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	02/13/2023

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 IN00401336. Complaint IN00401336 - Substantiated. State Residential Findings related to the allegations are cited at R0044 and R0217. Survey date: February 13, 2023. Facility number: 010682 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 16, 2023.	R 0000		
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassandra Dixon	AIT	03/01/2023

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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	(A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D).			
	Based on interview and record review, the facility failed to ensure residents were prepared for and appropriately discharged for 2 of 3 residents reviewed for discharge (Resident B and Resident C). Findings include: 1. Resident B's clinical record was reviewed on 2/12/23 at 9:20 a.m. Diagnoses included mild cognitive impairment of uncertain or unknown etiology, insomnia, unspecified mental disorder due to known physiological condition, diffuse	R 0044	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practices. · An Immediate Discharge was issued to resident B and C due to the concern for the risk of harm to themselves and others due to knowledge that both residents were out that night and returned appearing high on illegal drugs.	03/01/2023

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	traumatic brain injury, intracranial injury, personality disorder, pseudobulbar affect, mood [affective] disorder, disorder of brain, nicotine dependence, and major depressive disorder, recurrent, moderate. His medications included donepezil (treat dementia)10 mg (milligram) daily, escitalopram oxalate (antidepressant) 20 mg daily, olanzapine (antipsychotic) 20 mg daily, trazodone (treat insomnia) 150 mg daily, carbamazepine (anticonvulsant) 400 mg twice daily and buspirone (antianxiety) 5 mg three times daily. A Senior Living Level of Care evaluation, dated 10/24/22, indicated he was oriented to person, place and time. He did not require assistance with re-direction and orientation, he was not capable of independent decision making. He ambulated independently. He was at risk for elopement. He was independent with smoking and did not require any adaptations. He currently used alcohol excessively or had a known history of alcohol abuse. He currently used illegal drugs or had a known history of i.e. marijuana, heroin, methamphetamines, cocaine, or other illegal drugs. The comments indicated his POA (Power of Attorney) and staff felt in some ways he showed signs and symptoms of cognitive/behavioral decline in past few months. This decline showed in occasional agitation/frustration, his lack of keeping apartment picked up, or picking up his used cigarettes after smoking, etc. A care conference note, dated 10/28/22 at 2:59 p.m., indicated a relationship status was discussed with female resident. Staff had observed ongoing excessive time spent between Resident B and a female resident. Staff and his POA had discussions with him about the		· Resident B consented to a drug screen upon return and tested positive for methamphetamines, cocaine, and THC. Resident C refused the drug screen stat ordered by his MD. · Resident B's family was in support of discharge and picked residents up and moved out his belongings. · Resident C willing left community by packing items and driving himself to live with a local friend. · The facility will continue to follow admission and discharge criteria as described in the Admission and Discharge Criteria Policy. 2. How the facility will identify other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken. · Administrator and DON will ensure proper screening process for all new admissions. Which includes any history of drug abuse. · Upon admission resident will be knowledgeable of signing in and out policies. 3. What measures will be put in place or what systemic changes in the facility will make to ensure that the deficient practice does not recur.	

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	relationship and he reported it was consensual, they were boyfriend and girlfriend. They occasionally had sexual relations. His POA was not surprised, and verbalized understanding of situation. His POA and the facility agreed to continue to monitor the situation. A nurses note, dated 1/5/23 at 5:59 p.m., indicated the NP (Nurse Practitioner) was notified of "the situation" with the resident that evening. A behavior note, dated 1/5/23 at 9:24 p.m., indicated staff had observed him in the dining room with his table mates. He walked up and hit another male resident in the upper left arm with a closed fist. Staff immediately separated him from the other resident and spoke with him about incident. Staff educated him the proper way to be around peers in the community and rules respecting other personal space. He did show remorse and stated he would never hurt one of his friends. He acknowledged he knew he'd done wrong and understood he was going to be on 15 minute checks to ensure the behavior did not continue. His family representative was notified and stated she would be at the facility first thing in the morning, as he had a neurology appointment in the a.m. A nurses note, dated 1/5/23 at 10:09 p.m., indicated the NP advised to continue to monitor him, since his behavior was not out of anger. If behaviors continued, they would talk about behavioral unit placement. She would follow up with him on Thursday of the next week. She would be in sooner if behaviors continued, and the facility was to chart and monitor all behaviors. An Indiana Notice of Transfer or Discharge form, dated 2/5/23, indicated he was discharged to a		· An Admission/Discharge audit tool will be created to ensure full compliance with Wyndmoor' s Admission and Discharge Criteria Policy. · The Audit Tool will be completed weekly X4 weeks then monthly x 2 months until the alleged deficient practice does not recur. 4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · An Admission/Discharge audit tool will be created to ensure full compliance with Wyndmoor' s Admission and Discharge Criteria Policy. · The Audit Tool will be completed weekly X4 weeks then monthly x 2 months until the alleged deficient practice does not recur. 5. By what date will these systemic changes be implemented? · 3/1/2023	

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	private residence (family member), due to the safety of individuals in the facility were endangered and the health of the individuals in the facility would otherwise be endangered. A Notice of Discharge, dated 2/5/23, indicated it was hand delivered to Resident B via the Administrator in Training (AIT) and they had made several attempts to meet his needs at the facility. Currently, they were sending this letter as their official immediate discharge notice for failure to comply with their facility sign in and out sheet and continuous behavior issues with staff and residents. They felt like their health and safety was in jeopardy. In accordance with Indiana Transfer and Discharge requirements, he was given notice to immediately to vacate the facility. This discharge would not be rescinded, as he had put the residents health and safety in jeopardy. A move-out/discharge note, dated 2/11/23 at 1:13 p.m., indicated he left the facility with a family member. A few items were still in his room they did not want to take with them. A late entry nurses note, created on 2/13/23 at 9:21 a.m., with the effective date of 2/10/23 at 11:03 a.m., indicated he was discharged after multiple attempts to comply with rules and safety of the residents and the facility. He had failed to sign in and out, and left the facility with another resident against his family member's rules for him not to be with this resident. A phone call was received from the charge nurse on Saturday night stating he was not in his room or the facility when doing checks. The DON got in her vehicle to look for him and was concerned for his safety and whereabouts due to the time of night. His family member, who was his POA, was notified. His family member			

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	went out and looked for him also. He returned around 5:30 a.m. the next morning. His eyes were bulging and he was sweating. When asked what he had been up to, he had admitted to being with the other resident and doing drugs. His family member wanted him tested for drugs and it was explained to her the facility could not do a drug screen without a doctor's order, but the family could, as they had a POA. She administered a home drug screen to the resident, which showed positive results for cocaine, methamphetamine, and THC (Tetrahydrocannabinol). The DON sent him out to the ER for evaluation and lab results were faxed to the facility with high levels of cocaine and THC found in his system. Concerned for the safety of others, he was given an immediate discharge. A nurses note, dated 2/13/23 at 4:47 p.m., indicated the NP (Nurse Practitioner) was notified of his discharge with his family member. During an interview with Resident B's family member, on 2/13/23 at 10:50 a.m., she indicated on Saturday 2/4/23 she had received a phone call at 10:00 p.m. and was asked if the resident was with her. He had been missing since 2:00 p.m. She didn't know why the facility would wait so long to contact her. She arrived at the facility at 11:00 p.m. She knew the vehicle Resident C drove, as they had left together one other time to go to some bars. She had spoken to Resident C, and told him not to take Resident B out, and so did the AIT. At 5:00 a.m., her son was dropped off down the road by two men and he walked to the facility. Resident C was not with him. He was acting strange and after some coaxing, he indicated he had been to a bar and then stopped at Resident C's friend's house. The AIT indicated to her she was sorry the resident had gotten mixed up with			

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	Resident C, and Resident C was going to be discharged from the facility. The AIT had known Resident C was an addict, and she would do better at screening the residents when she admitted them to the facility. She left the facility at 7:15 a.m. and went back home. At 9:00 a.m. she was called and told the facility was discharging Resident B. She had packed what she could in her car and had to move all his stuff out throughout the week, and by Saturday 2/11/23, she had everything moved from the facility. The paper she was provided indicated the reason for him being kicked out was failure to comply with the facility's sign in/sign out sheet and continued behavior issues. The resident's health and safety was at risk. She felt he needed redirected, at times he lashed out by getting mad and cussing, but he did not have behaviors. He was not a danger to anyone. When he came back to the facility after being out all night with Resident C, he was very calm. He independently went outside to smoke, and he knew the code to get out of the door to the facility and he would walk down to the gas station. He had never done anything like this before. She didn't know what she was going to do with him. She had been granted a 30 day unpaid leave from work until she could find placement for him. During an interview with the DON, on 2/13/23 at 11:32 a.m., she indicated she had received a call from the facility nurse around 10:00 p.m. on Saturday night (2/4/23). During rounds, they noticed that Residents B and C were not at the facility and neither of them signed out. Resident C's van was gone, and she tried to call and text him but he didn't answer. She was concerned about their safety and went out looking for them. Resident B's family member came to the facility and stayed until he got back to the facility around			

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	5:30 a.m. the next morning. Resident C was not with him. His eyes were big and bulging, he was sweating and shaking, and she asked what he had been doing. His family member had a drug kit on her and he tested positive for methamphetamine, cocaine and THC. The NP was notified and ordered to send him out to the ER. Resident C returned to the facility between 8:00 a.m. and 9:00 a.m. He was smirky. He was sweaty and shaky, but refused to go to the ER. He indicated he would be alright. She told him he needed to sign in and out, and they had been out looking for them. She hadn't really seen them hang out together in the facility, but they sat at the same table for meals and they both smoked. They both knew the code to go in and out of the facility. They thought they had left during shift change, between 2:00 p.m. and 3:00 p.m. on 2/4/23. It was not typical for Resident B to leave at night time. She never suspected Resident B to do drugs before, but she had heard he had been getting in trouble at work lately. During an interview with the AIT, on 2/13/23 at 11:59 a.m., she indicated on 11/3/22, she got a call from the facility to report Resident B and C missing from the facility. She drove around Marion by the local bars to find them. She called Resident B's family member and she indicated she would be on her way to the facility. While she was out looking for them, she passed Resident C's van on the bypass. She called Resident B's family member back and told her she found them. They indicated they went to Walmart, and then admitted they went to the bar. They were asked on admission to sign in and out of the facility so they knew where they were if there was an elopement or a fire. Resident C had a vehicle and he was independent. He had been asked not to take Resident B out again and not to drink and			

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	drive. Resident B, his family member and the AIT had a private conversation about making good choices, and about signing out when he smoked and went to work. Then on 2/4/23, she received a call from the facility nurse to report both the residents were gone and they did not sign out. They were last seen around shift change at 2:00 p.m. Resident B showed up around 5:30 a.m. Sunday morning, and he indicated two men dropped him off near the facility. He had gone to someone's house and smoked crack cocaine, methamphetamine, and marijuana. His family member administered a drug test the facility gave to her and he tested positive for cocaine, methamphetamine, and marijuana. He was sent to the ER. Resident C came back around 7:00 a.m. The NP ordered a drug screen and he refused. He was joking around and was not very forthcoming. He was two months behind on rent, he did not sign in or out, and he was asked to get his belongings. He was discharged to the community. He had a friends in the community and was encouraged to look at VA housing. Resident B was also discharged on 2/5/23 for behavioral issues and putting himself and other residents in danger. He had behaviors of a well documented relationship with an older lady, fist bumping, and he had hit a resident in the shoulder. He didn't think he was being aggressive, but they had to keep others safe. She couldn't control what he did when he left the facility, but could when he returned. She didn't have time to babysit him when he was out of the building, and his condition had progressed. Her supervisor advised her she needed to get them out of the facility ASAP, due to the health and safety of residents. The residents were in danger with them being here. Resident C had not had any behaviors beside these incidents, but he knew how to work people. She tried to help him but he didn't want to			

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	help himself. During an interview with LPN 17, on 2/13/23 at 2:02 p.m., she indicated she was used to seeing Resident B in the halls, and then half-way through the shift, she hadn't seen either of the residents. She asked the CNAs if they had seen them. She checked the sign out log and neither signed out or in. She waited a little longer, then she got quite concerned. Resident B's family member was very active in his life so she called and asked her if he was with her. She didn't know if Resident B and C were together, she just knew they were both gone. Resident B's family member was very clear and had told Resident C not to take Resident B anywhere out of the facility. She left at 3:00 a.m., and neither of the residents were back to the facility. Resident B was normally easy going and he had a job. But he had started having problems and was about to lose his job, due to things like saying f-you to his co-workers. 2. Resident C's clinical record was reviewed on 2/13/23 at 10:30 a.m. Diagnoses included spinal stenosis, nicotine dependence, cigarettes, and unspecified cirrhosis of liver. His medications included methocarbamol (muscle relaxant) 1500 mg three times daily and gabapentin (treat nerve pain) 600 mg three times daily. A Senior Living Level of Care Evaluation, dated 10/25/22, indicated he was oriented to person, place and time. He did not require assistance with re-direction and orientation. He was capable of independent decision making. He used an ambulatory device independently. He was independent with smoking and did not require any adaptations and he had a known history of tobacco use. He currently used alcohol			

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	excessively or had a known history of alcohol abuse. He currently used illegal drugs or had a known history of i.e. marijuana, heroin,methamphetamines, cocaine, or other illegal drugs. He was not at risk for elopement. A note from the eMAR (electronic Medication Administration Record), dated 11/12/22 at 6:47 a.m., indicated a behavior was observed. A behavior note, dated 11/12/22 at 7:43 a.m., indicated he remained on positive COVID monitoring. He came out of the elevator on the main floor and was redirected to return to his room. He became angry, started yelling and cursed at two staff members that he came downstairs to test. He was redirected and told he would need to stay in his room for the five day isolation period. He complained that he was in pain and he had not received his pain pill. He was educated that his pain medication was PRN (as needed). The outcome/summary was once he received his pain medication, he was content and pleasant with staff. A note from the eMAR, dated 11/14/23 at 8:53 a.m., indicated a behavior was observed. A nurses note, dated 11/14/22 at 7:20 p.m., indicated he took himself to the emergency room (ER). He stated he had COVID-19 and pain and he wanted to be looked at. He had been administered PRN medication and he still took himself to the ER. He refused to wait for his paperwork. He returned with no new orders. The ER stated that COVID-19 had to run its course, there was nothing they could do about it, and they refused to give him anymore pain medications. A note from the eMAR, dated 12/14/22 at 5:53			

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	p.m., indicated a behavior was observed. A nurse note, dated 12/14/22 at 4:09 p.m. indicated he refused his shower because the CNA would not take her clothes off and assist him. A nurses note, dated 12/14/22 at 4:07 p.m., indicated the CNA asked him if he was ready for her to stand by and assist him with his shower. He stated if you take your clothes off, so they didn't get wet. The CNA educated him she would not take her clothes off and he was being inappropriate. He continued to make comments. A pain clinic telephone encounter, dated 12/27/22 at 10:04 a.m., indicated the lab obtained on 11/29/22 was positive for cocaine. He was discharged from the pain clinic on 12/27/22. A nurse note, dated 1/17/23 at 12:23 p.m., indicated the pharmacy was notified his oxycodone (pain reliever) needed filled. The pharmacy representative indicated he needed a new prescription. The pain clinic was notified and the nurse stated he was discharged due to his urine results. An Indiana Notice of Transfer or Discharge form, dated 2/5/23, indicated he was discharged to the community, due to the safety of the individuals in the facility was endangered and the health of the individuals in the facility would otherwise be endangered. A Notice of Discharge, dated 2/5/23 indicated it was hand delivered to Resident C, via the AIT. They had made several attempts to ask for his participation in not taking the resident out of the facility to go drinking or participate in illegal activity. Currently, they were sending him this			

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		A. BUILDING 00 B. WING	02/13/2023

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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	letter as their official immediate discharge notice from the facility for failure to comply with their request to not participate in taking residents out of the facility to participate in alcohol and drug behaviors, refusal of a drug screen by doctor order, and refusing to follow the sign in and out policy of facility. In accordance with Indiana Transfer and Discharge requirements, he was given notice to immediately vacate the facility. This discharge would not be rescinded as he had put residents' health and safety in jeopardy. A nurses note, dated 2/10/23 at 1:06 p.m., indicated the pain clinic was called and a request was made for the results of his urine toxicology screening. Results were received and scanned into the electronic chart. A nurses note, dated 2/10/23 at 1:48 p.m., indicated staff discovered he had not signed out several times in November of 2022. Reviewed sign in and out policy and educated him on the importance of signing in and out on 12/12/22 and he voiced understanding. A nurses note, dated 2/10/23 at 2:01 p.m., indicated he was spoken with about the discharge from the pain clinic. He stated if he didn't get narcotics, he would seek other alternatives on the street. He was educated on safety and importance of why it wouldn't be in his best interest. He stated he had to do what he had to do. The NP was notified. A nurses note, dated 2/10/23 at 2:06 p.m., indicated the DON was notified at home by facility staff at 10:00 p.m. of Resident C being out of the facility. When they did checks, they looked outside and his vehicle was gone. They checked the sign in and out sheet, he had not signed out.			

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	They made multiple attempts to call and text him on his phone, and he never responded. The DON drove around to different locations to look for him with no success. His PCP (Primary Care Provider) was notified of the incident. The resident returned to the facility around 9:00 a.m. the following morning. The DON was on duty, met him at the door, and inquired where he had been all night. Upon talking to him, he began to sweat and shake. He stated he was ok and refused to go to the ER. He appeared to be under the influence, based upon him being discharged from the pain clinic back in December for drug use. The DON obtained a drug screen order from the NP and notified the AIT. An attempt was made to drug screen him. He was educated and it was explained he had the right to refuse, but the NP had given the order to have it done. He still refused. He stated he would just leave. The AIT was made aware. He was discharged to the community and given advice on the Veteran's community. He gathered his belongings and stated he would be going to friend's house. A move-out/discharge note, created on 2/13/23 at 9:25 a.m., with the effective date of 2/13/23 at 8:22 a.m., indicated his move-out date/time was 2/5/23 at 12:00 p.m. to a friend's home. He gathered his belongings, packed them in his van, and left. A nurses note, dated 2/13/23 at 4:33 p.m., indicated the NP was notified of his discharge from the facility to the community friend's house. During an interview with Resident C, on 2/13/23 at 10:27 a.m., he indicated Resident B wanted a ride and took off the same time he did, but they were not together on 2/4/23. There was one time when he first moved into the facility when he took Resident B with him so he could help move the			

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	rest of his things to the facility. They went to Greentown to find someone with a trailer. They did go to the bar, but it was to find someone with a trailer. They couldn't find anyone, so they came back. He had asked the AIT if it was ok to take Resident B with him, and she told him it was okay. On Sunday, 2/5/23, he had no money, and they kicked him out. He was staying with one of his buddies. He didn't do drugs, but everyone at the facility thought he did. The last night he was here, he went by his buddy's house to drink beer and didn't want to drive home. He could come and go as he wanted to, and he came back around 7:00 a.m. The AIT asked if he was with Resident B, he told her no. They asked him to take a drug test and he refused, so they kicked him out. He was aware he was supposed to sign out, but forgot. He didn't go out that much. He paid rent at the facility, so they knew he was going to come back. A 7/1/10 revised, facility policy titled "Sign-in/Sign-out Book," provided by the AIT on 2/13/23 at 2:37 p.m., indicated the following: "...Policy Detail...2. Residents, visitors, and third party providers should sign in/sign out each time they enter or exit the building. 3. If a resident is not in the community and is not signed out, or has not returned at the appointed time, the "Missing Resident" Policy should be initiated...." A 7/1/03 revised, facility policy titled "Admission/Discharge Criteria Policy," provided by the AIT on 2/13/23 at 9:51 a.m., indicated the following: "...4. Discharge Notice: A resident being asked to relocate from the community will be given notice in accordance with the Residency Agreement. The community will issue the state prescribed Notice of Transfer and Discharge and Request for Hearing as outlined per state regulations...."			

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	The Licensed Residential Care Community Lease and Admission Agreement for the facility, indicated the following: "...I. Relocation and Early Termination of Agreement...C. Termination by Lessor...Lessor shall provide Resident with thirty (30) days prior written notice of Lessor's intent to terminate this Agreement early unless, in Lessor's judgement, a full such thirty (30) days creates an additional risk of harm to Resident or others, in which case Lessor may terminate earlier than the normal thirty (30) days, as conditions require, and Lessor shall consult with Resident's physician in making such determination. Lessor's written notice shall include those items required by Indiana statue...." This state residential finding relates to complaint IN00401336.			
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			

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	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 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 interview and record review, the facility failed to develop a service plan for 1 of 3 residents reviewed for service plans (Resident C). Findings include: Resident C's clinical record was reviewed on 2/13/23 at 10:30 a.m. Diagnoses included spinal stenosis, nicotine dependence, cigarettes, cirrhosis of liver, psoriasis, atrial flutter, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, vitamin D deficiency and chronic obstructive pulmonary disease. His medications included methocarbamol 1500 mg three times daily, gabapentin 600 mg three times daily, lisinopril 10 mg daily, apixaban 5 mg twice daily, naproxen 500 mg twice daily, and metoprolol tartrate 25 mg twice daily. He admitted to the facility on 10/25/22. The clinical record lacked a service plan for the resident. During an interview with the DON, on 2/13/23 at 1:57 p.m., she indicated his service plan should had been developed at his admission to the	R 0217	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practices. · All Nursing Staff were educated on Wyndmoor's Service Plan Policy. · All Current Resident Service plans were reviewed and are in place. 2. How the facility will identify other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken. · All Current Resident Service plans were reviewed and are in place. · Administrator and/or DON will monitor all service plans upon admission, every 6 months, and or upon change of condition to ensure compliance.	03/01/2023

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	facility. A 4/2015, revised facility policy, titled "Resident Service Plan," provided by the AIT (Administrator in Training), on 2/13/23 at 2:21 p.m., indicated the following: "...Policy Detail: 1. An initial Service Plan will be developed on admission/move in. The Service Plan will be completed and reviewed by the community care team and the resident/legally responsible party within 30 days after move-in of the resident or as required by state regulations...." This state residential finding relates to complaint IN00401336.		3. What measures will be put in place or what systemic changes in the facility will make to ensure that the deficient practice does not recur. · Administrator and/or DON will run monthly Service Plan report to ensure all service plans are updated and make sure they are in compliance with state standards and company policy. 4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · A Service Plan Audit Tool will be created. Administrator and/or DON will audit all service plans monthly to ensure compliance. 5. By what date will these systemic changes be implemented? 3/1/2023	