

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/30/2022
NAME OF PROVIDER OR SUPPLIER WYNDMOOR OF MARION, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint IN00388486. Complaint IN00388486 - Substantiated. No State Residential Findings related to the allegations were cited. Unrelated deficiencies are cited. Survey date: August 29 and 30, 2022. Facility number: 010682 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 7, 2022.	R 0000			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	The following is the plan of correction for the Wyndmoor of Marion regarding the statement of deficiencies dated on 8/30/2022. This plan of correction is not to be	09/19/2022	

for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:

(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

(A) epidemic outbreaks;

(B) poisonings;

(C) fires; or

(D) major accidents.

If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.

(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that

construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory. In this document we have detailed actions in response to identified issues. We detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective.

Administrator reviewed the the incident reporting basics per ISDH forms and could not determine if the incident was considered reportable. Administrator will follow the reportable unusual occurrences for future cases.

Anytime there is an unusual occurrence Administrator will report to ISDH immediately per ISDH guidelines. Camille Beeson AIT preceptor, will audit all future incident reports prior to submission for 3 months going forward.

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indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to report to the State Agency, a resident who fell from his powerchair while being transported in a facility bus. He fell into another resident and he required assistance of the EMS and the fire department to be assisted from the floor of the bus (Resident F).

Findings include:

Resident F's clinical record was reviewed on 8/30/22 at 9:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, obesity, heart

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failure and chronic obstructive pulmonary disease.

His nurses notes indicated, but were not limited to the following:

On 8/25/22 at 12:17 p.m., he fell out of his electric wheelchair while on an outing in the facility bus. EMS and the fire dept were called. He refused treatment. The ED, ADON and family were informed.

On 8/25/22 at 3:45 p.m., a community outing in the facility van, on a scooter, he did not fasten his seatbelt and slid out of his seat, a small part of his upper body rested on back of another client's shoulders. He landed on his bottom and was assisted from the floor with the assistance of staff. EMTs and the fire department called for lift assistance. No injuries were noted.

During an interview with the DON and ED, on 8/30/22 at 9:30 a.m., the DON indicated Resident F fell forward from his chair and fell onto another resident's shoulder. There were no injuries. ED indicated the resident he fell on, felt sore and bruised from the incident but did not need medical attention. DON indicated she did not report Resident F's incident.

A facility form, titled "Reportable Events Grid," provided by the DON and she indicated, on

8/30/22 at 12:10 p.m., that the grid was what she referred to when reporting and he did not require hospitalization. The grid indicated the following: "1. Accident, unusual event or emergency that results in an injury that results in an injury requiring hospitalization such as fracture or head trauma...Time frame to notify, as soon as practical; no later than 24 hours...."

Based on interview and record review, the facility failed to report to the State Agency, a resident who fell from his powerchair while being transported in a facility bus. He fell into another resident and he required assistance of the EMS and the fire department to be assisted from the floor of the bus (Resident F).

Findings include:

Resident F's clinical record was reviewed on 8/30/22 at 9:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, obesity, heart failure and chronic obstructive pulmonary disease.

His nurses notes indicated, but were not limited to the following:

On 8/25/22 at 12:17 p.m., he fell out of his electric wheelchair while on an outing in the facility bus. EMS and the fire dept were

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called. He refused treatment. The ED, ADON and family were informed.

On 8/25/22 at 3:45 p.m., a community outing in the facility van, on a scooter, he did not fasten his seatbelt and slid out of his seat, a small part of his upper body rested on back of another client's shoulders. He landed on his bottom and was assisted from the floor with the assistance of staff. EMTs and the fire department called for lift assistance. No injuries were noted.

During an interview with the DON and ED, on 8/30/22 at 9:30 a.m., the DON indicated Resident F fell forward from his chair and fell onto another resident's shoulder. There were no injuries. ED indicated the resident he fell on, felt sore and bruised from the incident but did not need medical attention. DON indicated she did not report Resident F's incident.

A facility form, titled "Reportable Events Grid," provided by the DON and she indicated, on 8/30/22 at 12:10 p.m., that the grid was what she referred to when reporting and he did not require hospitalization. The grid indicated the following: "1. Accident, unusual event or emergency that results in an injury that results in an injury requiring hospitalization such as

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	fracture or head trauma...Time frame to notify, as soon as practical; no later than 24 hours...."			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure the resident's powerchair and the resident was safely secured while being transported in a facility bus	R 0148	The following is the plan of correction for the Wyndmoor of Marion regarding the statement of deficiencies dated on 8/30/2022. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory. In this document we have detailed actions in response to identified issues. We detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. Staff in serviced and educated on safety while transporting. Staff will have a check off sheet in the facility bus to be checked off per driver and activity director. Sheet will include date of transport, resident on transport, and staff checked seat belt. This plan of correction is indefinite to ensure resident safety.	10/01/2022

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(Resident F).

Findings include:

During an interview with Resident H, on 8/29/22 at 3:20 p.m., she indicated less than a week ago, while the residents were on an outing, the bus driver did not secure residents on the bus that were in wheelchairs or powerchairs. One resident fell out of his powerchair, and the fire department was called and had to pick the man up.

During an interview, with the DON and ED, on 8/30/22 at 9:30 a.m., the DON indicated Resident F fell forward from his chair and fell onto Resident G's shoulder. There were no injuries. ED indicated Resident G felt sore/bruised from the incident but did not need medical attention.

During an interview with the Activity Director, on 8/30/22 at 9:37 a.m., she indicated Resident F was last one to go on to the bus in his electric wheelchair, he had a hard time maneuvering it and getting it into position, once he did, he shut the power off to the chair and she told him to put the seatbelt on. She was not with them but her assistant was and as they were going to a local store, they were turning the corner to go into the parking lot

off the bypass when he fell forward. His powerchair was not strapped down, but did not move, he came forward and bumped Resident G in front of him and her assistant held his head until they were able to get him up. Resident F indicated that he forgot that she told him to put on his seatbelt and then said he could not get the seatbelt buckled. Come to find out, his seatbelt was buckled, and he was sitting on it in his powerchair.

Resident F's clinical record was reviewed on 8/30/22 at 9:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, obesity, heart failure and chronic obstructive pulmonary disease.

His service care plans included, but were not limited to, the following:

His mobility, initiated on 2/12/22. His goal was he would be able to move about the community without assistance. His interventions were initiated on 2/12/22 and included, he was mobile with my wheelchair, he self-propelled in his apartment and outside of his apartment, he may require some assistance with his wheelchair for long distances and he would be able to communicate to his caregivers if he needed

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assistance with long distances or getting in/out of the facility.

His falls, initiated on 6/7/22. His goal was that he would be encouraged to call for assistance when needed. His fall intervention was wear appropriate shoes when ambulating, initiated on 6/7/22.

His nurses notes indicated, but were not limited to the following:

On 8/25/22 at 12:17 p.m., he fell out of his electric wheelchair while on an outing in the facility bus. EMS and the fire dept were called. He refused treatment. The ED, ADON and family were informed.

On 8/25/22 at 3:45 p.m., a community outing in the facility van, on a scooter, he did not fasten his seatbelt and slid out of his seat, a small part of his upper body rested on back of another client's shoulders. He landed on his bottom and was assisted from the floor with the assistance of staff. EMTs and the fire department were called for lift assistance. No injuries were noted.

On 8/26/22 at 5:34 a.m., he continued on fall follow up. He stated he had no pain related to the fall and bruises on his side.

On 8/26/22 at 2:03 p.m., he stated that he was sore and bruised but was okay. He had

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no change in his range of motion.

On 8/28/22 at 1:16 a.m., he was in his room, alert and oriented. No complaints voiced and no latent injuries were noted at that time. Would continue to monitor and update as needed. Call pendant was in place.

His clinical record lacked notification to his physician and his service care plan had not been updated.

During an interview with Resident G, on 8/30/22 at 11:00 a.m., she indicated she transferred to a bus seat in the van and was sitting in front of Resident F. The bus driver had turned into a parking lot and Resident F's chair tipped over and he flew out and hit her left shoulder, that was her bad side anyway from previous strokes. He tried to move and he just became more heavy. His head was in her lap. They could not get him up and had to wait for the EMS and the fire department to get there. His chair must have not been tied down. Her left shoulder was very sore and her back hurt, although she had a bad back and her pelvic area was sore. She felt like she had been in a wreck. She felt like the bus driver was in such hurry and always trying to rush.

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During an interview with Resident F, on 8/30/22 at 11:10 a.m., he indicated he was not secured in the facility van. He did not have seatbelt or harness on. They were supposed to strap the powerchair to the floor. They were in a hurry because one of the residents had an appointment but found out it was not until September. He was told that it was his responsibility to make sure his seatbelt was on. He felt like the bus driver was in a hurry. When he fell and he brushed up against Resident G in the aisle of the bus. His powerchair tipped forward but it did not fall on top of him. He received a couple of scratches on the back of his right calf and bruising to his left outer thigh and his right shoulder was a little tender.

An observation, during the interview with Resident F, he had two horizontal scratches on the back of right calf. On his left outer thigh there was a bruise size of a large egg that was blue and purple with a scratch in the middle of it and he had a few purple scattered bruises just below that area.

During an observation of the facility bus and interview with the bus driver, on 8/30/22 at 12:27 p.m., there were three sets of two seats on each side of the bus and one lone seat in the back to the left. The

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wheelchair lift was on the right side of the bus. He indicated he used two floor straps with hooks for the back and two floor straps with hooks for the front of the chairs and then a seatbelt that would go across the resident chest and strap the resident like a seat belt the front seat of a car. He indicated the resident was not wearing the shoulder strap seatbelt. Resident F was told by the Activity Director to put on his seatbelt in his powerchair but, after the incident he seen the residents seatbelt was buckled and was behind him, he had been sitting on it. Resident F was facing the front of the bus in his powerchair, he did not always strap down the powerchairs. The manual wheelchairs he always strapped down because they can move all over the place. Resident G was sitting in front of Resident F in the last row on the right in the seat next to the isle. He was turning at the traffic light off the bypass into the store parking lot when he heard the assistant yell at him that Resident F slid out of his chair. He came out of his wheelchair and went forward to the floor, the way he was sitting he thought he broke his leg. They could not get him up and the EMS and fire department was called. He was in a hurry that day, he was supposed to take them shopping at 9:45 a.m. and something came up and

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backed things up.

A driver job description, provided by the DON, on 8/30/22 at 12:10 p.m., indicated the following: "...Essential Functions, 4. Ensures residents are safely seated with seat belts secured...." The job description was signed by the bus driver on 5/18/22.

A Vehicle Safety Policy, provided by the DON, on 8/30/22 at 12:10 p.m. indicated the following: "...Driving Rules: Seat Belts - The driver and all occupants are required to wear seat belts when the vehicle is in operation or while riding in the vehicle. The driver is responsible for ensuring passenger wear their seat belts...." The driver acknowledgement was signed by the bus driver on 5/18/22.

Based on observation, interview and record review, the facility failed to ensure the resident's powerchair and the resident was safely secured while being transported in a facility bus (Resident F).

Findings include:

During an interview with Resident H, on 8/29/22 at 3:20 p.m., she indicated less than a week ago, while the residents were on an outing, the bus driver did not secure residents on the bus that were in

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seatbelt buckled. Come to find out, his seatbelt was buckled, and he was sitting on it in his powerchair.

Resident F's clinical record was reviewed on 8/30/22 at 9:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, obesity, heart failure and chronic obstructive pulmonary disease.

His service care plans included, but were not limited to, the following:

His mobility, initiated on 2/12/22. His goal was he would be able to move about the community without assistance. His interventions were initiated on 2/12/22 and included, he was mobile with my wheelchair, he self-propelled in his apartment and outside of his apartment, he may require some assistance with his wheelchair for long distances and he would be able to communicate to his caregivers if he needed assistance with long distances or getting in/out of the facility.

His falls, initiated on 6/7/22. His goal was that he would be encouraged to call for assistance when needed. His fall intervention was wear appropriate shoes when ambulating, initiated on 6/7/22.

His nurses notes indicated, but

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FORM APPROVED

OMB NO. 0938-0391

were not limited to the following:

On 8/25/22 at 12:17 p.m., he fell out of his electric wheelchair while on an outing in the facility bus. EMS and the fire dept were called. He refused treatment. The ED, ADON and family were informed.

On 8/25/22 at 3:45 p.m., a community outing in the facility van, on a scooter, he did not fasten his seatbelt and slid out of his seat, a small part of his upper body rested on back of another client's shoulders. He landed on his bottom and was assisted from the floor with the assistance of staff. EMTs and the fire department were called for lift assistance. No injuries were noted.

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His clinical record lacked

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During an interview with Resident F, on 8/30/22 at 11:10 a.m., he indicated he was not secured in the facility van. He did not have seatbelt or harness on. They were supposed to strap the powerchair to the floor. They were in a hurry because one of the residents had an appointment but found out it was not until September. He was told that it was his

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FORM APPROVED

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told by the Activity Director to put on his seatbelt in his powerchair but, after the incident he seen the residents seatbelt was buckled and was behind him, he had been sitting on it. Resident F was facing the front of the bus in his powerchair, he did not always strap down the powerchairs. The manual wheelchairs he always strapped down because they can move all over the place. Resident G was sitting in front of Resident F in the last row on the right in the seat next to the isle. He was turning at the traffic light off the bypass into the store parking lot when he heard the assistant yell at him that Resident F slid out of his chair. He came out of his wheelchair and went forward to the floor, the way he was sitting he thought he broke his leg. They could not get him up and the EMS and fire department was called. He was in a hurry that day, he was supposed to take them shopping at 9:45 a.m. and something came up and backed things up.

A driver job description, provided by the DON, on 8/30/22 at 12:10 p.m., indicated the following: "...Essential Functions, 4. Ensures residents are safely seated with seat belts secured...." The job description was signed by the bus driver on 5/18/22.

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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