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	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR ASSISTED LIVING LLC	1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802

(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 a State Residential Licensure Survey. Survey dates: April 25, 26, & 29, 2024 Facility number: 013389 Residential Census: 131 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 9, 2024.	R 0000		
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure residents' pets were up to date on required vaccinations for 1 of 15 residents reviewed for pet records (Resident 68). Findings include: On 4/29/24 at 1:00 p.m. Residents' pet records were reviewed. The records indicated that Resident 68 had a pet cat with a record on file that had an expiration date of 3/1/2022. On 4/29/24 at 1:20 p.m. Resident 68's pets records were reviewed. The record indicated the next feline (cat) viral rhinotracheitis (inflammation of the nose and windpipe caused by virus), calicivirus (contagious oral and respiratory	R 0151	On 4/29/2024 when oversight was pointed out, Facility helped resident schedule appointment with veterinarian that day, next available appointment was requested. Family member was notified and requested to assist resident with transportation. Appointment was scheduled for 5/17/24. Moving forward an audit tool flowsheet will be used for monitoring, Admission Director will monitor list monthly Administrator will double check the monitoring tool. 30 days before yearly vaccine expires resident / family will receive a phone call and reminder	05/17/2024

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

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	disease caused by virus), panleukopenia (contagious fatal blood disease caused by virus) and rabies (viral disease that causes encephalitis [inflammation of the brain] in humans and other animals) vaccinations would have been due 3/1/2022. During an interview on 4/29/24 at 1:15 p.m., the Administrator (ADM) indicated she did not realize how far past due Resident 68's pet record was, and that it had been an oversight on her part. She did not know how long Residents had to get it corrected and that Employee 13 oversaw the pet information. During an interview on 4/29/24 at 1:20 p.m., Employee 13 indicated she had tried to contact Resident 68's son several times, spoke to him once, and had not heard from him since. Her first contact with the son had been made on 2/8/24. She since had asked the resident to try and get ahold of his son regarding the outdated vaccinations. She did not know how long they had to get in compliance with the vaccinations before they asked for the pet to be removed. She indicated she started at the facility in September of 2023. On 4/25/24 at 8:37 a.m., the Business Office Manager (BOM) provided an undated document titled, "Attachment D to Rental Agreement - Pets," and indicated it was the policy currently being used by the facility. The policy indicated, " ...E. Resident(s) will maintain, and provide evidence to Administrator of, current and proper immunizations of the pet, in accordance with the laws, regulations, and health customs of the community in which Community is located. Resident(s) must complete and submit all documentation to Administrator prior to the pet		letter in the mail. If the family is unable or unwilling to assist the resident, Admission Director or Administrator will assist in making an appointment and setting up transportation at the resident expense.	

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	moving into the Community. F. It is the Resident(s) responsibility to keep the pet immunizations up to date and provide the annual immunizations records to the Administrator ...I. A breach of these condition shall allow Center, after providing all reasonable accommodations, to terminate or give Resident notice to remove the pet from Community ...."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review, and interview, the facility failed to ensure insulin (medication used to lower blood sugar) medication was labeled properly for 9 of 9 residents observed during medication administration (Residents 7, 47, 54, 56, 62, 95, 106, 89, and 51). Findings include: On 4//26/24 at 10:30 a.m., the following was observed during the medication administration pass:	R 0301	Nursing Staff will be educated on the insulin pen policy. Inservice on the policy will be done Upon new hires of any nurse and quarterly in-services year-round will be conducted, (minimum of 4 a year). A flow sheet was designed to help Director of Nursing to track the dates labeled on insulin pens it will be monitored weekly by the Director of Nursing or designated charge nurse in her absent. The pens will be dated with a black marker, and dates	05/17/2024

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	1. At 10:34 a.m., Licensed Practical Nurse (12) administered insulin medication using an insulin pen (an injection device that you can use to deliver preloaded insulin) to Resident 7. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 7's record was reviewed on 4/26/24 at 11:34 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition (when diabetes [a group of diseases that result in too much sugar in the blood] is caused by diseases such as cancer, pancreatitis, or nutrition deficiencies). A physician order, dated 4/2/23, indicated Humalog (insulin medication) Kwik Pen injector 100 unit/ml (milliliter). Inject per sliding scale before meals and at bedtime. 2. At 10:36 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 47. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 47's record was reviewed on 4/26/24 at 11:40 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. A physician order, dated 12/15/23, indicated Humalog Kwik Pen injector 100 unit/ml. Inject per sliding scale three times daily. 3. At 10:38 a.m., LPN 12, administered insulin medication using an insulin pen to Resident 54. The pen label lacked an open date, and the nurse was unaware of how long the pen had been		also noted on flow sheet. The continued use of the flowsheet will be done year-round and part of our daily practice of updating as a new insulin pen is put into use.	

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	opened. Resident 54's record was reviewed on 4/26/24 at 11:43 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. A physician order, dated 3/6/24, indicated Fiasp (insulin medication) Flex injector touch. Inject every morning subcutaneously (under the skin) 10 units at the start of the meal or within 20 minutes of the start of the meal. 4. At 10:43 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 56. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 56's record was reviewed on 4/26/24 at 11:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. A physician order, dated 10/18/23, indicated Insulin Lispro (insulin medication) injection solution. Inject 12 units subcutaneously before meals. 5. At 10:45 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 62. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 62's record was reviewed on 4/26/24 at 11:58 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition.			

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	A physician order, dated 10/19/23, indicated Humalog Kwik Pen injector 100 unit/ml. Inject before meals and at bedtime per sliding scale. 6. At 10:56 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 106. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 106's record was reviewed on 4/26/24 at 12:00 p.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus (a long- term condition in which the body has trouble controlling blood sugar and using it for energy). A physician order, dated 5/25/23, indicated Novolog (insulin medication) injector Flex Pen. Inject subcutaneously per sliding scale three times daily. 7. At 11:00 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 95. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 95's record was reviewed on 4/26/24 at 12:02 p.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus due to underlying condition. A physician order, dated 2/28/24, indicated Admelog (insulin medication) injection solution 100 unit/ml. Inject 36 units subcutaneously at lunch. 8. At 11:05 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 89.			

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	The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 89's record was reviewed on 4/26/24 at 12:05 p.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. A physician order, dated 2/9/23, indicated Novolog injector Flex Pen. Inject three times daily 10 units subcutaneously. 9. At 11:08 a.m., LPN 12 administered insulin medication using an insulin pen to Resident 51. The pen label lacked an open date, and the nurse was unaware of how long the pen had been opened. Resident 51's record was reviewed on 4/26/24 at 12:06 p.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus. A physician order, dated 12/19/23, indicated Humalog Kwik Pen injector 10o unit/ml. Inject 10 units subcutaneously three times a day. During an interview, on 4/26/24 at 11:28 a.m., the Director of Nursing (DON) indicated the staff did not place open dates on the insulin pens or vials because they went through the medication so fast that they did not usually go past the 28 days before the medication expired. The DON was not aware of a time when they did place an open date on the insulin medications. She further indicated insulin was good for 28 days once opened but she would not be able to verify how long the insulin pens had been opened that were used today during medication administration.			

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	During a telephone interview, on 4/26/24 at 2:24 p.m., the pharmacy consultant indicated it was best practice for facilities to place an open date on the insulin pens and vials because the nursing staff were administering the medication to the residents. Insulin pens and vials were good for 28 days once opened. On 4/26/24 at 1:25 p.m., the DON provided and identified an undated document as a current facility policy, titled, "Medication Delivery/Distribution." The policy indicated, " ...2) Nursing personal shall ensure that medication(s) is appropriately labeled ...." On 4/26/24 at 2:42 p.m., the DON provided and identified a document as a current facility policy, titled, "Insulin Pen," dated 11/14/20. The policy indicated, " ...2. Pens in use will be dated upon opening and stored at room temperature ...." On 4/26/24 at 2:42 p.m., the DON provided and identified a document as a current facility policy, titled, "Insulin Administration," dated 11/14/20. The policy indicated," ...C. Always check expiration date ...D ...Opened insulin vials stared at room temperature or in the refrigerator will last 28 days ...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference.			

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	(3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review, interview, and observation, the facility failed to ensure accurate emergency information was on file for 1 of 1 resident reviewed for clinical records (Resident 61). Findings include: On 4/29/24 at 11:00 a.m. Resident 61's electronic record was reviewed. Diagnoses included, but were not limited to, hypothyroid (thyroid gland cannot make enough hormone to keep the body running), diabetes mellitus (disorder characterized by high levels of sugar in the blood), hyperlipidemia (high fat amount in the blood), hemiplegia (one side of the body is weak or does not function), hemiparesis (weakness or inability to move one side), seizures (uncontrolled electric activity in the brain), depression (feeling of sadness), transient ischemic attack ([TIA] brief blockage of blood flow in the brain). The face sheet indicated do not resuscitate (revive from apparent death [DNR]). A cardiopulmonary (heart and lung) resuscitation (CPR) status form, signed by the Resident, was scanned into the Resident's chart on 7/28/23, indicated Resident 61's choice was to begin resuscitation with CPR after calling 911.	R 0356	An all-facility audit was done on 4/29/24 immediately when discrepancy was pointed out. No other discrepancies were noted. Moving forward and Aduit tool flowsheet, with a triple check method will be put into place with all new admissions, or when a resident decided to change their code status. The admission director will check that code status matches what the resident marks on admissions paperwork, matches the doctor orders, matches the evacuation sheet, door name tag, & matches the chart and the point click care system. Once the flow sheet is checked by admission director, the Director of Nursing will check that the information in the above locations and matches. When the Director of nursing has completed her audit, the flowsheet will be given to the Administrator to verify all locations have the correct information and place the completed audit in the chart. This	05/17/2024

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	On 4/29/24 at 11:15 a.m. Resident 61's paper record was reviewed. A CPR status form, signed and dated by the Resident, indicated his choice was to begin resuscitation with CPR after dialing 911. During an interview on 4/29/24 at 11:20 a.m., the Administrator indicated she did not know why the record did not match the form, but she would find out more information about Resident 61's CPR status. During an interview on 4/29/24 at 11:47 a.m., the Administrator (ADM) indicated Resident 61 was a DNR according to the Physician orders and the orders were put in after the form was filled out. She indicated every resident who was a DNR would have a dot on their door. She had recently talked to Resident 61 that day, and he indicated he wanted to be a DNR. The ADM indicated Resident 61 incorrectly filled out the form because there were so many forms to be completed upon admission. She indicated that the form had been corrected. The form was observed to have been errored, initialed, but not dated. During the interview, the ADM added the date next to the Resident's initials. During a random observation of the Resident 61's room on 4/29/24 at 12:00 p.m., a black dot was observed above the Residents name on the door tag. On 4/29/24 at 12:10 p.m., the ADM provided a copy of the evacuate/code status sheet, updated 4/29/24. The information included, but was not limited to, the code status of all residents, with residents who had been considered DNR highlighted in black. On this document, Resident 61 was highlighted in black, indicating he was		will be our practice moving forward with all new admissions or when a resident request to make changes.	

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	DNR. This document was compared to the same document that was provided by the Director of Nursing (DON) on 4/25/24 that had been updated on 4/19/24. On this document, Resident 61 was not highlighted black, indicating he was not DNR. During an interview on 4/29/24 at 12:15 p.m., the ADM indicated the evacuate/code status sheets were kept in the medication room as a backup. If a Resident required lifesaving efforts, the first thing staff would look for would be a dot on the Resident door. If the resident was anywhere but their room, staff would radio the nurse who would look in the documentation in the electronic chart. During an interview on 4/29/24 at 12:50 p.m., the Director of Nursing (DON) indicated the evacuate/code sheets were kept in all emergency bags, located in the medication rooms, certified nurse aide (CNA) office, nurse stations, kitchen, and outside the elevator door on each floor. She indicated it was a reference sheet to be used in the event of an emergency. If a resident needed lifesaving interventions while they were in the dining room, the kitchen staff would go by the information on the evacuation/code status sheet. On 4/29/24 at 1:25 p.m., the ADM provided an undated document, titled, "Wyndmoor Procedure on Responding to CPR," and indicated it was the procedure currently being used by the facility. The procedure indicated, " ...Procedure: When staff finds a resident, who is experience a cessation of circulatory and respiratory failure they will need to response with CPR if this is what the resident has choose to have done. It will be noted in the medical records and also noted on the emergency response clip boards located in 7 locations around the facility. It will also be noted on the name tag on the resident apartment door.			

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	...." On 4/29/24 at 1:25 p.m., the ADM provided a document, reviewed 11/22, titled, "Resident Code Status," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: The facility will observe the resident right to choose if they want to be a DNR or have CPR done. Procedure: 1. Upon admission to the facility the resident will choose if they want to be a DNR or have CPR. 2. Resident will sign the code status form and it will be filed in the Resident chart. It will also be noted on the POS sheet in the medical record and noted on our emergency response clip board. 3. When a resident move in or a current resident changes their status, staff will update the emergency response bag and make the changes in the resident medical records. 4. Resident door tags will be marked with their last name and a black dot to indicate a DNR ...." 410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review, and interview, the facility failed to ensure proper handwashing procedure during the medication administration pass for 6 of 9 residents observed for finger sticks (the procedure in which a finger is pricked with a lancet to obtain a small quantity of capillary blood for testing) (Residents 54, 56, 62, 106, 95, and 51). Findings include: On 4/26/24 at 10:30 a.m., the following was observed during the medication administration			
R 0414 Bldg. 00		R 0414	Handwashing Inservice's and Finger stick in-service will be held quarterly with the nursing staff year-round. The Director of Nursing or Administrator will monitor nurses doing hand washing / finger checks / gloves, a minimum of 6 finger sticks 5 days a week for 4 weeks, then a minimum of 6 finger sticks 4 times a week for 3 weeks, then a minimum of 6 finger sticks 2 times a week for 2 weeks, and a	05/17/2024

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	pass: 1. At 10:38 a.m., Licensed Practical Nurse (LPN) 12 performed a finger stick on Resident 54. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident. Resident 54's record was reviewed on 4/26/24 at 11:43 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition (when diabetes [a group of diseases that result in too much sugar in the blood] is caused by diseases such as cancer, pancreatitis, or nutrition deficiencies). 2. At 10:43 a.m., LPN 12 performed a finger stick on Resident 56. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident. Resident 56's record was reviewed on 4/26/24 at 11:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. 3. At 10:45 a.m., LPN 12 performed a finger stick on Resident 62. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident.		minimum of 6 finger sticks once a week. when this time frame is completed, random checks of observation will be our process monthly year-round moving forward to ensure practice is followed.	

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	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Resident 62's record was reviewed on 4/26/24 at 11:58 a.m. The profile indicated the resident's diagnosis included, but were not limited to, diabetes mellitus due to underlying condition. 4. At 10:56 a.m., LPN 12 performed a finger stick on Resident 106. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident. Resident 106's record was reviewed on 4/26/24 at 12:00 p.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus (a long- term condition in which the body has trouble controlling blood sugar and using it for energy). 5. At 11:00 a.m., LPN 12 performed a finger stick on Resident 95. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident. Resident 95's record was reviewed on 4/26/24 at 12:02 p.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus due to underlying condition. 6. At 11:08 a.m., LPN 12 performed a finger stick on Resident 51. The nurse was not observed washing her hands prior to or after the procedure nor did she put on gloves. After she obtained the resident's blood sugar level she proceeded to administer the insulin medication per insulin pen to the resident.			

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	Resident 51's record was reviewed on 4/26/24 at 12:06 p.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus. During an interview, on 4/16/24 at 11:28 a.m., the Director of Nursing (DON) indicated the staff should be wearing gloves and or washing their hands when performing finger sticks on the residents and during insulin administration. On 4/26/24 at 1:25 p.m., the DON provided and identified an undated document as a current facility policy, titled, "Handwashing Procedure." The policy indicated, " ...Key Procedural Points ...3. Before and after performing an invasive procedure (i.e. finger stick, blood sampling) ...14. When coming in contact with and after contact with residents intact skin ...."			