

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 04/02/2024	
NAME OF PROVIDER OR SUPPLIER WINDWARD POINTE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint IN00430595. Complaint IN00430595 - State deficiencies related to the allegations are cited at R0217 and R0349. Survey date: April 1 and 2, 2024 Facility number: 012396 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/8/24.	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	R 0217	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice? The resident's affected will have their service plan updated with the			05/01/2024	

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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. (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		correct information and signed by resident and/or POA.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident service plans will be audited to ensure they are and signed by and/or POA.3. What measures will be put into place or what systematic the facility will ensure that the deficient practice does not occur? DON or will review service plans monthly to ensure any residents change in care/condition was documented on service plan and signed by resident and/or POA.4. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs place? ED or will audit 5 random care plans, weekly for to ensure they are accurate and up to date with any change or care/condition along with a signature by and/or POA. Once audit shows full compliance for 4 consecutive weeks audit will stop.	
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interview, the facility failed to ensure the Service Plan was signed by the resident and they were revised and updated according to the resident's change in condition, for 2 of 12 residents reviewed for Service Plans. (Residents J and K)

Findings include:

1. Resident J's record was reviewed on 4/2/24 at 8:59 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and right below the knee post surgical amputation.

The Service Plan, dated 7/27/22, indicated the resident was cognitively intact, independent for activities of daily living, and received insulin and blood sugar monitoring.

A Wound Note, dated 2/28/24, indicated a referral was sent a the wound clinic to evaluate and treat a decubitus sacral ulcer.

A Wound Note, dated 4/1/24, indicated the resident had a wound to the left buttock measuring 0.4 centimeters (cm) by 0.4 cm by 0.1 cm. Skilled nursing would change the dressing weekly and as needed.

There was no updated service plan to reflect the resident was receiving skilled nursing services or wound care for a pressure ulcer.

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During an interview, on 4/2/24 at 12:20 p.m., the Executive Director indicated the service plan should have been updated and signed by the resident.

2. Resident K's record was reviewed on 4/1/24 at 4:55 p.m. Diagnoses included, but were not limited to, fracture of greater trochanter of right femur.

A Service Plan, dated 2/26/24, indicated the resident was cognitively intact, utilized home health services, and required assistance managing catheter care.

A Physician's Order, dated 2/9/24, indicated wound care to evaluate and treat.

A Physician's Order, dated 3/28/24, indicated a wound to the right medial foot which measured 1.3 cm (centimeters) by 1.2 cm by 0.2 cm. The current treatment, silvasorb (silver wound gel) with offloading foam and mepilex (sterile dressing), was to continue every 2-3 days and as needed. The wound to the left lateral leg measured 6 cm by 2 cm by 0.1 cm. The treatment continued with silvasorb and mepilex. A wound to the left hip was a stage 3 pressure ulcer and measured 1.7 cm by 1.8 cm by 0.3 cm. The treatment continued with silvasorb and mepilex every 2 to 3 days and

as needed.

There was no updated service plan to reflect the resident had any pressure ulcers or was receiving outside services for wound care.

During an interview, on 4/2/24 at 12:22 p.m., the Executive Director indicated the service plan should have been updated and signed by the resident.

This citation relates to Complaint IN00430595.

Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and they were revised and updated according to the resident's change in condition, for 2 of 12 residents reviewed for Service Plans. (Residents J and K)

Findings include:

1. Resident J's record was reviewed on 4/2/24 at 8:59 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and right below the knee post surgical amputation.

The Service Plan, dated 7/27/22, indicated the resident was cognitively intact, independent for activities of daily living, and received insulin and blood sugar monitoring.

A Wound Note, dated 2/28/24,

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A Wound Note, dated 4/1/24, indicated the resident had a wound to the left buttock measuring 0.4 centimeters (cm) by 0.4 cm by 0.1 cm. Skilled nursing would change the dressing weekly and as needed.

There was no updated service plan to reflect the resident was receiving skilled nursing services or wound care for a pressure ulcer.

During an interview, on 4/2/24 at 12:20 p.m., the Executive Director indicated the service plan should have been updated and signed by the resident.

2. Resident K's record was reviewed on 4/1/24 at 4:55 p.m. Diagnoses included, but were not limited to, fracture of greater trochanter of right femur.

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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	R 0349	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice?2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? we give insulin to will have	05/01/2024

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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 ensure Physician's Orders were followed, related to insulin administration, for 3 of 3 residents reviewed for insulin administration (Residents B, D, and J)

Findings include:

1. Resident B's record was reviewed on 4/2/24 at 9:49 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

A Service Plan, dated 12/13/22, indicated the resident was cognitively intact. She required insulin administration and blood sugar monitoring.

A Physician's Order, dated 2/6/24, indicated Humalog (insulin) 100 unit/milliliter, inject subcutaneously twice daily before meals per sliding scale: 151-200=1 unit (u), 201-250=2u, 251-300=3u, greater than 300=4u.

The March 2024 Medication

their MAR audited to ensure doses of insulin have been documented correctly and no blank days. If they also are affected, nursing staff will be reeducated on documenting correct dose and how to document when computer system goes down/glitches to ensure documentation is not left blank.3. What measures will be put into place or what systematic the facility will ensure that the deficient practice does not occur?4. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs place? DON or will audit 3 insulin dependent residents weekly for to ensure they are documented correctly. Once shows full compliance for 4 consecutive weeks will stop.

Administration Record, indicated the resident received 2u of Humalog on 3/5/24 at 7:00 a.m. with a blood glucose of 154. There was no documentation of blood glucose levels or administration of Humalog on 3/6/24 or 3/7/24 at 7:00 a.m. She received 2u of Humalog on 3/22/24 at 7:00 a.m. with a blood sugar of 176.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

2. Resident D's record was reviewed on 4/2/24 at 9:37 a.m. Diagnoses included, but were not limited to chronic kidney disease and type 2 diabetes mellitus.

A Service Plan, dated 11/15/22, indicated the resident was cognitively intact. She required insulin administration and blood sugar monitoring.

A Physician's Order, dated 5/29/21, indicated Humalog 100 unit/milliliter kwikpen, inject 4 times daily per sliding scale: 150-200=2 units (u), 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, and greater than 400=12u. Call the Physician if less than 60 or greater than 400.

The March 2024 Medication Administration Record was blank for the Humalog

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administration on 3/5/24 at 11:00 a.m., and 3/6/24 and 3/7/24 at 7:00 a.m.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

3. Resident J's record was reviewed on 4/2/24 at 8:59 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and right below the knee post surgical amputation.

The Service Plan, dated 7/27/22, indicated the resident was cognitively intact, independent for activities of daily living, and received insulin and blood sugar monitoring.

A Physician's Order, dated 8/8/23, indicated insulin lispro 100 unit/milliliter pen, inject 13 units subcutaneous three times daily before meals, hold for blood sugar less than 100.

The March 2024 Medication Administration Record for insulin lispro administration was blank on the following dates and times:

- 3/5/24 at 11:00 a.m.

- 3/6/24 at 11:00 a.m.

- 3/7/24 at 7:00 a.m.

- 3/16/24 at 11:00 a.m. The exception note indicated the

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resident said she was not going to eat lunch so the dose was held.

- 3/30/24 at 7:00 a.m. was blank. The exception note indicated the resident said she was not going to eat breakfast so the dose was held.

- 3/30/24 at 11:00 a.m. dose was blank. The exception note indicated the resident's blood sugar was 103.

There was no documentation of a Physician notification or Physician's orders to hold the medication.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

This citation relates to Complaint IN00430595.

Based on record review and interview, the facility failed to ensure Physician's Orders were followed, related to insulin administration, for 3 of 3 residents reviewed for insulin administration (Residents B, D, and J)

Findings include:

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1. Resident B's record was reviewed on 4/2/24 at 9:49 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

A Service Plan, dated 12/13/22, indicated the resident was cognitively intact. She required insulin administration and blood sugar monitoring.

A Physician's Order, dated 2/6/24, indicated Humalog (insulin) 100 unit/milliliter, inject subcutaneously twice daily before meals per sliding scale: 151-200=1 unit (u), 201-250=2u, 251-300=3u, greater than 300=4u.

The March 2024 Medication Administration Record, indicated the resident received 2u of Humalog on 3/5/24 at 7:00 a.m. with a blood glucose of 154. There was no documentation of blood glucose levels or administration of Humalog on 3/6/24 or 3/7/24 at 7:00 a.m. She received 2u of Humalog on 3/22/24 at 7:00 a.m. with a blood sugar of 176.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

2. Resident D's record was reviewed on 4/2/24 at 9:37 a.m. Diagnoses included, but were not limited to chronic kidney disease and type 2 diabetes

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mellitus.

A Service Plan, dated 11/15/22, indicated the resident was cognitively intact. She required insulin administration and blood sugar monitoring.

A Physician's Order, dated 5/29/21, indicated Humalog 100 unit/milliliter kwikpen, inject 4 times daily per sliding scale: 150-200=2 units (u), 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, and greater than 400=12u. Call the Physician if less than 60 or greater than 400.

The March 2024 Medication Administration Record was blank for the Humalog administration on 3/5/24 at 11:00 a.m., and 3/6/24 and 3/7/24 at 7:00 a.m.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

3. Resident J's record was reviewed on 4/2/24 at 8:59 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and right below the knee post surgical amputation.

The Service Plan, dated 7/27/22, indicated the resident was cognitively intact, independent for activities of daily living, and received insulin and blood sugar monitoring.

A Physician's Order, dated 8/8/23, indicated insulin lispro 100 unit/milliliter pen, inject 13 units subcutaneous three times daily before meals, hold for blood sugar less than 100.

The March 2024 Medication Administration Record for insulin lispro administration was blank on the following dates and times:

- 3/5/24 at 11:00 a.m.

- 3/6/24 at 11:00 a.m.

- 3/7/24 at 7:00 a.m.

- 3/16/24 at 11:00 a.m. The exception note indicated the resident said she was not going to eat lunch so the dose was held.

- 3/30/24 at 7:00 a.m. was blank. The exception note indicated the resident said she was not going to eat breakfast so the dose was held.

- 3/30/24 at 11:00 a.m. dose was blank. The exception note indicated the resident's blood sugar was 103.

There was no documentation of

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a Physician notification or Physician's orders to hold the medication.

During an interview, on 4/2/24 at 2:40 p.m., the Executive Director indicated she had no further information to provide.

This citation relates to Complaint IN00430595.

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
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