STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/04/2025

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 Complaints IN00451292, IN00451382, and IN00451646. Complaint IN00451292 - No deficiencies related to the allegations are cited. Complaint IN00451382 - No deficiencies related to the allegations are cited. Complaint IN00451646 - State deficiencies related to the allegations are cited at R0217. Survey dates: February 3 and 4, 2025 Facility number: 010682 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 5, 2025.	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: (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.	R 0217	• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility conducted an in-service for all Activity staff and Transportation staff for assisted devices. The facility will ensure that Activity and Transportation staff have a resident list and what assistance device each resident utilizes to ensure each resident is using proper assistance device. • 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.	07/31/2025

	(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 interview and record review, the facility failed to ensure a rollator walker was provided in accordance with the service plan to meet the needs of a resident who was at risk for falls and required the device for safe ambulation for 1 of 3 residents reviewed for falls. (Resident F) This deficient practice resulted in a fall and the resident sustaining two fractures of the left upper arm and a ruptured tendon of the left kneecap that required surgical repair. Finding includes: Resident F's closed clinical record was reviewed on 2/3/25 at 1:42 p.m. Diagnoses included unspecified dementia with behavioral disturbance, unsteadiness on feet, and traumatic spondylopathy (disease/disorder that affects the bones of the spine). Physician orders in place at the time of the resident's fall included risperidone (antipsychotic) 1 milligram (mg), citalopram (antidepressant) 40 mg daily, and donepezil (for dementia) 10 mg daily at		The facility along with the Transportation Department will audit each resident who goes on bus and ensure each resident has proper assisted device with them on each transportation trip. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Transportation will audit every resident that attends outings on the bus to ensure that they have and will use their assisted device on each trip/outing. Facility will continue this audit for 6 weeks. • 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 administrator will audit the Transportation log each week to ensure residents are taking their proper assisted	

	bedtime. A service plan, initiated 3/8/21 with a target date of 2/26/25, indicated Resident F was at risk for falling related to his right hip and low back pain and weakness. The resident used a rollator walker for support. He sometimes forgot to use his walker. When his caretakers saw him without his walker, they were to remind him to use it. A current approach initiated 11/8/23 indicated the staff was to remind the resident to use his walker at all times when ambulating. A current "Senior Living Level of Care Evaluation," dated 8/19/24, indicated the resident's orientation fluctuated. The resident used an ambulatory (walking) device. The resident had a known recent history of falling and was at risk for falling. Nurse Notes, dated 1/3/25 at 6:45 p.m., indicated the resident ambulated with a rollator walker. Nurse Notes, dated 1/7/25 at 12:26 p.m., indicated the resident was on an activity outside the facility. When he walked back to the bus, he fell and hit the right side of his face on the bus. His right temple/cheek area was bleeding. The ambulance was called and transported the resident to the hospital. The		device on each trip/outing they attend. The administrator will ensure that all existing and new Activity staff are familiar with the assisted device tool that defines what assisted device each resident uses. • By what date the systemic changes will be completed. The deficient practice will be corrected by April 5, 2025.	

note lacked indication of whether the rollator walker was in use as defined in the service plan.

Nurse Notes, dated 1/7/25 at 2:30 p.m., indicated the hospital indicated the resident had a left humerus (upper arm) fracture.

Nurse Notes, dated 1/8/25 at 9:44 p.m., indicated the resident had been transferred to a regional hospital where he had surgery to his left humerus, surgery to repair his left patellar (knee) tendon, and had to stay sedated and intubated (a tube in the trachea for breathing).

An operative report from the regional hospital, dated 1/8/25, indicated the resident's diagnoses included a left proximal (upper end) humerus fracture, a left humeral shaft (long part of bone) fracture, and a left quadriceps tendon rupture (a tear in the tendon that connects the quadriceps muscles to the kneecap). He received surgery to repair the fractures and the rupture.

During an interview, on 2/3/25 at 3:33 p.m., Activity Assistant 4 indicated when Resident F went on facility activities away from the facility, she always took his walker. The resident would sometimes say he did not need it, but she told him they should take it anyway, so they did not

have an accident. The one time the walker was not taken, on 1/7/25, the resident fell.

During an interview, on 2/4/25 at 11:01 a.m., the Activity Director indicated he saw the resident fall on 1/7/25 while on an outing to a restaurant, while walking back to the bus. He did not have his walker when he fell. The resident's walker had not been taken along with the resident on the outing on 1/7/25. The Activity Director was uncertain if the resident had taken his walker on previous outings. He indicated he generally knew what the residents needed on outings as he saw the residents most days in the facility. He was not given and did not know of any list or paper that indicated what assistive devices or interventions the residents required.

During an interview, on 2/4/25 at 11:38 a.m., the DON indicated the facility had CNA care sheets which indicated what interventions the residents required. The activities department should have the CNA care sheets but was uncertain if the activities department would know to utilize the CNA care sheets or where to get them. The resident should have had the walker with him and been reminded to use it while on the outing.

A current facility policy, provided by the Assistant Director of Nursing on 2/4/25 at 11:25 p.m., last revised 9/2011, titled "Outings-Resident-RP-1," indicated the following: the facility is " ...committed to providing a safe and enjoyable experience when residents participate in outings planned by the community ...."

This citation relates to Complaint IN00451646.

Based on interview and record review, the facility failed to ensure a rollator walker was provided in accordance with the service plan to meet the needs of a resident who was at risk for falls and required the device for safe ambulation for 1 of 3 residents reviewed for falls. (Resident F) This deficient practice resulted in a fall and the resident sustaining two fractures of the left upper arm and a ruptured tendon of the left kneecap that required surgical repair.

Finding includes:

Resident F's closed clinical record was reviewed on 2/3/25 at 1:42 p.m. Diagnoses included unspecified dementia with behavioral disturbance, unsteadiness on feet, and traumatic spondylopathy (disease/disorder that affects the bones of the spine).

Physician orders in place at the time of the resident's fall included risperidone (antipsychotic) 1 milligram (mg), citalopram (antidepressant) 40 mg daily, and donepezil (for dementia) 10 mg daily at bedtime.

A service plan, initiated 3/8/21 with a target date of 2/26/25, indicated Resident F was at risk for falling related to his right hip and low back pain and weakness. The resident used a rollator walker for support. He sometimes forgot to use his walker. When his caretakers saw him without his walker, they were to remind him to use it. A current approach initiated 11/8/23 indicated the staff was to remind the resident to use his walker at all times when ambulating.

A current "Senior Living Level of Care Evaluation," dated 8/19/24, indicated the resident's orientation fluctuated. The resident used an ambulatory (walking) device. The resident had a known recent history of falling and was at risk for falling.

Nurse Notes, dated 1/3/25 at 6:45 p.m., indicated the resident ambulated with a rollator walker.

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walked back to the bus, he fell and hit the right side of his face on the bus. His right temple/cheek area was bleeding. The ambulance was called and transported the resident to the hospital. The note lacked indication of whether the rollator walker was in use as defined in the service plan.

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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