STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF PORTAGE, LLC	3444 SWANSON RD, PORTAGE, , 46368

(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 IN00455828 and IN00456693. Complaint IN00455828 - State deficiencies related to the allegations are cited at R0045, R0217, and R0349. Complaint IN00456693 - No deficiencies related to the allegations are cited. Survey date: May 2 and 5, 2025 Facility number: 010889 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/8/25.	R 0000		
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or	R 0045	The following is the plan of correction for The Wyndmoor of Portage regarding the statement of deficiency dated 5/2/2025.	05/22/2025

	discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items		Staff will be given the policy/procedure regarding step-by-step instructions regarding what documents to send when transferring a resident out to ER, MD appointment or to another health facility. Staff will be educated to sign the bed hold policy, fill out transfer/discharge form and make copies to send with and keep original in the transfer/discharge binder in the nursing station. Nursing staff given the disciplinary action steps if the policy/procedures are not followed. Executive Director and director of nursing to audit within 24hrs of any transfers to ensure all copies of documents were sent with transfer and copies are in the binder. This audit will be indefinite. All signed education/in service sheets will be submitted.	

	described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You			

	have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to			

ensure transfer/discharge papers were completed and the resident's responsible party (POA) and physician were notified when a resident was transferred out of the facility for 1 of 3 records reviewed. (Resident B)

Finding includes:

Resident B's record was reviewed on 5/2/25 at 9:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and high blood pressure.

A Progress Note, dated 1/22/25 at 6:16 a.m., indicated the resident was sent out to the hospital on 1/21/25 for complaints of shortness of breath. A call was placed to the hospital regarding the resident's status, which indicated the resident was admitted to the hospital for shortness of breath.

A Progress Note, dated 1/30/25 at 8:43 a.m., indicated the resident was at a skilled nursing facility.

A Progress Note, dated 3/22/25 at 10:33 a.m., indicated the resident was sent to the hospital via ambulance for generalized weakness and shortness of breath.

The were no State Transfer/ Discharge papers available for

review for the transfers on 1/21/25 and 3/22/25.

There was no documentation related to the resident's POA and physician being notified of the transfers/discharges.

During an interview on 5/5/25 at 11:06 a.m., the Executive Director indicated the transfer forms should have been sent. The staff had copies of them available at the Nurses' Station to fill out and send with residents upon transfer/discharge. The staff were supposed to document when the POA and physician were notified of a transfer, but she was unable to find the documentation at the time. A policy related to transfer/discharge was requested at the time and was not provided.

This citation relates to Complaint IN00455828.

Based on record review and interview, the facility failed to ensure transfer/discharge papers were completed and the resident's responsible party (POA) and physician were notified when a resident was transferred out of the facility for 1 of 3 records reviewed. (Resident B)

Finding includes:

Resident B's record was

reviewed on 5/2/25 at 9:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and high blood pressure.

A Progress Note, dated 1/22/25 at 6:16 a.m., indicated the resident was sent out to the hospital on 1/21/25 for complaints of shortness of breath. A call was placed to the hospital regarding the resident's status, which indicated the resident was admitted to the hospital for shortness of breath.

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	The staff had copies of them available at the Nurses' Station to fill out and send with residents upon transfer/discharge. The staff were supposed to document when the POA and physician were notified of a transfer, but she was unable to find the documentation at the time. A policy related to transfer/discharge was requested at the time and was not provided. This citation relates to Complaint IN00455828.			
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	R 0217	The following is the plan of correction for The Wyndmoor of Portage regarding the statement of deficiency dated 5/2/2025. Policy/procedure given to nurses/QMA's regarding evaluation of resident such as new skin issues, change of condition, new treatment orders started and discontinued. Nursing staff given step by step instructions regarding evaluation/assessment of resident per change of condition, new skin area etc. Nursing staff educated/in serviced on notification to MD, responsible parties/POA's and outside home health services.	05/22/2025

	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 record review and interview, the facility failed to ensure service plans were updated with changes for 1 of 6 service plans reviewed. (Resident E) Finding includes: Resident E's record was reviewed on 5/2/25 at 3:34 p.m. Diagnoses included, but were not limited to, heart failure and type 2 diabetes mellitus. A Physician's Order, dated 12/6/24, indicated zinc oxide external paste 40%, apply to the		Nursing staff educated on documentation with signatures from all nursing staff with acknowledgment and understanding. If not followed disciplinary action will follow. Executive Director and director of nursing will review daily progress notes to ensure all evaluation/assessments have been properly completed per state regulations and company policy/procedures. This plan of correction/audit is indefinite.	

right buttock topically on day shift every 3 days for wound care and cover with an allevyn dressing. Change every 3 days and as needed if soiled/dislodged.

A Physician's Order, dated 4/17/25 and discontinued on 4/22/25, indicated to keep the dressing to the left foot dry and stay off the left foot. Assisted living facility and Home Health were to change the dressing as needed twice daily. Cleanse with betadine and apply gauze.

A Physician's Note, dated 4/22/25, indicated the area to the left foot was healed.

A Nurses' Note, dated 4/24/25 at 9:29 a.m., indicated the resident had a skin tear to the right buttock. The home health company was aware and would assess.

A Home Health Physician Order, dated 4/29/25 at 3:30 p.m., indicated skilled nursing to perform a skin tear treatment to the right buttock for one week. Cleanse/irrigate the wound with soap and water, pat dry, apply skin prep to the surrounding tissue, and apply a border gauze cover using aseptic technique. Skilled nursing may teach the patient/caregiver to perform wound care. Assisted living facility nurses were to re-enforce as needed.

A Monthly Skin Observation assessment, dated 4/30/25, indicated the resident had a scab on the left big toe that was healing with no drainage and a healing sore on the right buttock that the home health company was treating.

The current Service Plan indicated the resident had a pressure ulcer to the left foot near the great toe. She was being seen by a home health company for treatments to the area.

There was no documentation in the Service Plan related to a buttock wound or treatment being provided by a home health company.

During an interview on 5/5/25 at 10:19 a.m., the Director of Nursing indicated she was unaware of the buttock wound being treated currently as she thought it had healed out "a while ago." The service plan was not updated to reflect the buttock wound and the left great toe service plan should have been discontinued as that wound had healed out.

This citation relates to Complaint IN00455828.

Based on record review and interview, the facility failed to ensure service plans were updated with changes for 1 of 6 service plans reviewed.

(Resident E)

Finding includes:

Resident E's record was reviewed on 5/2/25 at 3:34 p.m. Diagnoses included, but were not limited to, heart failure and type 2 diabetes mellitus.

A Physician's Order, dated 12/6/24, indicated zinc oxide external paste 40%, apply to the right buttock topically on day shift every 3 days for wound care and cover with an allevyn dressing. Change every 3 days and as needed if soiled/dislodged.

A Physician's Order, dated 4/17/25 and discontinued on 4/22/25, indicated to keep the dressing to the left foot dry and stay off the left foot. Assisted living facility and Home Health were to change the dressing as needed twice daily. Cleanse with betadine and apply gauze.

A Physician's Note, dated 4/22/25, indicated the area to the left foot was healed.

A Nurses' Note, dated 4/24/25 at 9:29 a.m., indicated the resident had a skin tear to the right buttock. The home health company was aware and would assess.

A Home Health Physician Order, dated 4/29/25 at 3:30 p.m., indicated skilled nursing to

	perform a skin tear treatment to the right buttock for one week. Cleanse/irrigate the wound with soap and water, pat dry, apply skin prep to the surrounding tissue, and apply a border gauze cover using aseptic technique. Skilled nursing may teach the patient/caregiver to perform wound care. Assisted living facility nurses were to re-enforce as needed. A Monthly Skin Observation assessment, dated 4/30/25, indicated the resident had a scab on the left big toe that was healing with no drainage and a healing sore on the right buttock that the home health company was treating. The current Service Plan indicated the resident had a pressure ulcer to the left foot near the great toe. She was being seen by a home health company for treatments to the area. There was no documentation in the Service Plan related to a buttock wound or treatment being provided by a home health company. During an interview on 5/5/25 at 10:19 a.m., the Director of Nursing indicated she was unaware of the buttock wound being treated currently as she thought it had healed out "a while ago." The service plan			

	was not updated to reflect the buttock wound and the left great toe service plan should have been discontinued as that wound had healed out. This citation relates to Complaint IN00455828.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurate related to updating a treatment order for wound care for 1 of 3 resident records reviewed. (Resident E) Finding includes: Resident E's record was reviewed on 5/2/25 at 3:34 p.m. Diagnoses included, but were not limited to, heart failure and	R 0349	The following is the plan of correction for The Wyndmoor of Portage regarding the statement of deficiency dated 5/2/2025. The Executive Director and Director of nursing will audit care/service plan weekly pertaining to skin issues and significant changes of condition in residents. This audit is indefinite. Any resident with skin issues requiring outside skilled nursing treatment/wound care will have prn treatment order in the system to correlate with the skilled nursing team with care/service plan updated to correlate. If any resident has any skin issues, then weekly skin form will be completed until the area is healed. This plan of corrective action was completed on 5/5/2025. This will ensure that all services provided are documented in	05/22/2025

	type 2 diabetes mellitus. The current Service Plan indicated the resident had a pressure ulcer to the left foot near the great toe. She was being seen by a home health company for treatments to the area. A Physician's Order, dated 12/6/24, indicated zinc oxide external paste 40%, apply to right buttock topically every day shift every 3 day(s) for wound care and cover with allevyn dressing. Change every 3 days and as needed if soiled/dislodged. A Monthly Skin Observation assessment, dated 4/30/25, indicated the resident had a scab on the left big toe that was healing with no drainage, and a healing sore on the right buttock that the home health company was treating. Notes were requested from the Home Health company and received on 5/5/25.		progress notes with accurate orders in EMAR and updated care/service plan correlate. Any resident with outside home health services and hospices services will have active orders in PCC with contact information in body of order. This plan of corrective action was completed an 5/5/2025.	

The most recent Assisted Living Visit Coordination Note provided was dated 4/4/25. The communication indicated to cleanse the wound with normal saline, apply moistened Promogran (wound dressing) to the wound bed, cover with gauze and tape. The note did not indicate the wound location or type.

A Home Health Physician Order, dated 4/29/25 at 3:30 p.m., indicated skilled nursing to perform a skin tear treatment to the right buttock for one week. Cleanse/irrigate the wound with soap and water, pat dry, apply skin prep to the surrounding tissue, and apply a border gauze cover using aseptic technique. Skilled nursing may teach patient/caregiver to perform wound care. Assisted living facility nurses were to re-enforce as needed.

The Physician Order, dated 4/29/25, was not addressed with the facility until the notes were requested on 5/5/25.

During an interview on 5/5/25 at 10:19 a.m., the Director of Nursing indicated the orders were not updated on 4/29/25 for the wound care to the right buttock. She was not aware the treatment orders had changed as she thought the wound had healed out.

This citation relates to Complaint IN00455828.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurate related to updating a treatment order for wound care for 1 of 3 resident records reviewed. (Resident E)

Finding includes:

Resident E's record was reviewed on 5/2/25 at 3:34 p.m. Diagnoses included, but were not limited to, heart failure and type 2 diabetes mellitus.

The current Service Plan indicated the resident had a pressure ulcer to the left foot near the great toe. She was being seen by a home health company for treatments to the area.

A Physician's Order, dated 12/6/24, indicated zinc oxide external paste 40%, apply to right buttock topically every day shift every 3 day(s) for wound care and cover with allevyn dressing. Change every 3 days and as needed if soiled/dislodged.

A Monthly Skin Observation assessment, dated 4/30/25, indicated the resident had a scab on the left big toe that was healing with no drainage, and a healing sore on the right buttock

that the home health company was treating.

Notes were requested from the Home Health company and received on 5/5/25.

The most recent Assisted Living Visit Coordination Note provided was dated 4/4/25. The communication indicated to cleanse the wound with normal saline, apply moistened Promogran (wound dressing) to the wound bed, cover with gauze and tape. The note did not indicate the wound location or type.

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The Physician Order, dated 4/29/25, was not addressed with the facility until the notes were requested on 5/5/25.

During an interview on 5/5/25 at 10:19 a.m., the Director of Nursing indicated the orders were not updated on 4/29/25 for

	the wound care to the right buttock. She was not aware the treatment orders had changed as she thought the wound had healed out. This citation relates to Complaint IN00455828.			

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