STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427160 and IN00427196 Complaint IN00427160 - State deficiency related to the allegations is cited at R149. Complaint IN00427196 - State deficiencies related to the allegations are cited at R090 and R217. Survey date: February 5, 2024 Facility number: 010889 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/8/24.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. The Wyndmoor of Portage desires this Plan of Correction to be considered the facility's Allegation of Compliance effective 2/24/24	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible 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;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 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 observation, record review, and interview, the facility failed to notify the State Agency of an unusual occurrence related to a resident elopement for 1 of 3 residents reviewed for risk of elopement. (Resident B) Finding includes:	R 0090	·p paraid="1210387429" paraeid="{7140c2fd-85f8-443f-8888-4561b2373275}{182}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	02/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 2/5/34 at 8:40 a.m., Resident B was observed seated in the dining room eating breakfast. She was unable to verbally respond or answer questions. Resident B's record was reviewed on 2/5/24 at 8:50 a.m. Diagnoses included, but were not limited to, unspecified dementia, Parkinson's disease, and major depression. A Wandering Risk Scale, dated 1/23/24, indicted the resident was at high risk due to she cannot follow instructions or communicate, and has a history of wandering. A Note Text, dated 1/23/24 at 10:13 p.m., indicated the resident was observed out of bed and walking in facility corridors. Staff conducted a resident search and noted that the resident had opened the front door and was exiting the facility. Staff was able to redirect the resident back into the building. The resident was confused per usual. Family and the Physician were notified. There was no indication the elopement had been reported to the State Agency. During an interview with the Executive Director (ED), on 2/5/24 at 11:30 a.m., she indicated she had not been notified of the elopement, and therefore did not report it. The policy, "Resident Elopement", received from the ED as current on 2/5/24, indicated, "...this community will ensure that all unusual occurrence that directly threaten the welfare, safety or health of a resident, including, but not limited to resident elopement, will be reported to ISDH and other authorities within twenty-four hours...."		The incident has been reported to the Department. The facility had been working with the family to find an alternative placement, and the resident was relocated to a dementia unit on February 17, 2024. ·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? . All unusual occurrences will be reported to the department within 24 hours of the Executive Director or Health and Wellness Director being made aware of the occurrence. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This citation relates to Complaint IN00427196.		. The Executive Director has been re-educated on unusual occurrences and state reportable events by the Regional Director of Operations. All unusual occurrences, including elopements, shall be maintained on the Unusual Occurrence Log Sheet. 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? . ·An Unusual Occurrence Audit Tool has been developed to ensure all occurrences have been properly reported. The Executive Director or shall audit the unusual occurrence log sheet to ensure unusual occurrences are reported to the Department per regulation. Audits will be completed 4x per week for 4 weeks, 2x times per week for 4 weeks, then weekly for 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure an effective pest management program was in place related to a cockroach observed in 1 of 3 resident rooms observed. (Room 307) Finding includes: On 2/5/24 at 8:08 a.m., Room 307 was observed. There was no resident in the room at that time. On entry, a cockroach was observed crawling on the wall facing the door near the kitchenette. Another unidentified insect was flying around the room. The cockroach was hit with a binder and fell behind a waste paper basket. During an interview with the Executive Director (ED), on 2/5/24 at 8:10 a.m., she indicated the pest control company had been out Friday and had sprayed that room. During an interview with Housekeeper 1, on 2/5/24 at 8:24 a.m., she indicated she had seen a cockroach in that room at the beginning of January and had reported it to management. During an interview with the Maintenance Director, on 2/5/24 at 11:35 a.m., he indicated the pest control came monthly and there was a log for staff to document any pest sightings which the pest control reviewed. He did not indicate there was a specific plan to follow up on the effectiveness after treatments of room 307.	R 0149	p="" paraid="603294534" paraeid="{89206b19-81cb-4db2-a790-c203154afa0c}{18}">The facilty wishes to request a Video IDR as it relates to this allegation/tag. The facility followed its pest control policy as evidenced by contacting and following their recommended course of treatment. Before this complaint visit the pest control provider had treated room 307 on February 2, 2024. The cabinets were emptied and the whole room and cabinets were sprayed. No activity was noted at the time and the provider stated, "must allow 2 weeks from treatment, will return in two weeks for follow up treatment". This information and documentation was also provided to the surveyor. The pest control provider completed the 2-week follow-up visit on February 16, 2024, as previously scheduled, and completed their second application, and noted no pest activity. We respectfully ask that this tag and sample be removed as we had already identified and addressed the pest concern before the visit by IDOH and following the recommendation of the licensed	02/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A pest control company visit report indicated they had been out 2/2/24 and sprayed room 307. The cabinets had been emptied and sprayed. There was no pest activity observed. The policy, "Pest Exposure and Control", was received from the ED on 2/5/24, indicated, "...this community is committed to maintaining an environment in which the exposure to best is minimized in order to promote the resident's health and well being...." This citation relates to Complaint IN00427160.		pest control provider. p="" paraid="603294534" paraeid="{89206b19-81cb-4db2-a790-c203154afa0c}{18}"> p="" paraid="603294534" paraeid="{89206b19-81cb-4db2-a790-c203154afa0c}{18}"> p="" paraid="603294534" paraeid="{89206b19-81cb-4db2-a790-c203154afa0c}{18}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility maintains a pest agreement that provides monthly preventative treatment and any other needs that may arise regarding pests. Room 307 was treated on February 16, by a licensed pest control provider. 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? Any resident's apartment that has pests will be treated promptly by our contracted pest service provider. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The facility shall continue to provide monthly pest	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			control services throughout the building. Housekeepers shall record any activity of pests on their housekeeping assignment sheet. If pests are observed between the routinely scheduled visits, the Maintenance Director and additional service visits will be requested. 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? The Administrator or designee shall audit the housekeeping assignment sheets and pest control service records for continued compliance weekly for 4 months then monthly for 2 months.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 observation, record review, and interview, the facility failed to ensure a Service Plan was updated with interventions for a resident after an elopement, for 1 of 3 residents reviewed at risk for elopement. (Resident B) Finding includes: On 2/5/34 at 8:40 a.m., Resident B was observed seated in the dining room eating breakfast. She was unable to verbally respond or answer questions. Resident B's record was reviewed on 2/5/24 at 8:50 a.m. Diagnoses included, but were not limited to, unspecified dementia, Parkinson's disease and major depression. A Wandering Risk Scale, dated 7/29/20, indicated the resident was a moderate risk for wandering. A Wandering Risk Scale, dated 10/27/23, indicated the resident was a high risk for wandering. A Wandering Risk Scale, dated 1/23/24, indicted the resident was at high risk due to she cannot	R 0217	·p paraid="1823363500" paraeid="{89206b19-81cb-4db2-a790-c203154afa0c}{85}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The service plan of Resident B has been updated with interventions related to elopement. 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?	02/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	follow instructions or communicate and has a history of wandering. A Note Text, dated 1/23/24 at 10:13 p.m., indicated the resident was observed out of bed and walking in facility corridors. Staff conducted a resident search and noted that the resident had opened the front door and was exiting the facility. Staff was able to redirect the resident back into the building. The resident was confused per usual. Family and the Physician were notified. A Note Text, dated 1/25/24, indicated the resident was observed attempting to exit the side door two times that shift. Staff was able to redirect. A Note Text, dated 1/27/24, indicated resident remained confused, oriented to person only. She continued to shake exit doors and sit near exits, staff was unable to redirect. A Service Plan, dated 6/10/23, indicated the resident was an elopement risk and wandering. The goal was to maintain the resident's safety and resident would not leave the community unattended. Interventions were to provide directional cues, and provide structured activities. During an interview with the Wellness Director, on 2/5/24 at 10:00 a.m., she indicated Service Plans were updated on readmission, a significant change and every six months. She indicated after the elopement, she had contacted psych services for a medication to help the resident sleep. She had discussed memory care placement for the resident with the family. She indicated the resident always wandered, so she had not thought about updating the Service Plan, but would do so at that time. She indicated the resident had been able to exit the building due a door not being locked as it		All residents have the potential to be affected by the alleged deficient practice. Any resident who demonstrates elopement-related behavior shall have their risk assessment and service plan reviewed and updated with appropriate interventions. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? . The Health and Wellness Director has been educated on reviewing the service plan of any resident who is determined to be at risk for elopement quarterly and after any exit-seeking behavior. In the event of an elopement, actual or attempted, the Health and Wellness Director or designee shall update the service plan with interventions that will allow the resident to be independent and honor the resident's rights but reduce the risk of elopement within .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/05/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should have been. The policy, "Resident Elopement", was received from the Executive Director on 2/5/24, indicated, "...For residents who are determined to be at risk for elopement: a. Immediate interventions should be put into place that will allow the resident to be as independent and honor the resident's rights but reduce the risk of elopement...." This citation relates to Complaint IN00427196.		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? The Executive Director or Designee shall audit the service plan of any resident that has eloped or attempted, using the Unusual Occurrence Audit Tool 4x per week for 4 weeks, 2x times per week for 4 weeks, then weekly for 4 weeks.	