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	04/23/2024

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WYNDMOOR OF PORTAGE, LLC	3444 SWANSON RD PORTAGE, IN 46368

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00430991. Complaint IN00430991 - No deficiencies related to the allegations are cited. Survey dates: April 22 and 23, 2024 Facility number: 010889 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/26/24.	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. Compliance is effective 5/10/24	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
ZELLA RUTH GARRON	Executive Director	05/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure the required personnel documentation for references, job orientation, and annual inservices which included Dementia, Abuse, and Resident Rights were completed for 4 of 5 staff members reviewed. (CNA 1, CNA 2, LPN 1, and COOK 1) Findings include: Review of the employee records was completed on 4/23/24 at 1:12 p.m. a. CNA 1 was hired on 9/16/23. The CNA had no annual Resident Rights, Abuse, and Dementia training for 2023. b. LPN 1 was hired on 2/28/24. The LPN had no references or job orientation completed.	R 0120	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; CNA 1 has completed the annual Resident's Rights, Abuse, and Dementia training. LPN 1 The references and job orientation have been completed for LPN 1, Cook 1, and CNA 1. 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; Because all employees have the potential to be affected by the	05/10/2024

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	c. Cook 1 was hired on 3/1/24. The Cook had no references or job orientation completed. d. CNA 2 was hired on 1/8/24. The CNA had no references or job orientation completed. During an interview on 4/23/24 at 3:39 p.m., the Administrator indicated CNA 1 should have had the required training completed and all employees should have had references and job descriptions completed.		alleged deficient practice, the new Business Office Manager is performing a 100% employee file audit for compliance. The results of the audit shall be maintained on the employee file audit tool. 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 new Business Office Manager has been in-serviced by the Administrator on required employee file documentation and required in-services for licensed and non-licensed personnel. The Business Office Manager shall monitor training records in Relias monthly to ensure staff are completing required in-services, including in-services about residents' rights, abuse, and dementia. The BOM shall notify department managers when staff are due to complete ongoing training. 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; and The Administrator or designee shall review the employee file audit tool and the Relias training records monthly to ensure ongoing	

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			compliance. Employees who are not compliant will be removed from the schedule.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on record review and interview, the facility failed to ensure a resident with a pet had an environment that was clean, sanitary, and free of odors for 1 of 1 residents reviewed for pets in the facility. (Resident 2) Finding includes: On 4/22/24 at 2:10 p.m. Resident 2 was observed. The resident was awake and lying in his bed next to his cat. The room had a very strong odor, the room smelled of cat liter, cat urine, and cat dander. There was cat food littered along the floor in the front entryway. On 4/23/24 at 11:29 a.m., the resident was observed lying awake in his bed. The room had a strong odor that could be smelled from the entryway. The resident's pet cat was also in the room. Resident 2's record was reviewed on 4/22/24 at 11:01 a.m. Diagnoses included, but were not limited to, Alzheimer, hypertension (high blood pressure), diabetes, and hypothyroidism (underactive thyroid). A service plan, revised on 9/12/23, indicated the resident depended on team members to anticipate and meet their personal activity needs related to	R 0144	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident's room has been deeply cleaned and the family has been asked to rehome the cat due to the resident's inability to care for the cat. 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; The Activity Director will assess all residents with pets to ensure they can continue caring for their pet independently using the pet care assessment audit form. If a resident is determined to no longer be able to care for their pet independently, the Executive Director will meet with the Resident and/ or Responsible Party to rehome the pet. What measures will be put into place or what systemic changes	05/10/2024

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	cognitive deficits. The resident had an activities of daily living self-care performance deficit related to cognitive impairment. The resident required total assistance with bathing. The resident had bowel incontinence. During an interview on 4/22/24 at 2:23 p.m., the Administrator indicated the residents' rooms are cleaned on a weekly basis. The residents are required to clean up after their pets and Resident 2 has had his carpet cleaned more often and more frequently than any other resident in the facility.		the facility will make to ensure that the deficient practice does not recur; Residents with pets shall be assessed annually and as needed using the pet care assessment tool determine if they are still able to care for their pet independently. If a resident is determined to no longer be able to care for their pet independently, the Executive Director will meet with the Resident and/ or Responsible Party to rehome the pet. 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; and The Executive Director shall review the pet care assessment audit forms monthly and as needed to ensure compliance.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure a blood pressure medication was held per Physician's Orders for 1 of 7 records reviewed. (Resident 4)	R 0247	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	05/10/2024

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	Finding includes: The record for Resident 4 was reviewed on 4/23/24 at 9:49 a.m. Diagnoses included, but were not limited to, hypertension and atherosclerotic heart disease. A Physician's Order, dated 3/5/24, indicated the resident was to receive Midodrine HCl (a medication to treat low blood pressure) 10 milligrams (mg) three times a day. The medication was to be held if the resident's systolic (top number) blood pressure was greater than 120. The April 2024 Medication Administration Record (MAR), indicated the resident received the Midodrine on the following dates and times when her systolic blood pressure was greater than 120: 8:00 a.m. - 4/4 127/70 - 4/5 130/70 - 4/9 124/70 - 4/13 125/70 - 4/22 122/76 12:00 p.m. - 4/4 130/76 - 4/5 122/72 - 4/8 126/78 - 4/9 132/76 8:00 p.m. - 4/4 132/72 - 4/5 122/72 - 4/6 127/76 - 4/13 138/72 - 4/21 128/75 The March 2024 MAR, indicated the resident		The resident was assessed and there were no negative outcomes as a result of the alleged deficient practice. The resident's physician has been made aware of the error in medication administration. 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 residents have the potential to be impacted by this alleged deficiency. To ensure the physician has been notified of any resident that has had an error in medication administration with the actual or potential detrimental side effects, the Director of Nursing shall audit the charts of all residents with medications requiring parameters as part of the administration using a physician notification audit tool. 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 Director of Nursing shall in-service all nursing staff on proper medication administration including medication parameters, and physician notification.	

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	received the Midodrine on the following dates and times when her systolic blood pressure was greater than 120: 8:00 a.m. - 3/7 126/70 - 3/11 122/72 - 3/17 124/69 - 3/20 122/82 - 3/28 122/74 - 3/31 124/70 12:00 p.m. - 3/7 132/76 - 3/11 130/70 - 3/16 132/82 - 3/17 127/74 - 3/25 140/89 - 3/31 124/70 8:00 p.m. - 3/17 130/71 - 3/18 132/72 - 3/23 127/72 - 3/29 128/72 - 3/30 124/70 During an interview on 4/23/24 at 2:03 p.m., the Director of Nursing indicated the Midodrine should have been held as ordered.		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; and The DON will audit resident charts using a physician notification audit tool, 3 times a week for four weeks then weekly for 3 months then monthly for 3 months.	
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, interview and record	R 0270	What corrective action(s) will be	05/10/2024

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	review, the facility failed to ensure food was prepared in a form to meet individual needs related to incorrectly made pureed food. This had the potential to affect 2 residents who received a pureed diet. (Main Kitchen, Dietary Aide 1) Finding includes: On 4/23/24 at 12:36 p.m., Dietary Aide 1 was observed preparing a pureed beef recipe. The beef was substituted for chicken with the resident's permission. The Dietary Aide prepared the ingredients prior to the demonstration and indicated she cut the recipe in half to make 2 servings. The beef, thickener, and beef base were added to the mixer. The mixer ran for about a minute and the contents were then stirred and the mixer began again for another 30 seconds. The mixer was then removed from the base and the dietary aide began pouring the mixture onto ready to serve plates. On 4/23/24 at 12:41 p.m., the Dietary Aide indicated she was finished and the food was ready to be served. At that time, the large chunks of beef and lumpy texture of the recipe was pointed out to Dietary Aide 1. The product was not appropriate to be served. On 4/23/24 at 12:44 p.m., Dietary Aide 1 indicated she would mix the recipe some more. The contents were remixed and at 12:46 p.m., the beef recipe was ready to be served and was observed to be the appropriate consistency. During an interview on 4/23/24 at 12:42 p.m., the Dietary Manager indicated the recipe needed to be free of lumps and chunks and required a		accomplished for those residents found to have been affected by the deficient practice; The staff member involved has been in serviced by the Registered Dietician on how to properly puree food. 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 with a pureed diet has the potential to be impacted by this alleged deficiency. All dietary staff responsible for preparing food shall be in-served on properly preparing foods that must be pureed. 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 Dietary Manager or designee shall visually inspect all pureed items before it is plated to ensure proper consistency and immediately correct. 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; and	

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	smooth consistency. During an interview on 4/23/24 at 2:10 p.m., the Administrator indicated the food should not have had chunks in the completed recipe.		To ensure continued compliance, the Dietary Manager or designee shall use a pureed audit tool to ensure the food is properly prepared daily for one month, then weekly for 3 months, then every two weeks for 3 months.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure each resident's drug regimen was reviewed at least once every 60 days by the Consulting Pharmacist for 5 of 7 records reviewed. (Residents 4, 5, 6, 2, and 8) Findings include: 1. The record for Resident 4 was reviewed on 4/23/24 at 9:49 a.m. Diagnoses included, but were not limited to, hypertension, major depressive disorder, anxiety, seizure disorder, and type 2 diabetes. The facility administered the resident's	R 0298	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has entered into a new contract with a different pharmacy provider with significant SNF/AL experience to ensure compliance moving forward. How the facility will identify other residents having the potential to	05/10/2024

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	medications. A medication review was completed by the Pharmacist on 6/29/23. The next medication review was not until 2/29/24. During an interview on 4/23/24 at 2:03 p.m., the Director of Nursing indicated the facility had changed pharmacies during that time frame and the new Pharmacist had not been completing medication reviews, even though she told him they needed to be done. 2. The record for Resident 5 was reviewed on 4/23/24 at 11:13 a.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension, and type 2 diabetes. The facility administered the resident's medications. A medication review was completed by the Pharmacist on 6/29/23. The next medication review was not until 2/29/24. During an interview on 4/23/24 at 2:03 p.m., the Director of Nursing indicated the facility had changed pharmacies during that time frame and the new Pharmacist had not been completing medication reviews, even though she told him they needed to be done. 3. Resident 6's record was reviewed on 4/22/24 at 11:07 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertension, major depressive disorder, gastroesophageal reflux disease, psychotic disorder with delusions and presence of prosthetic heart valve. There were no pharmacy reviews completed every 60 days between July 2023 through January 2024. During an interview on 4/23/24 at 10:30 a.m., the		be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficiency. The DON shall receive and maintain a pharmacy review calendar to ensure future compliance with the pharmacy vendor. 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 has contracted with a new pharmacy effective July 1, 2024, and the contract specifically includes pharmacy consult services per applicable law. 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; and The DON or designee shall review the pharmacy calendar and immediately notify the pharmacy and Executive Director of any potential for non-compliance so that it may be addressed timely. The DON or designee shall review the pharmacy calendar for 8 months to ensure continued compliance.	

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	Director of Nursing (DON) indicated there were no pharmacy reviews completed every 60 days between July 2023 through January 2024. 4. Resident 8's record was reviewed on 4/22/24 at 2:36 p.m. Diagnoses included, but were not limited to, diabetes, osteoarthritis, hyperlipidemia (high cholesterol), and anemia. There were no pharmacy reviews completed every 60 days between July 2023 through January 2024. During an interview on 4/23/24 at 2:03 p.m., the Director of Nursing (DON) indicated there were no pharmacy reviews completed every 60 days between July 2023 through January 2024. 5. Resident 2's record was reviewed on 4/22/24 at 11:01 a.m. Diagnoses included, but were not limited to, Alzheimer, hypertension (high blood pressure), diabetes, and hypothyroidism (underactive thyroid). There were no pharmacy reviews completed every 60 days between July 2023 through January 2024. During an interview on 4/23/24 at 2:03 p.m., the Director of Nursing (DON) indicated there were no pharmacy reviews completed every 60 days between July 2023 through January 2024.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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.			

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	(3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to lack of follow up documentation after a change in condition and no order to self administer medications for 1 of 7 records reviewed. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 4/22/24 at 11:15 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, heart failure, seizures, and anxiety. The Senior Living Level of Care Evaluation, dated 2/22/24, indicated the resident administered her own medications. The April 2024 Physician's Order Summary (POS) indicated there was no order for the resident to self administer her medications. A Nurses' Note, dated 9/7/23 at 5:06 a.m., indicated the resident approached staff and informed them she was going to the walk in clinic to have her right hand examined. The right hand had a bruise and the resident indicated it was getting bigger after she had hit it a couple of hours earlier. Ice was offered but the resident refused. The resident would inform staff upon her arrival. The next entry in the nurses' notes was on 9/29/23. The entry was completed by the Registered Dietitian. A Nurses' Note, dated 10/23/23 at 5:23 p.m., indicated the resident was not feeling well. She indicated she was taking herself to the emergency room. The next entry in the nurses' notes was not	R 0349	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident's order to self-administer was updated in the orders. 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 residents have the potential to be affected by this alleged deficiency. The DON or designee shall audit resident charts to ensure follow-up documentation is accurate related to any change of conditions and/or orders to self-administer medications. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All nursing staff shall be in-serviced on documenting any change in condition and/or orders to self-medicate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	05/10/2024

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	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	until 11/2/23. A Nurses' Note, dated 11/9/23 at 4:30 p.m., indicated the resident was complaining of having loose stools several times a day over the last week. The resident was requesting to have a BRAT (bananas, rice, applesauce, and toast) diet until 11/12/23. The next entry in the nurses' notes was dated 11/13/23 at 6:03 p.m., the resident complained of still having loose stools and wanting to go to the emergency room. The resident returned from the emergency room at 11:15 p.m. There was no follow up documentation after the resident returned. During an interview on 4/23/24 at 2:05 p.m., the Director of Nursing indicated the resident should have had an order to self administer her medications and follow up documentation should have been completed after the hospital and walk in clinic visits.		quality assurance program will be put into place; and The DON or designee shall audit residents' charts using a clinical documentation audit tool 3 times a week for four weeks then weekly for four weeks and monthly thereafter.	