/2025, indicated a phenobarbital blood level and a complete blood count (CBC) to have been obtained. However, the phenobarbital level had not been obtained.A Physician's Order, dated 10/15/2025, indicated a phenobarbital and valproic acid blood level to have been obtained. However, the level had not been obtained.A Care Plan, initiated on 9/20/2018 and revised on 5/12/2025, indicated Resident 22 had a diagnoses of seizure disorder and had interventions that included, but were not limited to: obtain and monitor lab/diagnostic work as ordered, report results to the physician and follow up as indicated and obtain labs per physician orders and report any sub therapeutic or toxic results to the physician. During an interview, on 11/19/2025 at 2:02 P.M., the Quality Assurance Administrator indicated the ordered laboratory tests for 6/13/2025 and 10/15/2025 were not available. She indicated the CBC had been obtained, but not the phenobarbital blood level. On 11/20/2025 at 1:12 P.M., the Quality Assurance Administrator provided a current policy dated 3/17/2022 and titled, Physician Orders. The policy indicated, .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines 3.1-48(a)(3)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to ensure laboratory services were obtained timely for 1 of 5 residents whose labs had been reviewed. (Resident 31)Finding includes:During an interview on 11/17/2025 at 11:01 A.M., Resident 31's family indicated they had been notified several weeks ago that the resident was to have her urine tested for an infection, but the family had not received the results of the testing.Resident 31's record review was completed on 11/20/2025 at 3:30 P.M. Diagnoses included but were not limited to: Lewy Body Dementia, major depressive disorder and anxiety.A Physician's Laboratory order, marked as completed, had been initiated on 11/11/2025 and indicated Resident 31 was to have her urine collected and sent for UA (urinalysis) and C&S (culture and sensitivity test).A Nurse's Note, dated 11/17/2025 at 8:12 A.M., seven days after the initial physician's order had been received for the urinalysis testing, indicated the lab had reported Resident 31's urine test sample had been contaminated and a new specimen would be needed.During an interview with the Assistant Director of Nursing (ADON) on 11/20/2025 at 11:30 A.M., the ADON indicated the lab used to process orders for the UA and C&S was located in Kentucky and it was not unusual for the facility to wait more than 5 days for the laboratory results. The ADON indicated long turnaround times for labs were due to the fact that the sample took a day or longer to reach the lab and the facility had no other laboratory they could utilize to process the labs in a more timely manner.During an interview with a Customer Service Representative (CSR) for the laboratory the facility used, on 11/20/2025 at 12:05 P.M., the CSR indicated the expected turn around time for a UA and C&S was 72 hours from the time the lab received the sample to the time the results were communicated back to the facility with any culture and sensitivity results.On 11/20/2025 at 2:30 P.M., the Quality Assurance Administrator indicated the facility did not have a policy related to the timeliness of the facility's laboratory services.3.1-49 (a)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review, record review and interview, the facility failed to ensure the recommended dental services was completed timely for 1 of 1 resident reviewed for dental services. (Resident 22)Finding includes:A record review for Resident 22 was completed on 11/18/2025 at 1:08 P.M. Diagnoses included, but were not limited to: quadriplegia, brain damage d/t birth injury, intellectual disabilities and dementia. A Quarterly Minimum Data Set (MDS) assessment, completed on 10/23/2025, indicated Resident 22 had moderate cognitive dysfunction, had no oral issues and required assistance with oral hygiene practices.A Dental Assessment Note, dated 6/20/2025, indicated x-rays had been taken and suggested tooth #31 (right back tooth) be extracted with a community dentist.A Nursing Progress Note, dated 7/8/2025 at 2:42 P.M., indicated a dental referral for right back tooth pain had been received.A Nurse Practitioner Progress Note, dated 9/22/2025 at 11:59 P.M., indicated Resident 22 had pain to her back right molar. Resident 22 had expressed interest having a dental referral and management of the molar pain. A Care Plan, initiated on 5/12/2017 and revised on 10/29/2025, indicated Resident 22 was at risk for oral/dental problems related to activities of daily living deficits, cognitive deficits and physical limitations. Interventions included,but were not limited to: Coordination for arrangements for dental care, transportation as needed/as ordered and observe for/document/report to the physician/nurse practitioner of oral/dental problems that needed attention.During an interview, on 11/19/2025 at 2:02 P.M., the Quality Assurance Administrator indicated there was nothing in the chart that indicated the dental referral had been completed or the tooth extraction had been completed for Resident 22.A policy was provided by the Quality Assurance Administrator, on 11/20/2025 at 2:18 P.M. The policy titled, Mouth Care, indicated, .The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. The policy did not address dental visits or recommendations.3.1-24(a)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection control practices related to urinary catheters for 1 of 3 residents reviewed for urinary catheters. (Resident 3) Finding includes:A record review was completed on 11/18/2025 at 1:40 P.M. for Resident 3. Diagnoses included, but were not limited to, obstructive and reflux uropathy.Physician Orders for Resident 3 included, but were not limited to:3/10/2025 16 french (refers to the catheter size) foley catheter with a 10 cubic centimeters (cc) balloon with drainage bag to gravity. May change as needed for leakage.4/16/2025 Enhanced barrier precautions due to foley catheter. Gown and gloves must be worn for the following care dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, urinary catheter use or care, every shift due to foley catheter.A current Care Plan, initiated on 11/13/2025, indicated Resident 3 had a urinary tract infection. The resident was to receive the ordered antibiotic and staff were to monitor for further symptoms.During an interview and observation on 11/17/2025 at 11:12 A.M., Resident 3 indicated the catheter was hurting and she thought it was due to the large amount of urine in the drainage bag. The urinary drainage (UD) bag was noted to be laying on the floor with no barrier between it and the floor. CNA 4 entered the room to empty the UD bag, applied gloves and bent over to pick up the bag when Resident 3 reminded her to put on a gown. CNA 4 then went into the hall to put on a gown. Resident 3 indicated staff did not always use a gown when they should.During an interview on 11/20/2025 at 2:11 P.M., the Corporate Quality Assurance Administrator indicated CNA 4 should have worn a gown and the UD bag should not have been on the floor.On 11/20/2025 at 2:34 P.M. the Corporate Quality Assurance Administrator provided a current policy dated 9/2014, and titled, Catheter Care, Urinary. The policy indicated, .Be sure the catheter tubing and drainage bag are kept off the floor 3.1-18(a)

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	11/21/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, and clean environment related to dirty floors in the laundry rooms; cracked and buckled flooring in the 100, 200, and 300 units; and non-functioning electrical outlets. Findings include: 1.During an environmental tour on 11/21/2025 at 9:23 A.M., the floors in the dirty and clean laundry rooms were dirty with brown/black marks and debris. During an interview on 11/21/2025 at 9:50 A.M., the Housekeeping Director indicated the floors in the dirty and clean laundry rooms should have been clean. On 11/21/2025 at 11:13 A.M., the Corporate Quality Assurance Administrator provided a current policy dated August 2019, and titled, Cleaning and Disinfection of Environmental Surfaces. The policy indicated, .Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled 2. During an environmental tour on 11/21/2025 at 9:23 A.M., the tiled floors on units 100, 200, and 300, were buckled and cracked. During an interview on 11/21/2025 at 10:15 A.M., the ED indicated she was aware the floors were a problem and they had been noted during the December 2024 survey. She indicated the facility had a plan to replace the floors, but there was no specific information provided. 4. During an interview on 11/17/2025 at 11:01 A.M., Resident 31's family indicated they had informed the facility that Resident 31 had been unable to watch television because the outlets in her room were not working. During an observation of Resident 31's room with the Quality Assurance Administrator (QAA) and the Executive Director on 11/19/2025 at 11:09 A.M., the ED tried plugging a fan into all four of the electric outlets under the resident's television. None of the outlets were working. During an interview with the Quality Assurance Administrator (QAA) on 11/19/2025 at 1:10 P.M., she indicated Resident 31's family had notified the facility about the nonworking outlets and the facility had believed a work order had been filled out. The QAA indicated the facility had not submitted a work order and Resident 31's outlets had not been working since July 2025. During an interview with the QAA on 11/20/2025 at 9:46 A.M., the QAA indicated the facility did not have a policy related to maintaining the building or keeping the building in working condition. 3.1-19 (f)