STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF MARION, LLC	2452 W KEM RD, MARION, , 46952

(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 the Investigation of Intake 468449. Intake 468449 - State deficiencies related to the allegations are cited at R217. Survey date: March 19, 2026 Facility number: 010682 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 23, 2026.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:	R 0217	Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The services plan for the three residents noted were all immediately reviewed, and	03/27/2026

	(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview, and record review, the		appropriate interventions added and implemented. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Any resident at risk for falls has the potential to be affected by the alleged deficient practice. All resident service plans were reviewed by the Director of Nursing to ensure falls were noted on the services plans with proper interventions in place. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Director of Nursing will do regular audits on service plans which will include review of falls, frequency of needs, preferences of needs and all-over general person-centered care for residents' service plans. A Fall intervention Audit Tool has been created for service plan evaluation/fall intervention.	

	facility failed to ensure service plans were reviewed and updated following falls for 3 of 3 residents reviewed for falls. (Resident B, C, and D) Findings include: 1. Resident B's clinical record was reviewed on 3/19/26 at 9:27 a.m. Diagnoses included (idiopathic) normal pressure hydrocephalus, essential (primary) hypertension, history of falling, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, acquired deformities of unspecified lower leg, pain in right shoulder, and patient's noncompliance with medical treatment and regimen. A Brief Interview for Mental Status (BIMS) assessment dated 12/9/25 indicated she had severe cognitive impairment. Her fall focused service plan, initiated on 12/27/23, indicated that she was at risk for fall related to balance problems, gait problems, history of falls, and impaired mobility. Interventions included encourage participation in activities that would increase strength and mobility (12/27/23), reminding her about safety and what to do if a fall occurred (12/27/23), reminding her to use		• How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Director of Nursing will audit all falls weekly to ensure falls are noted with interventions in the resident service plans and update the fall intervention audit tool accordingly. • By what date the systemic changes will be completed. April 7, 2025	

assistive devices and her call pendant for assistance as needed (12/27/23), reminding her to use the call pendant/pull cord and to call for assistance as needed (1/25/24), and providing a safe environment (7/8/25).

Nurse's notes included the following falls:

On 1/10/26 at 4:55 p.m., she slid out of her wheelchair onto the floor. No injuries were noted.

On 1/30/26 at 10:44 a.m., she was found lying on her right side next to her wheelchair in her room. She reported attempting to pick up a blanket from the floor when her pants pocket caught on the brake and pulled her to the floor. A small abrasion was noted to her right outer knee.

On 1/31/26 at 9:55 a.m., she slid out of her wheelchair in the hallway outside of her room. No injuries were noted.

On 2/4/26 at 12:51 p.m., she was found on the floor in her apartment, scooting to the door on her bottom. She reported she slid off the bed and was going to the door for assistance. She did not use her call pendant. A skin tear was noted to her right elbow.

On 2/24/26 at 5:31 p.m., she

reported that she had fallen. A bruise was noted on her left eye.

On 2/26/26 at 2:03 a.m., bruising was noted to her right eye and surrounding area, with slight bruising to her left eye and a small bruise on her right shoulder.

On 3/9/26 at 7:30 p.m., she reported that two hours prior to dinner, she had fallen out of her wheelchair and hit her head on the floor, then lifted herself back onto the bed. She complained of right shoulder pain. She was encouraged to report falls when they occurred and to use her call light.

On 3/10/26 at 4:27 p.m., she was banging on the inside of her door. An aide found her sitting on the floor leaning against the kitchen cabinet; her wheelchair was approximately 15 feet away. She reported her wheelchair seat became slippery when she urinated in her clothing, causing her to slide to the floor. No injuries were noted, and she refused to go to the hospital.

Her service plan lacked updated fall-prevention interventions to mitigate the risk of repeated falls.

2. Resident C's clinical record was reviewed on 3/19/26 at

10:20 a.m. Diagnoses included primary osteoarthritis, fibromyalgia, hypertension, bipolar disorder, other malaise, and cerebral infarction.

Her BIMS assessment dated 2/8/26 indicated she had moderate cognitive impairment.

Her fall service plan was initiated on 4/22/25. Interventions included maintaining a safe environment and reminders to call for assistance, using mobility devices, using the bathroom, and going to activities (4/22/25).

Nurse's notes included the following falls:

On 2/3/26 at 11:04 a.m., other residents witnessed her locking her wheelchair, walking to get coffee and falling. She hit her right arm while returning to her chair. She was sent to the emergency room.

On 2/3/26 at 1:49 p.m., the hospital report indicated she was discharged with a displaced humeral right neck fracture and instructed to wear a sling at all times. She was not to lay flat and required the head of her bed to be elevated 40-45 degrees.

On 2/3/26 at 7:00 p.m., she was found on the floor in front of her recliner. No new injuries were

noted. She would be checked on every 15 minutes.

Her service plan lacked updated fall-prevention interventions to mitigate the risk of repeated falls.

3. Resident D's clinical record was reviewed on 3/19/26 at 10:45 a.m. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, delusional disorders, peripheral vascular disease, essential (primary) hypertension, epilepsy, not intractable without status epilepticus, monoplegia of upper limb following unspecified cerebrovascular disease affecting right dominant side, chronic pain syndrome, age-related physical debility, repeated falls, unsteadiness on feet, muscle weakness (generalized), and fibromyalgia.

Her BIMS assessment dated 12/1/25 indicated she had moderate cognitive impairment.

Her fall service plan was initiated on 12/1/25. Interventions included encouraging her to stay in common areas for increased supervision (12/1/25), reminding her to rise and change positions slowly (12/1/25), reminding her to use assistive devices, call device pendant, and pull cord for assistance with transfers

	(12/16/25), and encourage her to use call pendent when getting out of bed (1/29/26). Nurse's notes included the following falls: On 12/13/25 at 7:15 a.m., she reported she fell in her room between her recliner and the wheelchair during a transfer. She complained of right foot, back, and head pain and requested to go to the emergency room. On 12/13/25 at 4:36 p.m., a bruise was noted to her coccyx/sacrum area and a sprained ankle. She reported that the hospital did not wrap her ankle. Hospital paperwork indicated she could use a warm rice pack to the area. On 12/16/25 at 3:00 a.m., she complained of left foot and ankle pain. The left ankle was swollen and slightly red. Elevation and ice were offered to relieve pain. Medication provided no relief. She requested to go to the emergency room.			

On 12/18/25 at 7:15 a.m., she returned from the emergency room on 12/16/25 with a nondisplaced left fibula fracture and a walking boot. Verbal instructions included maintaining a non-weight bearing status until tolerated.

On 12/24/25 at 8:18 p.m., she was found on the floor next to her bed. She reported she tried to get up and slid to the floor.

On 1/15/26 at 1:20 a.m., she was found lying on her left side on the floor by her toilet. She reported that she fell asleep and fell to the floor, hitting her head. She complained of pain in her left shoulder and hip. A small abrasion was noted on her left knee and scattered bruising on her arms. She was sent to the emergency room and admitted for hyponatremia and weakness.

On 1/21/26 at 3:47 p.m., she was found on her bedroom floor. She reported she tried to get into her wheelchair and slid to the floor.

On 1/29/26 at 6:49 a.m., she called for assistance after falling while transferring from her wheelchair to the toilet. She complained of left arm, hip and knee discomfort. Mobile x-rays were ordered.

On 1/29/26 at 9:46 p.m.,

	radiology results indicated no fracture or dislocation with minimal degenerative changes. On 2/2/26 at 10:31 p.m., she was found on bathroom floor. She reported she got on and off the toilet without calling for help. On 3/11/26 at 10:13 a.m., an order was received for a rollator walker. On 3/15/26 at 10:27 a.m., she had an unwitnessed fall on the evening of 3/14/26. A small bruise with two pinpoint marks were noted on her left forehead and a skin tear to her left knee. She complained of head and left ankle pain and was sent to the emergency room. On 3/15/26 at 5:24 p.m., she returned from the emergency room. An x-ray showed partial healing of the distal fibular fracture from 12/25. The recommendations included placing the pneumatic walker back on her foot for two weeks and an orthopedic follow-up. Approximately 10 minutes after returning, she was observed ambulating in her room without assistance. She was encouraged to call for assistance with transfers.			

	Her service plan lacked updated fall-prevention interventions to mitigate the risk of repeated falls. During an interview with the Executive Director and the DON on 3/19/26 at 1:37 p.m. the DON indicated her goal was to review past falls and update service plans as needed. They were working on developing a pocket tool for CNAs with residents' information, including fall interventions. There was a gap between the last DON and herself and she was scheduled for service plan training. A current facility policy, titled "Fall Management," and provided by the Executive Director on 3/19/26 at 2:23 p.m. indicated the following: "Policy... When a fall occurs... Review the resident's service plan for potential fall interventions and update as necessary...." This citation relates to Intake 468449.			

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 SIGNATURECassandra L. Dixon	TITLE04/07/2026	(X6) DATE04/07/2026