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	08/23/2023

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

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R 0000 Bldg. 00	This visit was for Investigation of Complaints IN00412976 and IN00415413. Complaint IN00412976-No deficiencies related to the allegations are cited. Complaint IN00415413-State deficiencies related to the allegations are cited at R0064. Survey dates: August 22 and 23, 2023 Facility number: 009894 Residential: 144 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 30, 2023.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview and record review, the facility failed to ensure residents' money and checkbook was kept safe and secure during their admission for 3 of 4 residents being reviewed for misappropriation of property. (Resident C, E and D) Findings include:	R 0064	***R 064 Residents' Rights – Noncompliance*** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Associate in question was	09/15/2023

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

Camille Beeson | Executive Director | 09/15/2023

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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	During an interview, on 8/22/23 at 11:44 p.m., with the Executive Director (ED) and the Director of Nursing (DON) in attendance, the ED indicated on 8/16/23, Resident C brought to her attention Server 3 wrote a check out to herself and signed the back of it, for $200. Server 3 was working that day, so she was brought to the ED's office and questioned regarding the $200 check. She never admitted to doing it, but the ED and the DON pulled her employee file. The signature on the back of the check and the signature on the paperwork in her employee file were written the same way. She was terminated for theft at that time. At that same time, two other residents (Residents C and D) had cash, which came up missing, so they (the ED and DON) "assumed" Server 3 took the cash as well, since the missing cash happened around the same timeframe as the check being stolen. When Resident C was asked if she knew Server 3, he indicated he did not know her and there was no reason for a dietary person to be in his apartment. 1. On 8/22/23 at 1:56 p.m., the ED provided a copy of Resident C's check number 126 made out to Server 3 on the front of the check and her signature on the back of the check. The back of the check indicated the check was deposited by "Step Mobile Inc" on 8/6/23 at 9:13 p.m. On 8/22/23 at 1:56 p.m., the ED provided a copy of Resident C's check register for check number 126. The check cleared the bank and the $200 was taken out of his checking account on 8/8/23. On 8/22/23 at 3:00 p.m., Resident C was observed unlocking his apartment door and he invited the surveyor into his apartment to interview him. At that time, he indicated he had a check stolen by a		immediately pulled to office following check being brought to our attention and was immediately terminated. ·Facility completed a full background screen on associate prior to hire and background was clear. Theft is a bar on employment with Wyndmoor. ·Unusual Occurrence reporting was completed following discrepancies. Including notification of IDOH, Medicaid and APS. ·Investigation completed on reports of lost or stolen property and results of the investigation were reported to resident or responsible party. ·Interview of residents was completed and notification to responsible party was completed. Police were notified of incidents and case number was issued. ·Resident interviews were conducted to ensure no trend existed. ·Facility makes no representations or guarantees that we can prevent theft or other criminal acts perpetrated by another resident or person; therefore, we recommend that valuables such as money, not be kept at the Community. **How will the facility identify other residents with the potential to be affected by the same alleged deficient practice**	

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	server who worked at the facility. The date on the check was 8/6/23 and it was deposited on 8/8/23. He knew he did not write the check because it was check number 126 and the last check he wrote was check number 113, so he was skeptical about the $200 check, which was written and started investigating. He kept his checkbook in the drawer next to his bed. He did not eat his meals in his room and he went to the dining room to get his own food, so there was no reason for a server to be in his room. The servers have a master key to get into all the residents rooms to deliver the trays, so this was how she most likely got into his room. He locked his door whether he was in or out of his apartment. The record for Resident C was reviewed on 8/23/23 at 1:10 p.m. Diagnoses included, but were not limited to, liver disease, severe protein-calorie malnutrition, emphysema, and atherosclerotic heart disease of native coronary artery without angina pectoris. A handwritten progress note, written on 8/16/23 without a time, indicated Resident C reported the theft of one of his checks totaling $200. A progress note, written on 8/17/23 at 11:50 a.m., indicated Resident C reported seeing a check written to Server 3 and the money was pulled from his bank account. An investigation was started and it was discovered there was an employee whose name was the same as the name written on the check. 2. On 8/22/23 at 3:55 p.m., Resident E was observed unlocking her door and invited the surveyor in to her apartment to interview her. She indicated she went to the bank a week ago Thursday (approximately 8/10/23) and took out		**and what corrective action will be taken?** ·The community completed resident interviews to ensure they were not affected by the same alleged deficient practice. ·Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to abuse, neglect, or exploitation including misappropriation of property. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** ·Facility will continue to run background checks on new hires and theft will remain a bar on employment. ·Staff Education completed monthly on community Abuse, Neglect and Exploitation policy and will be ongoing. ·Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to abuse, neglect, or exploitation including misappropriation of property. ·Facility exercised reasonable care for the protection of residents' property from loss and theft by fully executing policies and procedures including but not limited to: Abuse, Neglect, &	

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	$100 from her bank account. She spent over $50 at the store leaving $49 and some change. On Friday 8/11/23, she noticed the change was missing. That Saturday, on 8/12/23, she took $140 out of the bank and she spent $57 at a grocery store and she spent $25 at two different pharmacies, leaving approximately $58 in change. On Sunday 8/13/23, she noticed her change from Saturday was missing as well. The change in cash, from both bank withdrawls, was in her purse in her bedroom. She left her door unlocked at times. There was no camera in her hallway. She indicated the ED informed her there was no camera in the hallway, which pointed to her apartment, so she could not view if someone entered her apartment or not. The recore for Resident E was reviewed on 8/23/23 at 1:40 p.m. Diagnoses included, but were not limited to, heart failure and osteoarthritis. A progress note, written on 8/16/23 without a time, indicated Resident E reported a possible theft. During an interview, on 8/22/23 at 4:17 p.m., the ED indicated the servers have to sign a master key out at the front desk during meal time, then return it after meal trays were delivered. The servers could use the master key to get into the apartments of the residents who could not get out of bed or have very little mobility and required assistance to get their food trays or answer the door. There was no camera in the hallway facing Resident E's apartment. 3. On 8/23/23 at 10:32 p.m., Resident D was observed being assisted into the private dining room with her rollator walker and a facility staff member. She indicated she went to the beautician to get her hair done and when she returned to her		Exploitation Policy, Personnel Policy, Unusual Occurrence Reporting Policy, Reportable Events Policy, and Grievance Procedure. Facility will continue to follow company policies. **How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place?** ·The facility will continue to run background checks on new hires. Any associate with findings on their record must be reviewed by the Executive Director or Designee to ensure it is not a bar on employment. Existing employees are required as stated in our employee handbook to report any new criminal actions taken upon them. ·Resident interviews will be conducted weekly X 1-month, Monthly X 6 months and ongoing with investigations or concerns related to abuse, neglect, or exploitation including misappropriation of property. ·A Resident Abuse, Neglect and Exploitation Interview Completion Audit Tool will be completed monthly to ensure community remains in compliance. ·The Executive Director will receive reports monthly regarding results of such audits and will direct further action if required.	

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	apartment to check her cash in her wallet, she discovered $80 in cash was missing from her wallet. She did not take her wallet to the beauty shop with her. She left her door unlocked at times when she left her apartment and did not have a specific place where she stored her wallet. The record for Resident D was reviewed on 8/23/23 at 2:00 p.m. Diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage, dementia, Parkinson's Disease, and unsteadiness on her feet. A progress note, written on 8/16/23 without a time, indicated Resident D reported a possible theft of $60 to $80. A document, titled "Personnel Action Form/Termination Wyndmoor of Castleton," dated 8/17/23, for CNA 3 indicated her last day worked was 8/16/23, she was not eligible for rehire, and she was terminated for misconduct. In the comment section was the word "Theft." A current document, titled "Residency Agreement" undated, provided by the ED on 8/22/23 on 12:59 p.m., indicated "...YOUR RESPONSIBILITIES AND REPRESENTATIONS...RIGHT OF ENTRY: For your safety and comfort, our associates must be permitted to enter your Suite to provide services under the terms of this Agreement, to respond to emergencies, to make repairs and improvements, or if there is reasonable belief that your safety or the safety of others is in question or that our policies and procedures are being violated, as we deem necessary or advisable. Therefore it is not permissible to change the locks or add additional locks to the entrance door to your Suite. When feasible, our associates will attempt to give you		**By what date will the systemic changes be implemented?** ·09/15/23	

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	reasonable notice before entering your suite...." A current policy, titled "Abuse, Neglect & Exploitation Policy," with an effective date of 1/1/23 and provided by the ED on 8/22/23 at 12:59 p.m., indicated "...Policy Detail: 1. Definitions...c. 'Exploitation' (Misappropriation of Resident's Funds or Property) is defined in Indiana as the patterned or deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 2. Parties Potentially Involved: a. Two or more residents. b. One or more resident (s), family member (s) and/or visitor (s) 3. One or more resident (s) and associates...5. Investigation: f. Employment Response Based upon Investigation Results: Based upon the results of its investigation, Wyndmoor may take such action as it deems appropriate with respect to the employment or contract status of the accused, up to and including termination of employment or the contract...." This State tag relates to Complaint IN00415413.			