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	06/23/2021

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 a State Residential Licensure Survey. Survey dates: June 22 and 23, 2021 Facility number: 010889 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/25/21.	R 0000		
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment in the kitchen for 1 of 1 kitchens observed. This had the potential to affect all 40 residents who received food from the kitchen. (The Main Kitchen) Finding includes: On 6/22/21 at 9:15 a.m., the kitchen floor and walls underneath the dishwasher were observed to have debris, old food on the floor, and a dark yellow/green substance on the walls. Interview with the Dietary Manager on 6/22/21 at 9:35 a.m., indicated the floors were cleaned every	R 0154	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will	08/02/2021

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

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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	night by the kitchen staff that closed the kitchen for the night. She was unable to get under the dishwasher area to clean the debris off of the walls and was unaware on which chemical to use to remove the substance from the walls. Interview with Administrator in Training on 6/22/21 at 12:15 p.m., indicated the Dietary Manager's position was to make sure the kitchen and the kitchen equipment was kept clean and sanitized.		continue to make changes and improvement to satisfy the objective. Dietary manager and staff inserviced on kitchen sanitation regarding walls floors and under the dishwasher with EPA approved products. Floors to be cleaned professionally twice a year with next scheduled visit on 7/22/2021. Dietary manager to audit and keep daily log of sanitation checklist. Dietary staff to complete checklist each shift indefinite. Dietary Manager and AIT/LPN will audit weekly to ensure checklist is complete.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure Service Plans were reviewed and revised after a condition change for 1 of 7 records reviewed. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 6/22/21 at 2:29 p.m. Diagnoses included, but were not limited to, Multiple Sclerosis, major depressive disorder, repeated falls, and stress incontinence.	R 0214	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our	08/02/2021

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	Nurses' Notes, dated 1/8/21 at 8:57 a.m., indicated the resident was being quarantined due to having a positive COVID-19 test on 1/7/21. Nurses' Notes, dated 1/9/21 at 1:32 p.m., indicated the resident was having hematuria (blood in the urine) and scant urination. Orders were received to send the resident to the emergency room for evaluation. She returned to the facility with a diagnosis of urinary tract infection (UTI) and orders for an antibiotic. The current Service Plan had not been revised related to the resident having COVID-19 and a UTI. Interview with the Health and Wellness Director on 6/23/21 at 4:20 p.m., indicated the resident's Service Plan should have been updated to reflect her changes in condition.		ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. Director of nursing has been inserviced on annual service plans and change of condition service plans. All residents service evaluation plans have been evaluated and reviewed and sent to POA and self POA for review and signature. Director of nursing and nursing staff have been educated on when to update service plans due to change of condition. Director of nursing and AIT to audit service plans and change of conditions weekly for six months to ensure all nursing staff is current with change of conditions.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to obtain contracted services to provide wound care for 1 of 2 residents reviewed for skin care. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 6/22/21	R 0240	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of	08/02/2021

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	at 1:19 p.m. Diagnoses included, but were not limited to, type 2 diabetes, fractured femur, fusion of lumbar region of the spine, and hypertension. The resident was admitted to the facility on 5/29/21. A Physician's Order, dated 5/30/21, indicated the resident's left buttock was to be cleansed daily with wound wash and the area was to be patted dry. Hydrocortisone cream was to be applied to the left buttock and Santyl (a debriding agent) ointment, nickel thick, was to be applied to the wound bed and the area was to be covered with an ABD pad and secured with tape. Nurses' Notes, dated 5/29/21 at 6:18 p.m., indicated the resident arrived to the facility at 9:35 a.m. She was observed with two open areas. The left buttock measured 1 centimeter (cm) x 0.9 cm and the side of the left buttock measured 1.8 cm x 0.4 cm x <0.1 cm. Nurses' Notes, dated 5/31/21 at 3:49 p.m., indicated a skin assessment of the left buttock revealed a stage 3 pressure ulcer (full thickness skin loss) that had an order to be cleansed and a Santyl dressing applied. The procedure had been completed as ordered. Nurses' Notes, dated 6/2/21 at 2:22 p.m., indicated the resident's dressing to the left buttock had been changed. The resident had an HMO and a second agency had been referred to see if they could care for her wound. There was no further documentation in the record indicating any attempts to obtain contracted wound care services. The May 2021 Treatment Administration Record (TAR), indicated the treatment had been signed		deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. All nursing staff inserviced on their scope of practice regarding wound care. EMAR will be audited twice weekly for eight weeks per Director of nursing, then weekly for six months to ensure proper documentation is provided. DON inserviced to audit new admission orders within 24hours to ensure all proper services are arranged for new admissions. DON inserviced to monitor nursing staff to ensure all follow up is completed.	

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	out as ordered on 5/31/21. The June 2021 TAR, indicated the treatment had been signed out daily through 6/23/21 except for 6/3 and 6/9/21. Interview with the Health and Wellness Director on 6/23/21 at 10:30 a.m., indicated nursing staff were completing the treatment as ordered due to the resident being denied previous home health services, but they would attempt again to find contracted services for wound care.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) was initiated for an unresponsive resident for 1 of 2 closed records reviewed. (Resident 8) Finding includes: The closed record for Resident 8 was reviewed on 6/23/21 at 9:00 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, persistent mood disorder, major depressive disorder, anxiety, and stroke. The resident passed away at the facility on 6/8/21. A Physician's Order, dated 11/5/18 and listed on the June 2021 Physician's Order Summary (POS), indicated the resident's advance directive was a	R 0241	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and	08/02/2021

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	full code. Nurses' Notes, dated 6/8/21 at 3:13 a.m., indicated the CNA had completed a check and change on the resident at 11:30 p.m. The resident was "ok", provided incontinence care and then she went back to sleep. The CNA was rounding at 2:15 a.m., and the resident was expired. The nurse was notified and the resident was assessed with no pulse present. 911 was called and they directed the facility to contact the coroner. Report was given to the coroner. The resident's Physician, Power of Attorney (POA), and the funeral home were notified. There was no documentation indicating that CPR had been initiated when the resident was found unresponsive. Interview with the Administrator in Training (AIT) on 6/23/21 at 10:30 a.m., indicated staff had called her and told her about the resident. She instructed the staff to call 911. When 911 was contacted and given the resident's status, they instructed staff to contact the coroner. The AIT indicated the resident was already "gone" so that was why CPR was not initiated. Interview with the Health and Wellness Director on 6/23/21 at 11:45 a.m., indicated the CNA should have gotten help and CPR started when the resident was first found. Interview with the AIT on 6/23/21 at 3:00 p.m., indicated the CNA who had found the resident unresponsive was CPR certified.		improvement to satisfy the objective. All staff was re-educated on CPR policy and procedure. New employed staff will be CPR first aid certified upon hire and current employees kept current with renewal of certification. Facility room roster has been updated with resident's code status for staff to be informed during each shift. Resident code status will be audited and updated if any changes monthly per Director of nursing for 12 months to ensure all resident's status is current and verified.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the			

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	medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure a resident was administered insulin as ordered. The facility also failed to notify the Physician based on blood glucose parameters for 1 of 1 residents reviewed for insulin use. (Resident 6) Finding includes: Resident 6's record was reviewed on 6/23/21 at 10:10 a.m. Diagnoses included, but were not limited to, diabetes mellitus. The June 2021 Physician's Order Summary (POS) indicated to inject Trulicity Solution (injectable insulin to help control blood sugars) 1.5 milligrams subcutaneously (under the skin), weekly on Saturdays. Novolin R Solution (a fast acting insulin) was to be injected as per the sliding scale of: - If blood sugars were 0-199, no insulin was to be given; 200-250 give 5 Units; 251-300 give 6 Units; 301-350 give 7 Units, and notify the Physician if blood sugars were below 60 and over 351. The sliding scale insulin was to be given before meals. The June 2021 Medication Administration Record (MAR), lacked an indication the Trulicity was administered as ordered on 6/19/21. On 6/15/21 at 12:00 p.m., the residents blood sugar was 397. On 6/16/21 at 12:00 p.m., the resident's blood sugar	R 0243	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. All nursing staff inserviced on policy and procedure for blood glucose and insulin administration. Orders and EMAR audited and reviewed to ensure blood glucose parameters are documented accurately with MD notification if blood glucose out of range. EMAR audited to ensure insulin administration with proper documentation. DON to audit EMAR three times weekly for	08/02/2021

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	was 394. There was no documentation indicating the Physician had been notified of the blood sugars greater than 351. There was also no documentation indicating the resident's Novolin R insulin had been administered on 6/15 and 6/16/21 at 12:00 p.m. The MAR was coded with an "11" on 6/15 and 6/16/21. Interview with the Health and Wellness Director on 6/23/21 at 1:30 p.m., indicated the "11" was a code for no sliding scale required. She also indicated the Physician should have been notified of the blood sugars greater than 351 to determine what dose of sliding scale insulin should have been given.		eight weeks then twice weekly for eight weeks then weekly for three months. Plan of correction will be reviewed to see if further auditing is needed.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was stored under safe and sanitary conditions related to foods and drink not being used by the use by date. The facility also failed to maintain a sanitary and clean environment related to lack of hand hygiene, improper storage of left over foods, not testing the low temperature/chemical dishwasher for the correct chemical concentration, and storage of dented cans for 1 of 1 kitchens. This had the potential to affect the 40 residents who resided in the facility and were served food from the kitchen. (The Main Kitchen) Findings include: 1. During the initial tour of the kitchen, on 6/22/21	R 0273	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and	08/02/2021

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	at 8:55 a.m., the following was observed: a. Cranberry juice was observed in a pitcher with a "use by" date of 6/21/21. b. The Dietary Manager was observed to use the same gloved hand while plating breakfast foods. She picked up a plate from the center, placed sausage on the plate, saran wrapped the plate, placed the plate in the microwave oven, touched the buttons to heat the sausage, cleaned the food thermometer with a probe wipe, removed the sausage from the microwave, checked the temperature of the sausage and plated the sausage in 3 styrofoam boxes. She did not change gloves or perform hand hygiene in between tasks. 2. The kitchen refrigerator was observed with the Dietary Manager on 6/22/21 at 9:15 a.m., foods were not stored in their original containers and were still in use after the "use by" dates on the container. The kidney bean salad had a use by date of 6/19, applesauce had a use by date of 6/19 and jello had a use by date of 6/17/21. Interview with the Dietary Manager at that time, indicated the food should have been discarded. 3. During an observation with the Dietary Manager of the dishwasher, on 6/22/21 at 9:30 a.m., the wash cycle was 133 degrees Fahrenheit and the rinse cycle was 128 degrees. She indicated it was a low temperature/chemical dishwasher. She also indicated she was not aware she had to use a test strip to check for the chemical concentration. 4. During an observation of the dry storage room with the Dietary Manager on 6/22/21 at 9:40 a.m., two 108 ounce cans of navy beans and three 105		improvement to satisfy the objective. Dietary manager and staff inserviced on policy/procedure on proper glove use during meal preparation/serving. Dietary manager and staff inserviced on policy/procedure proper labeling/storage dates of food, drink. Dietary manager and staff trained on chemical test strip for dishwasher. Dietary manager and staff inserviced on handwashing in kitchen services and inserviced on receiving dented products and the procedure of discarding dented merchandise. Dietary manager will audit kitchen staff daily with proper glove usage and changing of gloves for sixty days with review to see if further auditing needs to continue. Dietary manager and staff will audit food storage/dates three times weekly for one month then weekly for a month with review to see if further auditing needed. Dietary manager and staff to chemical strip test dishwasher daily this will be ongoing log. Dietary manager and staff to weekly audit delivery of goods to facility and audit dry storage room and will return or dispose of dented products per policy/procedure. Audit to be weekly for six months with review to see if auditing to continue.	

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	ounce cans of carrots were dented. Interview with the Dietary Manager at that time, indicated she still used the dented cans, due to she was the one that dropped them. She was not aware that she could not use the dented cans. Interview with the Administrator in Training (AIT) on 6/22/21 at 12:15 p.m., indicated the Dietary Manager's position was to know how to properly store foods and liquids after opening, hand hygiene while plating food, to use a test strip to check the chemical concentration of the low temperature/chemical dishwasher and to not use dented cans due to possible spoilage of the food. The facility policy titled, " Labeling and Dating for Safe Storage of Food," was provided by the AIT on 6/22/21 at 12:15 p.m. The current policy indicated, "...Policy Overview: Labeling and Dating are critical in order to promote food safety. All products should be dated upon receipt. Use 'use-by-dates' on all food once opened and stored in refrigeration. Policy...E. When food is taken out of an original container write the name of the food being stored on the container and the use by date....." The facility policy titled, "Hand washing," was provided by the AIT on 6/22/21 at 12:15 p.m. This current policy indicated, "Policy: This policy is to enforce hand washing procedure as part of infection and control planning...Hand washing will be performed; Before, during and after preparing food...."			
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			

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	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 observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to oxygen use and monitoring oxygen saturation for 1 of 7 records reviewed. (Resident 5) Finding includes: On 6/22/21 at 11:30 a.m., an oxygen in use sign was observed on Resident 5's door. A oxygen concentrator was observed in the resident's room and was set at 2 liters per minute. A large oxygen tank was also observed in the room. Interview with Resident 5 on 6/22/21 at 11:30 a.m., indicated she only used the oxygen sometimes. Resident 5's record was reviewed on 6/22/21 at 10:30 a.m. Diagnoses included, but were not limited to, bipolar disease. The June 2021 Physician's Order Summary (POS), indicated there was no order for the resident's oxygen. The resident's oxygen saturation (oxygen levels in the blood) was to be monitored twice a day and she was to be sent to the emergency room if her saturation was below 90%. The April, May and June 2021 Medication Administration Records, indicated the oxygen saturations were not monitored as ordered.	R 0349	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. All nursing staff inserviced on receiving orders with monitoring prompts such as Temperature O2 SAT Blood pressure etc. All orders will be reviewed to ensure any monitoring orders have prompts in EMAR to ensure that it is documented. All new orders will be audited per DON and AIT to ensure they are submitted in EMAR correctly. Audit of orders will be twice weekly for four weeks then weekly for six months.	08/02/2021

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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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	Interview with the Health and Wellness Director on 6/22/21 at 2:50 p.m., indicated the hospital had to have ordered the oxygen and had it delivered before the resident was discharged from the hospital. The orders for the oxygen and monitoring of the oxygen saturations were not put into the computer correctly.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction, incomplete staff and visitor screening, and touching pills with bare hands for 1 of 5 residents observed during medication administration. (Residents 2 and 9, LPN 1 and Dietary Aide 1) Findings include: 1. Upon entering the facility on 6/22/21 at 8:40 a.m., the Activity Director checked the surveyors temperatures and instructed them to sign the	R 0407	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and	08/02/2021

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	visitation log. The surveyors were not asked any COVID-19 screening questions. On 6/23/21 at 8:30 a.m., the surveyors entered the facility. Again, their temperatures were checked and they were asked to sign the visitation log. No COVID-19 screening questions were asked. An open binder was observed on the table. The binder contained "Visitor Fit for Duty" screening sheets. Interview with the Administrator in Training (AIT) and the Health and Wellness Director on 6/23/21 at 3:30 p.m., indicated all visitors should have their temperatures checked and the visitor screening sheets were to be completed. The Long Term Care Facilities Guidelines in Response to COVID-19 Vaccinations, updated on 6/1/21, indicated "screening must occur for all who enter the facility; (e. g. visitors, vendors, and staff) for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)." 2. During a random observation on 6/22/21 at 12:35 p.m., Dietary Aide 1 was observed checking her own temperature. The Dietary Aide indicated she screened herself by checking her temperature and filling out the employee screening form. When asked what she would do if she was running a temperature or entered a negative response for one of the screening questions, the Dietary Aide indicated she was new and she didn't know what she would do. She also		improvement to satisfy the objective. All staff inserviced on handwashing per policy and procedure and proper use of mask while working in the facility. All staff instructed on policy of non vaccinated residents and the requirement of face mask while in the presence of vaccinated residents. All staff instructed of their requirement to wear face mask at all times while in the facility. All staff inserviced on the COVID-19 screening procedure for visitors and staff entrance to facility. All staff retrained on entrance screening per AIT/LPN also instructed not to screen self per entrance. Education provided on vaccination for those resident's families and employees who are not vaccinated. AIT/LPN to monitor all staff COVID-19 screening weekly for six months. Residents will be monitored daily per staff regarding facemask until all residents have been fully vaccinated.	

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	indicated she wouldn't come to work if she was sick. Interview with the Administrator in Training and the Health and Wellness Director on 6/23/21 at 3:30 p.m., indicated staff should not be screening themselves. They also indicated the Dietary Aide would be inserviced on the screening procedure. 3. During a random observation on 6/22/21 at 9:20 a.m., Resident 2 was observed ambulating throughout the facility. The resident was not wearing a mask at that time. Four residents were seated in the lounge area. None of the residents were wearing masks. Interview with the Administrator in Training (AIT) at that time, indicated all four residents in the area had been vaccinated for COVID-19. She also indicated 37 of 40 residents residing in the facility had been vaccinated for COVID-19. At 9:23 a.m., Resident 2 entered the lounge area and sat down with the residents. The AIT indicated at that time, Resident 2 had not been vaccinated for COVID-19. The AIT indicated all of the residents in the area should have been wearing masks since the resident was not vaccinated. At 9:35 a.m., twelve residents were in the main dining room waiting to play bingo. Three residents were not wearing masks and some of the residents had their masks pulled down below their noses. The Activity Director did not tell the residents to pull up their masks. When asked at the time if everyone in the dining room had been vaccinated, the AIT indicated Resident 9 had not been. Resident 9 had her mask pulled down and resting on her chin. The AIT			

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	indicated all residents in the dining room should be wearing their masks due to the resident not being vaccinated. At 11:10 a.m., Residents 2 and 9 were observed in the lounge area with their masks pulled down around their chins. One other resident was also in the area. Staff did not redirect the residents to pull up their masks. On 6/23/21 at 10:45 a.m., Residents 2 and 9 were participating in an activity in the lounge area with other residents. Both residents had their masks pulled down and resting on their chins. The Activity Director did not tell the residents to pull their masks up. The Long Term Care Facilities Guidelines in Response to COVID-19 Vaccinations, updated on 6/1/21, indicated "The core principles of infection prevention should be the guiding principles for any activity that directly relates to the health and safety of the individual residents as we move toward more activities as a response to vaccinations in the communities. For services and activities that have all fully vaccinated residents involved, residents may remove facemasks and are not required to physically distance. HCP will continue to wear source controls so long as they are indoors, i.e., facemask and/or eye protection as noted for county positivity rates > 5% when providing direct care within 6 feet of the resident: If any one person congregates during a group activity or service area and they are not fully vaccinated, everyone should wear facemask during the activity and unvaccinated persons must physically distance > 6 feet. If the attending HCP involved in the service or activities listed below is unvaccinated, the residents should remain masked and unvaccinated persons must			

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	maintain > 6 feet of social distance. The unvaccinated HCP should continue to wear source controls and physically distance if they are not needed to assist the residents in any activity." 4. During the breakfast service on 6/22/21 at 8:55 a.m., the Dietary Manager was not wearing a face mask during the entire meal service. The Dietary Manager was observed in the kitchen plating the resident's food. Interview with the Dietary Manager on 6/22/21 at 9:15 a.m., indicated she was unaware that she needed to wear a face mask during meal service. Interview with the Administrator In Training, on 6/22/21 at 12:15 p.m., indicated all staff should wear a surgical mask due to COVID-19 precautions. 5. During the preparation of medications for Resident 11 on 6/22/21 at 11:54 a.m., LPN 1 was observed to have washed her hands. LPN 1 then proceeded to unlock her medication cart, pull out a medication punch card, punch the tablet out with her bare hand and placed the medication into the medication cup, without sanitizing her hands. LPN 1 then pulled out the next punch card and punched the tablet out with her bare hands and placed the medication into the medication cup. The LPN then proceeded to unlock the narcotic drawer. She removed the medication punch card and removed the tablet using her bare hands without sanitizing. Interview with LPN 1 on 6/22/21 at 12:12 p.m., indicated she was unaware that she had to sanitize her hands before touching the medications with her bare hands. Interview with the Administrator in Training on			

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	6/22/21 at 12:15 p.m., indicated LPN 1 should have removed the tablets over the medication cup.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure an annual tuberculin skin test was completed for 2 of 7 residents whose records were reviewed. (Residents 2 and 6) Findings include: 1. The record for Resident 2 was reviewed on 6/22/21 at 10:56 a.m. Diagnoses included, but were not limited to, vascular dementia without behavior disturbance, psychotic disorder with delusions, and anxiety disorder. The resident was admitted to the facility on 1/13/20.	R 0410	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated June 23,2021. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather is is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory	08/02/2021

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	The resident's first step tuberculin (TB) skin test was on 1/13/20. The resident's second step TB test was on 1/27/20. There was no documentation related to the resident receiving an annual TB test in January 2021. Interview with the Health and Wellness Director on 6/23/21 at 4:15 p.m., indicated the resident's annual TB test was missed and a TB test would be given. 2. Resident 6's record was reviewed on 6/23/21 at 10:10 a.m. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted on 1/15/2020. The record lacked an indication of a current Tuberculin Test (TB). The last TB test was completed on 1/29/2020. Interview with the Administrator In Training (AIT) and Health and Wellness Director on 6/23/21 at 4:15 p.m., indicated the TB test should have been completed annually. A policy titled, " Tuberculosis Screening," was provided by the AIT on 6/23/21 at 3:42 p.m. This current policy indicated, "...Subsequent years will be followed by a single step/annual test...."		requirements. In this document we have detailed actions in response to identified issues. We will continue to make changes and improvement to satisfy the objective. All residents immunization record was audited on 6/24/2021 per DON and AIT. All resident's that needed annual TB was administered on 6/24/2021 and 6/25/2021. At this time all residents are current with annual TB immunization. Immunization record will be audited monthly for twelve months per DON to ensure residents are current and any new admitted residents are current as well.	