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	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR OF MARION, LLC	2452 W KEM RD MARION, IN 46952

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00441864. Complaint IN00441864 - State deficiencies related to the allegations are cited at R0044. Survey dates: September 13 and 16, 2024 Facility number: 010682 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 19, 2024.	R 0000		
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from discharge from the facility without indication for 3 of 3 residents reviewed for involuntary discharge. (Residents B, C, and J) Findings include: Review of a facility self-reported incident to the Indiana Department of Health indicated, on 8/25/25, Resident B's visitor was in her room and complained of being tired. Resident B's visitor was identified as a resident of the facility, and was found to have white powder in his nose when staff assisted him to ready for bed. The unidentified resident indicated he had used Ativan (anti-anxiety medication) and was sent to	R 0044	Facility is requesting IDR because we feel that we provided proper documentation for the deficiencies • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Facility will provide supporting documentation residents who are breaking policy/policies up to termination of lease agreement. Facility will ensure that any involuntary transfer/discharge will	04/02/2025

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

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	the emergency department for treatment. 1. Resident B's closed clinical record was reviewed on 9/13/24 at 10:17 a.m. Discharge diagnoses included unspecified seizures, anxiety, and post traumatic stress disorder. A current service plan, dated 3/15/23 through 8/28/24, indicated Resident B was able to self-administer her medication. The objectives and approaches to this service plan did not address securing medication in the resident's room. The resident had a 7/12/24, "Self-Administration of Medication Review," completed by the DON, which indicated "Demonstrates secured storage for medication stored in room?-Fully Capable" and "Approval for self administration granted." A "Notice of Transfer or Discharge" dated 8/26/24 and provided by the Administrator on 9/13/24, indicated a 30-day notice of involuntary discharge for Resident B, effective date 9/25/24. The transfer or discharge was necessary to meet the resident's welfare and the resident's needs could not be met in the facility. The accompanying letter indicated, Resident B "continues to break the facility rules and policies regarding our self-medication administration criteria. Due to health and safety of other residents we have no choice but to give you notice." The information provided did not contain supporting documentation of the resident's breaking of the rules for self-administration of medication, nor did the documentation identify how the facility was unable to meet the resident's needs. The clinical record for September 2023 to August 2024 lacked documentation of the resident		be emailed or faxed directly to local ombudsman. • 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. Audit every resident lease agreement (Attachment 1) upon admission understands the criteria for transfer/discharge whether it is voluntary of involuntary. Administrator will attach an Addendum to the lease agreement (Attachment 2) that states the resident has read and reviewed the policies on Smoking, Drug and Alcohol and Self-Medication Administration and understand criteria for transfer/discharge whether voluntary or involuntary. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Audit every resident lease agreement (Attachment 1) upon admission understands the criteria for transfer/discharge whether it is voluntary of involuntary. Quarterly for 6 months/or change of condition facility will reassess the residents who are self-administrators of medications. (Attachment 3	

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	violating the self-medication administration policy, the resident reporting missing medication, or the facility offering guidance/assistance/direction in the area of self-medication administration. An 8/25/24 at 1:45 p.m., "General Progress Note" indicated the resident brought a paper plate with a crushed white powder and a straw to the nurse's station and indicated they found it in their room under the griddle. An 8/26/24, 8:22 p.m., "General Progress Note" indicated a nurse and the Administrator went to the resident's room and removed and secured the resident's medication. The facility would begin to administer medication for the resident. An 8/27/24, 10:27 a.m., "General Progress Note" indicated the resident had been given a 30-day notice. A 9/5/24, 3:43 p.m., "Move Out/ Discharge Note" indicated the resident the resident said goodbye to others. The resident indicated they desired to return to the facility as a resident in the future. During an interview on 9/13/24 at 11:49 a.m., the Administrator indicated Resident B had a history of failure to secure their medication. Following the August 2024 reported event, the resident had allowed the facility to store and administer her medications. No issues had occurred while the facility administer the resident's medication. The facility did offer medication administration as one of their services. The Administrator indicated the resident was not given the option of allowing the facility to administer their medication and remain in the facility. The Administrator held Resident B responsible for Resident C's choice to steal and		Self-Medication Assessment) Care plans will be updated with any changes. • 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 Administrator will keep a log of new resident's lease agreement and signed Addendum that resident has reviewed and acknowledged the Smoking, Drug Alcohol and Self Medication Administration policies, and criteria for transfer/discharge whether voluntary or involuntary. The Facilities Nursing Leadership will quarterly for 6 months/ or change of condition will reassess resident who are self-administration of medication. • By what date the systemic changes will be completed. 6 months from the date of deficient practice.	

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	take Resident B's medications, causing Resident B to be deemed unsafe to remain in the facility. The Administrator indicated Resident C was in a relationship with Resident B and was therefore aware of a history of drug use. The Administrator would obtain documentation regarding the resident's statement of the events on 8/25/24, documentation of any services/support offered by the facility to ensure the resident maintained their medication in a safe manner, and all documented events of the resident maintaining their medications in an unsafe manner during the past year. During an interview on 9/13/24 at 2:29 p.m., the Administrator indicated the documentation regarding unlocked medications for Resident B were in 2022 and 2023 as follows: On 9/23/22, Resident B thought she had lost Ativan (an anti-anxiety medication). The pills were found in her suitcase. On 8/25/23, Resident B lost her set of keys and the facility provided a lock box for her medication. The Administrator had no statements, signed by the resident, of their account of the 8/25/24 medication event. During an interview on 9/16/24 at 11:43 a.m., the ADON (Assistant Director of Nursing) indicated the facility did not have any documented instances of Resident B failing to secure their medication from September 2023 to August 2024. In addition, the facility had zero instances of anyone accessing or attempting to take the resident's medication. The facility had no documentation of services or support regarding medication safety offered to the resident within			

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	the last year. The facility had no documentation of Resident C having a history of illicit drug use and it was all just "hearsay." A 9/16/24 at 12:29 p.m. email from the Area Ombudsman indicated she had never received the notification of the 30-day involuntary transfer/discharge notice for Resident B. 2. Resident C's clinical record was reviewed on 9/13/24 at 10:54 a.m. Current diagnoses included Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder, and anxiety. An 8/26/24 "Notice of Transfer or Discharge"/ 30 day involuntary discharge notice, provided by the Administrator on 9/13/24, indicated the following: "The transfer or discharge is necessary to meet the resident's welfare. An attached document indicated: the resident "continues to break the rules and policies regarding our smoking policy, and drug and alcohol policy." A 7/9/24 "Smoking Evaluation Tool" indicated the resident understood and displayed safe smoking practices. A current 7/11/23 service plan indicated the resident was able to use tobacco product independently. An 8/25/24 at 5:30 p.m., "General Progress Note," indicated Resident C had been escorted down stairs by a friend. The resident was unable to keep his eyes open. When being assisted to bed, staff saw white powder on the resident's nose. When asked if they had taken any substances, the resident answered "Ativan". The resident was taken by the ambulance to the hospital.			

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	An 8/25/24 at 8:25 p.m., "General Progress Note" indicated the resident would be admitted to the hospital for observation. The resident had tested positive for alcohol, Tylenol, and Ativan. An 8/28/24, 2:00 p.m., "General Progress Note", indicated the resident had been given a 30-day discharge notice due to noncompliance with rules and regulations. The clinical record lacked documentation of the Resident C using drugs or alcohol other than the 8/25/24 event. The clinical record lacked documentation of the resident ever smoking unsafely or had a past history of illicit drug use or chemical dependency. During an interview on 9/13/24 at 11:49 a.m., the Administrator indicated the use of illegal drugs was not tolerated per the facility policy and the resident was given a 30-day involuntary discharge notice. During an interview on 9/16/24 at 11:43 a.m., the ADON (Assistant Director of Nursing) indicated the facility did not have documented instances of the resident being under the influence of any substance nor the resident practicing unsafe smoking. The facility had no documentation of Resident C having a history of illicit drug use and it was all just "hearsay." During an interview on 9/16/24 at 1:02 p.m., Resident C indicated they had been in a relationship with Resident B. Resident B had invited them into their room where they spent time together. The resident took Resident B's medication without their knowledge or permission while Resident B was sleeping. They were told by the facility they had to move, but did not			

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	remember getting any paperwork and most definitely believed they were not told they had the right to appeal. Resident C would have appealed the discharge if they realized they could. A 9/16/24 at 12:29 p.m. email from the Area Ombudsman indicated she had never received the notification of the 30-day involuntary transfer/discharge notice for Resident C.3. Resident J's clinical record reviewed on 9/16/24 at 9:30 a.m. The resident's diagnoses included hypertension, arteriosclerotic heart disease, a crushing injury of head (part unspecified), benign prostatic hyperplasia, and Type 2 diabetes mellitus. On 8/26/24, Resident J received a Notice of Transfer or Discharge. The transfer/discharge indicated he was going to another nursing facility. The reason for the transfer indicated it was necessary to meet the resident's welfare and the resident's needs could not be met in the (current) facility. A "Notice of Discharge" indicated it was hand-delivered to Resident J on 8/26/24. This letter indicated the facility was issuing an official 30-day notice for Resident J because he continued to break the facilities rules and policies regarding their smoking policy. The effective date of discharge was 9/25/24. The letter was signed by the Administrator. A Smoking Evaluation Tool for Resident J, dated 6/4/24, indicated the resident had no desire to quit smoking. He did not require supplemental oxygen. He had a history of falling in his room and in the courtyard where residents were allowed to smoke. He refused resources to help with smoking cessation. He was educated about the smoking			

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	policy and the designated area(s). He was able to safely remove the smoking materials out of the container. He could safely utilize a lighter "most of the time". He could safely handle lit smoking materials. He was able to demonstrate safe smoking behaviors while interacting with other residents. His hands and fingernails showed no signs of burns. He did not require a smoking apron. His care plan was reviewed and revised for appropriate supervision and smoking directions to include "general supervision". Staff were to light his cigarettes for him. A hand-written note, provided by the Administrator on 9/16/24 at 12:42 p.m. and signed by the Administrator and dated 7/22/24, indicated she had spoken to the resident's family about an upcoming smoking policy change. The resident would have to be supervised by either a family member or his home care representative. Neither the resident's or his family member's signature were included on the document. A hand-written note, provided by the Administrator on 9/16/24 at 12:42 p.m. and signed by the Administrator and dated 7/24/24, indicated the home health caregiver was notified of the smoking policy change. The resident would require the supervision of the caregiver or that of a family member, during smoking activities. The caregiver's signature was not included on the document. After the smoking policy change on 8/7/24, no pharmacological or non-pharmacological alternatives were offered to the resident to aid with his nicotine habit. No accommodations were made to assist the resident to smoke after the policy change on 8/7/24.			

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	A Level of Care Evaluation, dated 8/27/24 at 12:59 p.m., indicated the resident used tobacco products, was able to smoke independently, and did not require any adaptations. A facility policy titled "Smoking Policy - Effective 8/7/24" was provided by the administrator on 9/13/24 at 2:29 p.m. and indicated the following: "The [facility] will no longer allow residents to smoke in the courtyard inside the facility. Residents who choose to smoke will have to physically be able to sign themselves out and proceed out the front door to smoke in the gazebo that is located on the southwest corner of the property. Residents who are unable to physically take themselves out of the facility will not be able to smoke. Residents are required to be able to safely get themselves out of the facility with no assistance. Staff and other residents will not be permitted to take residents outside to smoke. Failure to comply with these requests will result in up to termination of resident's lease agreement." A general progress note, dated 8/15/24 at 3:02 p.m., indicated the resident was at the front door trying to get out of the building to go smoke. The resident was unable to put in the code to get in or out of the facility. The resident was unable to smoke by himself. He was not easily directed and kept yelling and cussing at the staff. A behavior note, dated 8/20/24 at 8:33 p.m., indicated the resident refused to follow smoking policy. He was noted outside smoking in the front by the gazebo. He argued with staff about allowing him to go outside to smoke. The resident stated "I don't care, I'm going to smoke. I'm not a prisoner." A behavior note, dated 8/21/23 at 10:53 p.m.,			

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	indicated the resident was going out the front door to smoke and had asked other residents to help him out the door. He was returned inside by a staff member who told him he could not go outside without a family member or his home health aid. During an interview with the Administrator on 9/16/24 at 2:00 p.m., she indicated the resident was unable to put the code into the keypad at the front door because his range of motion restricted his arms from reaching the keypad. He was not always able to remember the code. He was not safe to be outside by himself. The resident also owed the facility at least $11,000.00. A 9/16/24, 12:29 p.m., email from the Area Ombudsman indicated she had never received the notification of the 30-day involuntary transfer/discharge notice for Resident J. During a confidential interview, a resident indicated the Administrator had been trying to get rid of Resident B for years. The Administrator had done a great job "cleaning this place up. She got rid of the smokers who were leaving their cigarette butts in flower pots. We have had a lot of "unsavory characters" here but the Administrator has been doing a great job "getting rid of that type of people." The new marketer has also done a good job "weeding out the kind of people you don't want around." A current, 5/1/2019, policy tiled, "Admission/Discharge Policy", which was provided by the Administrator on 9/13/24 at 11:23 a.m., indicated: "...Discharge Criteria. The community may discharge a resident based on the following criteria:			

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	a) The community is unable to meet the resident's needs.... f) The resident is a danger to himself/herself or others. g.) The health of individuals in the community is endangered..." This finding relates to complaint IN00441864.			