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	08/30/2022

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 IN00388486. Complaint IN00388486 - Substantiated. No State Residential Findings related to the allegations were cited. Unrelated deficiencies are cited. Survey date: August 29 and 30, 2022. Facility number: 010682 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 7, 2022.	R 0000		
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and			

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

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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	comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure the resident's powerchair and the resident was safely secured while being transported in a facility bus (Resident F). Findings include: During an interview with Resident H, on 8/29/22 at 3:20 p.m., she indicated less than a week ago, while the residents were on an outing, the bus driver did not secure residents on the bus that were in wheelchairs or powerchairs. One resident fell out of his powerchair, and the fire department was called and had to pick the man up. During an interview, with the DON and ED, on 8/30/22 at 9:30 a.m., the DON indicated Resident F fell forward from his chair and fell onto Resident G's shoulder. There were no injuries. ED indicated Resident G felt sore/bruised from the incident but did not need medical attention. During an interview with the Activity Director, on 8/30/22 at 9:37 a.m., she indicated Resident F was last one to go on to the bus in his electric wheelchair, he had a hard time maneuvering it and getting it into position, once he did, he shut the power off to the chair and she told him to put the seatbelt on. She was not with them but her assistant was and as they were going to a local store, they were turning the corner to go into the parking lot off the bypass when he fell forward. His powerchair was not strapped down, but did not move, he came forward and bumped Resident G in front of him and her assistant held his head until they were able to get him up. Resident F	R 0148	The following is the plan of correction for the Wyndmoor of Marion regarding the statement of deficiencies dated on 8/30/2022. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory. In this document we have detailed actions in response to identified issues. We detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. Staff in serviced and educated on safety while transporting. Staff will have a check off sheet in the facility bus to be checked off per driver and activity director. Sheet will include date of transport, resident on transport, and staff checked seat belt. This plan of correction is indefinite to ensure resident safety.	10/01/2022

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	indicated that he forgot that she told him to put on his seatbelt and then said he could not get the seatbelt buckled. Come to find out, his seatbelt was buckled, and he was sitting on it in his powerchair. Resident F's clinical record was reviewed on 8/30/22 at 9:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, type 2 diabetes mellitus, obesity, heart failure and chronic obstructive pulmonary disease. His service care plans included, but were not limited to, the following: His mobility, initiated on 2/12/22. His goal was he would be able to move about the community without assistance. His interventions were initiated on 2/12/22 and included, he was mobile with my wheelchair, he self-propelled in his apartment and outside of his apartment, he may require some assistance with his wheelchair for long distances and he would be able to communicate to his caregivers if he needed assistance with long distances or getting in/out of the facility. His falls, initiated on 6/7/22. His goal was that he would be encouraged to call for assistance when needed. His fall intervention was wear appropriate shoes when ambulating, initiated on 6/7/22. His nurses notes indicated, but were not limited to the following: On 8/25/22 at 12:17 p.m., he fell out of his electric wheelchair while on an outing in the facility bus. EMS and the fire dept were called. He refused treatment. The ED, ADON and family were informed.			

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	On 8/25/22 at 3:45 p.m., a community outing in the facility van, on a scooter, he did not fasten his seatbelt and slid out of his seat, a small part of his upper body rested on back of another client's shoulders. He landed on his bottom and was assisted from the floor with the assistance of staff. EMTs and the fire department were called for lift assistance. No injuries were noted. On 8/26/22 at 5:34 a.m., he continued on fall follow up. He stated he had no pain related to the fall and bruises on his side. On 8/26/22 at 2:03 p.m., he stated that he was sore and bruised but was okay. He had no change in his range of motion. On 8/28/22 at 1:16 a.m., he was in his room, alert and oriented. No complaints voiced and no latent injuries were noted at that time. Would continue to monitor and update as needed. Call pendant was in place. His clinical record lacked notification to his physician and his service care plan had not been updated. During an interview with Resident G, on 8/30/22 at 11:00 a.m., she indicated she transferred to a bus seat in the van and was sitting in front of Resident F. The bus driver had turned into a parking lot and Resident F's chair tipped over and he flew out and hit her left shoulder, that was her bad side anyway from previous strokes. He tried to move and he just became more heavy. His head was in her lap. They could not get him up and had to wait for the EMS and the fire department to get there. His chair must had not been tied down. Her left shoulder was very sore and her back hurt,			

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	although she had a bad back and her pelvic area was sore. She felt like she had been in a wreak. She felt like the bus driver was in such hurry and always trying to rush. During an interview with Resident F, on 8/30/22 at 11:10 a.m., he indicated he was not secured in the facility van. He did not have seatbelt or harness on. They were supposed to strap the powerchair to the floor. They were in a hurry because one of the residents had an appointment but found out it was not until September. He was told that it was his responsibility to make sure his seatbelt was on. He felt like the bus driver was in a hurry. When he fell and he brushed up against Resident G in the isle of the bus. His powerchair tipped forward but it did not fall on top of him. He received a couple of scratches on the back of his right calf and bruising to his left outer thigh and his right shoulder was a little tender. An observation, during the interview with Resident F, he had two horizontal scratches on the back of right calf. On his left outer thigh there was a bruise size of a large egg that was blue and purple with a scratch in the middle of it and he had a few purple scattered bruises just below that area. During an observation of the facility bus and interview with the bus driver, on 8/30/22 at 12:27 p.m., there were three sets of two seats on each side of the bus and one lone seat in the back to the left. The wheelchair lift was on the right side of the bus. He indicated he used two floor straps with hooks for the back and two floor straps with hooks for the front of the chairs and then a seatbelt that would go across the resident chest and strap the resident like a seat belt the front seat of a car. He indicated the resident was not wearing			

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	the shoulder strap seatbelt. Resident F was told by the Activity Director to put on his seatbelt in his powerchair but, after the incident he seen the residents seatbelt was buckled and was behind him, he had been sitting on it. Resident F was facing the front of the bus in his powerchair, he did not always strap down the powerchairs. The manual wheelchairs he always strapped down because they can move all over the place. Resident G was sitting in front of Resident F in the last row on the right in the seat next to the isle. He was turning at the traffic light off the bypass into the store parking lot when he heard the assistant yell at him that Resident F slid out of his chair. He came out of his wheelchair and went forward to the floor, the way he was sitting he thought he broke his leg. They could not get him up and the EMS and fire department was called. He was in a hurry that day, he was supposed to take them shopping at 9:45 a.m. and something came up and backed things up. A driver job description, provided by the DON, on 8/30/22 at 12:10 p.m., indicated the following: "...Essential Functions, 4. Ensures residents are safely seated with seat belts secured...." The job description was signed by the bus driver on 5/18/22. A Vehicle Safety Policy, provided by the DON, on 8/30/22 at 12:10 p.m. indicated the following: "...Driving Rules: Seat Belts - The driver and all occupants are required to wear seat belts when the vehicle is in operation or while riding in the vehicle. The driver is responsible for ensuring passenger wear their seat belts...." The driver acknowledgement was signed by the bus driver on 5/18/22.			