STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF CASTLETON, LLC	8480 CRAIG ST, INDIANAPOLIS, , 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00412013, IN00408126 and IN00406625 Complaint IN00412013 - No deficiencies related to the allegations are cited. Complaint IN00408126 - No deficiencies related to the allegations are cited. Complaint IN00406625 - No deficiencies related to the allegations are cited. Survey dates: July 6, 7, and 10, 2023 Facility number: 009894 Residential Census: 146 Wyndmoor of Castleton, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure and the Investigation of	R 0000		

	Complaints IN00412013, IN00408126 and IN00406625. Quality review was completed on July 18, 2023.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to protect a resident with vascular dementia from neglect when staff did not respond to the residents calls for help for 1 of 1 resident reviewed for neglect. (Resident 3) Resident 3 was found lying on the floor in her room. Finding includes: During an observation of the Terrace Unit, on 07/07/23 at 5:03 a.m., Resident 3 was heard yelling for help from behind a closed door. CNA 3 had passed the room and continued to walk	R 0052	***R 052 Residents' Rights – offense*** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** **The community disputes the finding of a Resident Rights – Offense R052 410 IAC 16.2-5-1.2(v)(1-6) which stated "the facility failed to protect a resident with vascular dementia from neglect when staff did not respond to the residents calls for help for 1 of 1 residents reviewed for neglect."** • The facility requests an IDR for this deficiency. • Facility has camera footage that disputes the series of events that	08/03/2023

	down the hall. She indicated the resident did that all the time, and she talked to herself. The CNA continued walking down the hall toward the office. After knocking on and opening the door, the resident was observed to be laying on her back on the floor. The bed was noted to be in a high position. The resident had blankets under her body. The resident indicated "help I need a drink, I am dying, help." CNA 3 returned to the room and entered. The resident asked for a drink and the CNA indicated the faucet was not running. The CNA indicated she would get the nurse and contacted the nurse via walkie talkie. LPN 4 arrived at the room at 5:10 a.m. She indicated to the CNA the bed was high. The CNA responded she left the bed in a high position; she had just checked the resident. The nurse then told the CNA to assist her and without performing an assessment on the resident, the nurse positioned on the resident's right and the CNA on the resident's left, moved Resident 3 to a sitting position. Once in a sitting position the nurse asked Resident 3 if she had any pain. Resident 3 indicated "my back hurts". The two staff members then hooked their arms under the resident's arm pits and lifted her buttocks off the floor and dragging her feet, moved the resident into the recliner which was to the		are listed in R 052 Resident Rights – Offense. • Associate was in residents' room and is seen exiting at 4:52 after doing a check and change and surveyor confirmed with us that when she entered resident was dry. Clearly showing no signs of neglect. • The surveyor is seen stopping at resident room (never opening the door – just listening) at 5:05 and associate is not in view because she was disposing of trash from another resident room. Associate is then seen coming back around the corner and interacts with the surveyor and immediately approached her by the resident door. She never left the	

resident's left. Once the resident was in the recliner, the nurse checked her vital signs.

The record for Resident 3 was reviewed on 07/10/23. Diagnoses included, but were not limited to, vascular dementia (changes to memory, thinking, and behavior resulting from conditions which affect the blood vessels in the brain), abnormality of gait and mobility, and hypertensive heart disease with heart failure.

A nurse's note, dated 07/07/23 at 5:26 a.m., indicated "...resident fell from foot side of bed side rails up bed left in high position resident c/o some back discomfort resident assisted up and placed in her recliner back pain relieved with position change...."

There were no neurochecks or other assessment information found in the record at the time of the record review.

During an interview, on 07/07/23 at 5:16 a.m., LPN 4 indicated the fall protocol was to assess for injury first, check the vital signs then notify the family and physician, and complete a fall report.

surveyor's side, and the door was opened with the CNA standing next to her where they found the resident was on the floor next to her bed. Again, showing associate attended to residents yelling out for someone.

- The associate did state and confirmed that she said to the surveyor that she yells frequently but showed no delay in responding when the surveyor is seen pointing out that she heard yelling. The resident was care planned for yelling out frequently with interventions of redirection, and pharmaceutic interventions.
- The resident was assessed by nurse and vitals collected. Back pain was relieved with position change.
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During an interview, on 07/07/23 at 5:38 a.m., LPN 4 indicated when transferring a resident, a gait belt or Hoyer lift should be used.

During an interview, on 07/07/23 at 2:58 p.m., the Executive Director indicated Resident 3's door should have been open, so the resident was visible; she did yell out and call for help.

During an interview, on 07/10/23, the Director of Nursing indicated the CNA 3 should have checked on the resident and not treated the yelling out as a behavior. The procedure for a fall was to assess for injury, ask the resident if they hit their head, check the vital signs, and move the resident after the assessment, using a gait belt and two people. It is more beneficial to keep the resident's door open on night shift and the bed should have been in a low position unless providing care. Staff should not leave a resident in a high bed and walk away.

A current policy, titled "Abuse, Neglect & Exploitation Policy-IN-1," dated as effective 01/01/23 and received from the Executive Director on 07/10/23 at 10:13 a.m., indicated "...Neglect...is defined...as an act or omission which places a resident in a situation that may endanger the resident's life or

The statement regarding the drink came (per the Nurse) from her.
She stated the resident kept asking for a drink while laying on the
floor and they were redirecting the resident so they could get her assessed and off the floor. A drink was at her bedside and full and had just been
filled when staff was in the room at 4:50.

How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?

health...depriving a resident or necessary support, including...medical care...."

Based on observation, interview and record review, the facility failed to protect a resident with vascular dementia from neglect when staff did not respond to the residents calls for help for 1 of 1 resident reviewed for neglect. (Resident 3) Resident 3 was found lying on the floor in her room.

Finding includes:

During an observation of the Terrace Unit, on 07/07/23 at 5:03 a.m., Resident 3 was heard yelling for help from behind a closed door. CNA 3 had passed the room and continued to walk down the hall. She indicated the resident did that all the time, and she talked to herself. The CNA continued walking down the hall toward the office. After knocking on and opening the door, the resident was observed to be laying on her back on the floor. The bed was noted to be in a high position. The resident had blankets under her body. The resident indicated "help I need a drink, I am dying, help." CNA 3 returned to the room and entered. The resident asked for a drink and the CNA indicated the faucet was not running. The CNA indicated she would get the nurse and contacted the nurse via walkie talkie. LPN 4

- The community completed resident interviews including ensuring staff always respond to their call for help, to ensure they were not affected by the same alleged deficient practice. No concerns noted.

What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?

- Facility will continue to run background checks on new hires and abuse, neglect and exploitation will remain a bar on employment.
- The facility will continue to run associate’s licenses upon hire and annually to ensure no disciplines or actions against their licenses have been issued related to

	arrived at the room at 5:10 a.m. She indicated to the CNA the bed was high. The CNA responded she left the bed in a high position; she had just checked the resident. The nurse then told the CNA to assist her and without performing an assessment on the resident, the nurse positioned on the resident's right and the CNA on the resident's left, moved Resident 3 to a sitting position. Once in a sitting position the nurse asked Resident 3 if she had any pain. Resident 3 indicated "my back hurts". The two staff members then hooked their arms under the resident's arm pits and lifted her buttocks off the floor and dragging her feet, moved the resident into the recliner which was to the resident's left. Once the resident was in the recliner, the nurse checked her vital signs. The record for Resident 3 was reviewed on 07/10/23. Diagnoses included, but were not limited to, vascular dementia (changes to memory, thinking, and behavior resulting from conditions which affect the blood vessels in the brain), abnormality of gait and mobility, and hypertensive heart disease with heart failure. A nurse's note, dated 07/07/23 at 5:26 a.m., indicated "...resident fell from foot side of bed side rails up bed left in high		abuse, neglect or exploitation. • Staff Education completed monthly on community Abuse, Neglect and Exploitation policy and will be ongoing. • Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to abuse, neglect, or exploitation. **How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place?** • The facility will continue to run background checks on new hires. Any associate with findings on their record must be reviewed by the	

	position resident c/o some back discomfort resident assisted up and placed in her recliner back pain relieved with position change...." There were no neurochecks or other assessment information found in the record at the time of the record review. During an interview, on 07/07/23 at 5:16 a.m., LPN 4 indicated the fall protocol was to assess for injury first, check the vital signs then notify the family and physician, and complete a fall report. During an interview, on 07/07/23 at 5:38 a.m., LPN 4 indicated when transferring a resident, a gait belt or Hoyer lift should be used. During an interview, on 07/07/23 at 2:58 p.m., the Executive Director indicated Resident 3's door should have been open, so the resident was visible; she did yell out and call for help. During an interview, on 07/10/23, the Director of Nursing indicated the CNA 3 should have checked on the resident and not treated the yelling out as a behavior. The procedure for a fall was to assess for injury, ask the resident if they hit their head, check the vital signs, and move the resident after the assessment, using a gait belt			Executive Director or Designee to ensure it is not a bar on employment. Existing employees are required as stated in our employee handbook to report any new criminal actions taken upon them. • Facility will continue to run associate licenses upon hire and annually to ensure no disciplines or actions against their licenses have been issued. • A Resident Abuse, Neglect and Exploitation Interview Completion Audit Tool will be completed monthly to ensure community remains in compliance. • The Executive Director will receive reports monthly regarding the results of such audits and will direct further action if required.	

	and two people. It is more beneficial to keep the resident's door open on night shift and the bed should have been in a low position unless providing care. Staff should not leave a resident in a high bed and walk away. A current policy, titled "Abuse, Neglect & Exploitation Policy-IN-1," dated as effective 01/01/23 and received from the Executive Director on 07/10/23 at 10:13 a.m., indicated "...Neglect...is defined...as an act or omission which places a resident in a situation that may endanger the resident's life or health...depriving a resident or necessary support, including...medical care...."		**By what date will the systemic changes be implemented?** • 08/03/2023	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE