STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD POINTE SENIOR LIVING	6235 STERLING CREEK 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 Intake IN00463594. Intake IN00463594 - State deficiencies related to the allegations are cited at R0036 and R0240. Survey date: September 25, 2025 Facility number: 012396 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/29/25.	R 0000	Deficiency's will be completed.	

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure a resident's family/responsible party and physician were notified of a fall for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: Resident B's record was reviewed on 9/25/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism. An Indiana Department of Health Reportable Incident, dated 7/22/25 at 11:01 a.m., indicated the resident was noted by the fall monitoring camera in his room attempting to straighten out a sheet on his	R 0036	1.What corrective actions will beaccomplished for those residentsfound to have been affected bydeficient practice? other residents having the potentialto be affected by the same deficientpractice and what corrective actionwill be taken? be monitored to ensure thedeficient practice will not recur,in place? .DON or designee will audit all falls weekly for 8 weeks. If 100% compliance, audits will continue monthly. ED or designee will audit 2 random falls monthly. Falls will also be discussed monthly at the Continuous Quality Improvement Meeting.	10/20/2025

bed and fell on to his right hip. The camera system called the facility and alerted that the resident may be on the floor. The resident complained of right hip pain and was sent to the hospital for evaluation.

A Late Entry Progress Note, dated 7/23/25 at 11:36 a.m., indicated facility staff had called the hospital for an update on Resident B and were told he was in surgery due to a left hip fracture.

A Late Entry Progress Note, dated 7/23/25 at 11:42 a.m., indicated the resident had fallen, complained of hip pain, emergency services were called, and the resident was sent to the Emergency Room.

There was a lack of documentation to indicate the resident's physician and family/responsible party had been notified of the fall or the resident being sent to the hospital.

During an interview on 9/25/25 at 11:55 a.m., the Administrator indicated she was unable to provide any documentation that the resident's family/responsible party and physician had been notified of the fall or the resident being sent to the hospital.

A facility policy, titled Accidents, Incidents, and Unusual Occurrences, received as

current, indicated, "...1...E. Notify the resident's primary healthcare provider [physician, nurse practitioner, and/or physician's assistant] and the resident's responsible party..."

This citation relates to Intake IN00463594.

Based on record review and interview, the facility failed to ensure a resident's family/responsible party and physician were notified of a fall for 1 of 3 residents reviewed for falls. (Resident B)

Finding includes:

Resident B's record was reviewed on 9/25/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism.

An Indiana Department of Health Reportable Incident, dated 7/22/25 at 11:01 a.m., indicated the resident was noted by the fall monitoring camera in his room attempting to straighten out a sheet on his bed and fell on to his right hip. The camera system called the facility and alerted that the resident may be on the floor. The resident complained of right hip pain and was sent to the hospital for evaluation.

A Late Entry Progress Note, dated 7/23/25 at 11:36 a.m.,

	indicated facility staff had called the hospital for an update on Resident B and were told he was in surgery due to a left hip fracture. A Late Entry Progress Note, dated 7/23/25 at 11:42 a.m., indicated the resident had fallen, complained of hip pain, emergency services were called, and the resident was sent to the Emergency Room. There was a lack of documentation to indicate the resident's physician and family/responsible party had been notified of the fall or the resident being sent to the hospital. During an interview on 9/25/25 at 11:55 a.m., the Administrator indicated she was unable to provide any documentation that the resident's family/responsible party and physician had been notified of the fall or the resident being sent to the hospital. A facility policy, titled Accidents, Incidents, and Unusual Occurrences, received as current, indicated, "...1...E. Notify the resident's primary healthcare provider [physician, nurse practitioner, and/or physician's assistant] and the resident's responsible party..." This citation relates to Intake IN00463594.			

R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure a resident who had fallen was assessed after the fall by a licensed nurse for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: Resident B's record was reviewed on 9/25/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism. An Indiana Department of Health Reportable Incident, dated 7/22/25 at 11:01 a.m., indicated the resident was noted by the fall monitoring camera in his room attempting to straighten out a sheet on his bed and fell on to his right hip. The camera system called the facility and alerted that the resident may be on the floor. The resident complained of right hip pain and was sent to the hospital for evaluation. A Late Entry Progress Note,	R 0240	1.What corrective actions will beaccomplished for those residents found to have been affected bydeficient practice? DON will audit all residents who have had a fall within the last 30 days to ensure an assessment has been completed and documented. the same deficientpractice and what corrective actionwill be taken? be affected. Audit for falls/incidents will occur as stated above by DON. All nurses and QMA’s to be reeducated for fall policy which includes ensuring resident is assessed by a nurse. ensure that thedeficient practice does not occur? DON willcreate a new checklist form that the nursing staff will use for every fall to ensure assessment	10/20/2025

	dated 7/23/25 at 11:36 a.m., indicated facility staff had called the hospital for an update on Resident B and were told he was in surgery due to a left hip fracture. A Late Entry Progress Note, dated 7/23/25 at 11:42 a.m., indicated the resident had fallen, complained of hip pain, emergency services were called, and the resident was sent to the Emergency Room. There was a lack of any documentation of when the fall occurred or any assessment of the resident after the fall by a licensed nurse. During an interview on 9/25/25 at 11:55 a.m., the Administrator indicated she was able to review the fall monitoring camera system and determined the resident's fall had occurred on 7/21/25 at 1:14 a.m. She was unsure exactly what time the resident had been sent out to the hospital but indicated it was on the 7/21/25 midnight shift. She was unable to provide any documentation of a post-fall assessment. A facility policy, titled Accidents, Incidents, and Unusual Occurrences, received as current, indicated, "...2...B. If a medication tech, licensed nurse, administrator or health services director discovers an incident,		is completed.Nurses will be reeducated on properlydocumenting all incidents and injuries. practice will not recur,in place? falls at morning meeting Monday-Friday,DON or will audit all falls weekly for 8 weeks. If 100% compliance, audits will continue monthly. ED or designee will audit 2 random falls monthly	

accident, and unusual occurrence an incident report form will be completed...The information includes: a. Accident or incident date and time...g. The final disposition of the resident, i.e., stayed in the community or went out for treatment. h. Vital signs. i. What the individual provided for the resident at the time of accident or incident. j. Initial interventions for the resident. k. Notification date and times for supervisor, primary provider, and the responsible party..."

This citation relates to Intake IN00463594.

Based on record review and interview, the facility failed to ensure a resident who had fallen was assessed after the fall by a licensed nurse for 1 of 3 residents reviewed for falls. (Resident B)

Finding includes:

Resident B's record was reviewed on 9/25/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and hypothyroidism.

An Indiana Department of Health Reportable Incident, dated 7/22/25 at 11:01 a.m., indicated the resident was noted by the fall monitoring camera in his room attempting to straighten out a sheet on his

bed and fell on to his right hip. The camera system called the facility and alerted that the resident may be on the floor. The resident complained of right hip pain and was sent to the hospital for evaluation.

A Late Entry Progress Note, dated 7/23/25 at 11:36 a.m., indicated facility staff had called the hospital for an update on Resident B and were told he was in surgery due to a left hip fracture.

A Late Entry Progress Note, dated 7/23/25 at 11:42 a.m., indicated the resident had fallen, complained of hip pain, emergency services were called, and the resident was sent to the Emergency Room.

There was a lack of any documentation of when the fall occurred or any assessment of the resident after the fall by a licensed nurse.

During an interview on 9/25/25 at 11:55 a.m., the Administrator indicated she was able to review the fall monitoring camera system and determined the resident's fall had occurred on 7/21/25 at 1:14 a.m. She was unsure exactly what time the resident had been sent out to the hospital but indicated it was on the 7/21/25 midnight shift. She was unable to provide any documentation of a post-fall

	assessment. A facility policy, titled Accidents, Incidents, and Unusual Occurrences, received as current, indicated, "...2...B. If a medication tech, licensed nurse, administrator or health services director discovers an incident, accident, and unusual occurrence an incident report form will be completed...The information includes: a. Accident or incident date and time...g. The final disposition of the resident, i.e., stayed in the community or went out for treatment. h. Vital signs. i. What the individual provided for the resident at the time of accident or incident. j. Initial interventions for the resident. k. Notification date and times for supervisor, primary provider, and the responsible party..." This citation relates to Intake IN00463594.			

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 SIGNATUREKristin Pawlak	TITLEExecutive Director	(X6) DATE10/13/2025