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	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR OF PORTAGE, LLC	3444 SWANSON RD PORTAGE, IN 46368

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434795, IN00435357, IN00436019, IN00436226, and IN00436508. Complaint IN00434795 - No deficiencies related to the allegations are cited. Complaint IN00435357 - State deficiencies related to the allegations are cited at R0117 and R0217. Complaint IN00436019 - No deficiencies related to the allegations are cited. Complaint IN00436226 - No deficiencies related to the allegations are cited. Complaint IN00436508 - State deficiencies related to the allegations are cited at R0349. Survey dates: June 18 and 19, 2024. Facility number: 010889 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 21, 2024	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. The Wyndmoor of Portage desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective July 5, 2024.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and			

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

Zella Garron | Executive Director | 07/15/2024

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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	services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certificate for 6 of 16 shifts reviewed. This had the potential to affect 85 of 85 residents residing in the facility. Finding includes: Facility staffing schedules for 6/12/24 through 6/19/24 were reviewed on 6/18/24 at 10:00 a.m. The staff worked 12 hour shifts and the schedules indicated there were no staff members who were CPR certified on the following dates and shifts: Night shift (6 p.m. to 6 a.m.) on 6/12/24, 6/15/24, 6/16/24, 6/17/24, 6/18/24, and 6/19/24. During an interview on 6/19/24 at 10:39 a.m., the Administrator indicated she had provided all the staff CPR certificates she had. She had reached	R 0117	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Because all residents have the potential to be affected by the alleged deficient practice, the Business Office Manager has	07/05/2024

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	out to some night shift staff to see if they could provide their certification but had not received any more back yet. This citation relates to Complaint IN00435357.		identified all LPN's and QMA's who do not have current CPR certifications in their personnel files. Those staff members have completed a CPR course or have provided documentation of current CPR certification. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Business Office Manager has been in-service on CPR certification as it relates to scheduling and this rule. The BOM shall notify the Director of Nursing when staff are due to renew their CPR certification to ensure continued compliance and schedule adjustments as needed. Newly hired staff shall be required to provide proof of current CPR certification. Newly hired nursing staff who do not have CPR certification will only be scheduled on shifts with another CPR-certified staff member until they obtain CPR certification. How the corrective action(s) will be monitored to ensure the deficient	

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			practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee shall review the employee CPR Certification audit tool monthly for a minimum of 6 months to ensure ongoing compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate			

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	no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to update a Service Plan related to smoking for 1 of 3 residents reviewed for smoking. (Resident B) Finding includes: Resident B's record was reviewed on 6/18/24 at 11:58 a.m. Diagnoses included, but were not limited to, high blood pressure and chronic obstructive pulmonary disease. The current Service Plan indicated the resident was able to self-administer current medications, she had a mood problem, pain related to diabetic neuropathy, and diabetes mellitus. The Level of Care Evaluation, dated 4/8/24 at 3:13 p.m., indicated the resident was alert and oriented, capable of independent decision making, and did not smoke but had a history of tobacco use. There were no Service Plans related to the resident smoking. During an interview on 6/18/24 at 4:48 p.m., the Director of Nursing indicated the resident enjoyed smoking. The resident had not had any issues or broken any rules regarding smoking, but it should have been reflected on the Level of Care evaluation and the Service Plan that she was an active smoker in the facility. This citation relates to Complaint IN00435357.	R 0217	R217 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident service plan has been updated to indicate that she is a smoker. 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; Any resident who begins or ceases to smoke shall have their service plan reviewed and updated with appropriate interventions. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health and Wellness Director has been educated on reviewing and or updating the service plan of any resident who has a change in behavior, including smoking. All department heads have also been educated on timely reporting of observed resident behavioral changes during morning stand-up. During the routine Service Plan updates, the DON or designee shall also confirm and update the service plan for any behavioral	07/05/2024

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			changes, including the starting or cessation of smoking. 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 The Executive Director or Designee shall audit the service plan of any residents that have had a behavioral change, including smoking, using the Service Plan Audit Tool 4x per week for 4 weeks, 2x times per week for , then weekly for .	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to medications not signed out as administered for 1 of 3 records reviewed for medication administration. (Resident C) Finding includes: Resident C's record was reviewed on 6/18/24 at 10:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease, and bipolar disorder.	R 0349	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; How the facility will identify other	07/05/2024

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	The Senior Living Level of Care Evaluation, dated 6/14/24 at 12:14 p.m., indicated the resident was not always oriented to person, place, or time. She was not capable of independent decision making. She had a mental health history. A Physician's Order, dated 3/8/23, indicated the resident received insulin lispro solution 100 unit/milliliters, inject as per sliding scale (insulin given based on blood sugar result): 201 - 250 = 2 units, 251 - 300 = 3 units, 301 - 350 = 4 units, and 351 - 400 = 5 units. Notify the Physician if blood sugar is less than 60 or greater than 400. The May 2024 Medication Administration Record (MAR) was blank for the administration of insulin lispro on 5/13/24 at 8:00 a.m., 5/27/24 at 12:00 p.m. and 5/27/24, at 5:00 p.m. A Physician's Order, dated 5/23/24, indicated to give ciprofloxacin (antibiotic) tablet 500 milligram (mg) every day for two days. The May 2024 MAR was blank for the administration of the ciprofloxacin tablet on 5/23/24 through 5/25/24 at 5:30 p.m. A Physician's Order, dated 5/24/24, indicated to give diltiazem 90 mg tablet every morning for heart failure. The May 2024 MAR was blank for the administration of the dilitazem tablet on 5/24/24 through 5/27/24 at 8:00 a.m. A Physician's Order, dated 5/24/25, indicated divalproex 500 mg tablet three times daily for bipolar disorder. The May 2024 MAR was blank for the		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The DON or shall audit resident charts to ensure medication administration documentation is complete and accurate. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All nursing staff shall be in- on completing and accurately recording medication administration. 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 The DON or shall audit residents' charts using a clinical documentation audit tool 3 times a	

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	administration of the divalproex tablet on 5/24/24 through 5/27/24 for the AM medication pass, 12:00 p.m., and 9:00 p.m. During an interview on 6/18/24 at 4:06 p.m., the Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00436508.		week for four weeks then weekly for two months and monthly for three months.	