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	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR OF CASTLETON, LLC	8480 CRAIG ST INDIANAPOLIS, IN 46250

(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 Investigation of Complaint IN00417408. Complaint IN00417408-State deficiencies related to the allegations are cited at R148. Survey dates: September 25 and 26, 2023 Facility number: 009894 Residential: 130 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 3, 2023.	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 comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Camille Beeson	Executive Director	10/20/2023

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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	Based on observation, interview and record review, the facility failed to ensure the metal threshold strips to floors were kept in good repair for 2 of 5 residents' rooms and failed to establish and implement a written program for maintenance to ensure the continued upkeep of the metal threshold strips to residents' floors for residents' rooms being reviewed for physical environment. (Residents B and F) Findings include: 1. A complaint was sent to the Indiana Department of Health's redcap system regarding, in April 2023, Resident B had a metal threshold strip on her floor of her apartment between her carpet and bathroom linoleum, with a screw or nail sticking out of it. This issue was reported to maintenance. When the maintenance person finally came to repair the metal threshold strip, the screw or nail did not want to go down flush with the strip, so he hammered it down to the side, but it was not flush with the floor. Resident B struck it with her foot as she was walking into or out of the bathroom and took a chunk of her right great toe out. The metal threshold strip was not replaced by maintenance until August 2023, after Resident B was admitted to the hospital for amputation of the rest of her right great toe from a severe infection to the bone and several rounds of antibiotics during the months of April 2023 to August 2023. During an interview, on 9/25/23 at 2:35 p.m., the Maintenance Director with the Sales and Marketing Director in attendance, indicated he did not know anything about the metal threshold strip in Resident B's apartment. If it was loose and nailed down to fix it, in April 2023 or replaced in August 2023, his Maintenance Assistant must have done it and he no longer worked for the	R 0148	***R148 – Sanitation and Safety Standards - Deficiency*** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Resident B's apartments metal threshold strips were checked and repaired in April of 2023 and again in August of 2023 per the maintenance service request log. On the date of the survey visit Resident B's apartment was inspected and all strips were properly fastened down. ·Resident B's scraped toe from April 2023 was immediately addressed and was being followed by facility, residents PCP, Home Health, and Podiatry. ·Resident B also noted in May of 2023 that infection to great toe was cleared after 2 rounds of antibiotics. ·Resident B had infection to great toe that reoccurred in August of 2023. The resident had a history of infection in that toe and history of partial amputation to the same toe prior to living at the facility. ·Resident F's transition strip that was found loose on the date of the survey was immediately repaired and fastened back down. ·All facility apartments were inspected for loose metal threshold (transition) strips effective immediately during the	10/20/2023

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	company. During an interview, on 9/25/23 at 2:40 p.m., with the Maintenance Director and the Sales and Marketing Director in attendance, Resident B indicated ever since she moved into the apartment, she had a screw or nail in the metal threshold strip going from her bedroom carpet onto the bathroom linoleum, which was not flush with the strip and the floor. The Maintenance Assistant tried to hammer it down to be flush with the strip and the floor. She scraped her toe on it in April 2023, received a severe toe infection she fought with antibiotics until August 2023, then her right great toe was amputated. Approximately one week after her surgery, in August 2023, the Maintenance Assistant came to her apartment and replaced the metal threshold strip with a new one. She indicated "they" knew about the metal strip being like that since she moved into the apartment and did not fix it. She could not indicate who "they" were. She indicated the Maintenance Director was not the person who came to her apartment in April 2023 or August 2023 and worked on the metal threshold strip. The Maintenance Director indicated the metal threshold strip in Resident B's apartment going from her bedroom into the bathroom was a new metal strip. All the nails in the metal threshold strip were observed to be flush with the strip and floor. During an interview, on 9/25/23 at 3:00 p.m., with the Maintenance Director and the Sales and Marketing Director in attendance, the Maintenance Director indicated the residents' apartments with motorized wheelchairs and scooters were the apartments where the metal threshold strips were replaced or nailed back down the most because those chairs "rip" the		surveyor's visit and were ongoing until all had been inspected. **How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** ·All facility apartments were inspected for loose metal threshold (transition) strips effective immediately during the surveyors visit and were ongoing until all had been inspected. ·Any metal threshold strip found damaged or loose were repaired or replaced. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** ·The facility has created a metal threshold strip preventative maintenance plan. Metal threshold strips will be checked formally every other month. Any loose or damaged strips between that time will be entered as work orders and can be requested for repair by residents, families, or staff. Preventative Maintenance plan will be overseen by Maintenance Director or designee and will permanently remain in place. **How the corrective actions will be monitored to ensure the**	

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	strips up going across them at the speeds they go. The second floor was worse than the first floor because the first-floor metal threshold strips were nailed directly into the cement floors with dowl rods. The second-floor strips had to be nailed into the subflooring, so they were not anchored down to the floor as well. The facility did not have a plan as to a routine maintenance check for the metal threshold strips to check if they were coming up or not. He depended on the residents, nursing staff and housekeeping staff to notify the Maintenance department when they observed a problem with the strips, then the Maintenance department fixed the issue. On 9/26/23 at 11:00 a.m., work order sheets for the last six months were reviewed for any metal threshold strips, which may have been repaired. The work order sheets were provided by the Executive Director on 9/26/23 at 10:06 a.m. A work order was reviewed for Resident B for the metal strip between her bathroom and carpet. The description of the problem indicated "Stated she cut her foot on metal strip between bathroom and carpet?" The status indicated "completed." The assigned to section was blank. The start date was 4/7/23. The due date section was blank. The completed section was blank. According to the work order document, there was no way to indicate what date the metal threshold strip was repaired, what kind of repair was done to it, or how many times it was repaired. The 4/7/23 entry, was the only entry for the metal threshold strip concern for Resident B. There was no work order placed for the replacement of the strip in August 2023. 2. On 9/25/23 at 3:10 p.m., Resident F's apartment was observed with his permission with the Maintenance Director and the Sales and		**alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place?** ·The facility has created a metal threshold strip preventative maintenance plan. Metal threshold strips will be checked formally every other month. Any loose or damaged strips between that time will be entered as work orders and can be requested for repair by residents, families, or staff. Preventative Maintenance plan will be overseen by Maintenance Director or designee and will permanently remain in place. ·A Preventative Maintenance Plan Audit Tool for metal threshold strips has been developed. Audit tool will be completed monthly X6 monthly or until the deficient practice does not recur. ·The Executive Director will receive reports monthly regarding the results of such audits and will direct further action if required. **By what date will the systemic changes be implemented?** ·10/20/23	

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	Marketing Director in attendance. The resident was observed sitting in a chair with a power wheelchair in front of him. The metal threshold strip leading from the front room carpet onto the kitchen linoleum was observed to be loose on the right side. There was a drywall screw in the third hole, which was not flush with the strip and floor and in the fifth hole there was a nail, which was not flush with the strip and the floor. The guest hall bathroom metal threshold strip had a nail in the second hole, which was not flush with the strip and the floor and in the fifth hole there was a drywall screw, which was not flush with the strip and the floor. At that time, the Maintenance Director indicated the nails and drywall screws in both the metal threshold strips were not flush with the strip and the floor. Also, he indicated drywall screws should not have been used in those metal threshold strips. There were nails, which had a small nail head and were longer, which were to be used to nail down those threshold strips. The Maintenance Assistant must have placed those drywall screws in those strips because he had worked at the facility a long time and he did not do it. During an interview, on 9/26/23 at 10:06 a.m., with the Executive Director and Director of Nursing in attendance, the Director of Nursing indicated Resident F will ambulate a short distance in his apartment only such as from his electric wheelchair to the toilet. Depending on where he placed his electric wheelchair there was a possibility, he might have to walk over the metal threshold strip in between the bedroom and bathroom. On 9/26/23 at 2:15 p.m., a written maintenance program for facility upkeep (repairs) of items such as metal threshold strips were requested.			

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	On 9/26/23 at 2:52 p.m., at the time of exit, the Executive Director indicated there was no written maintenance program for facility upkeep (repairs) of items such as metal threshold strips. This State finding relates to Complaint IN00417408.			