STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 6/23/21. Survey dates: September 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 9/27/21.	R 0000		
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 not being used by the use by date and stored foods were unlabeled and undated. The facility also failed to maintain a sanitary and clean environment related lack of hand hygiene in 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, Cook 1 and Dietary Manager) Findings include: 1. The Main Kitchen refrigerator was observed on	R 0273	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated September 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	10/18/2021

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

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	9/23/21 at 9:50 a.m. with the Dietary Manager (DM). A clear container of potato salad had a use by date of 9/21/21. A foil covered pan was observed without a label and undated. Interview with the DM on 9/23/21 at 10:00 a.m., indicated it was the kitchen staff and her responsibility to clean out the refrigerators of foods past the use by dates. The foil pan was pork that was cooked last night and the cook should have placed a label to indicate the type of food and the date. 2. During lunch service on 9/23/21 at 12:10 p.m., Cook 1 was observed to wash his hands and don gloves. He proceeded to place 2 pans on the stove top, opened the refrigerator, removed a container of oil and poured some oil in to the pan with the same gloved hands. Cook 1, with the same gloved hands, then opened the freezer door, removed a clear package of chicken tenders, opened the package and removed 3 chicken tenders from inside of the package and placed them in the oiled pan. and began to cook the chicken tenders. Interview with Cook 1 on 9/23/21 at 12:13 p.m., indicated he should have changed gloves before removing the chicken tenders from the package. 3. During lunch service on 9/23/21 at 12:15 p.m., the DM was observed prepping for grilled cheese sandwiches. The DM washed her hands, gloved, gathered a loaf of bread and the butter container. She then regloved, touching the outside of the loaf of bread and removed the twist tie. With the same gloved hand, she removed 6 pieces of bread, buttered them and placed them in the pan and began cooking.		to identified issues. We will continue to make changes and improvement to satisfy the objective. Dietary manager has re-educated dietary staff on handwashing procedure and gloving procedure on 9/24/2021. Dietary manager also had dietary staff demonstrate handwashing and proper gloving of hands. Dietary manager also demonstrated her handwashing and gloving of hands. Dietary manager will have daily assignment sheets for the dietary staff to check labeling and dates of food in refrigerator and storage room staff sign off daily sheets. Dietary manager was re-educated on policy and procedure of labeling and storage in kitchen. Dietary manager will audit three times a week.	

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	Interview with the DM on 9/23/21 at 1:15 p.m., indicated she should have changed her gloves before removing the pieces of bread. A policy titled, "Labeling and Dating for Safe Storage of Food," was provided by the Administrator in Training. This current policy indicated, "...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...F. Storage of Leftovers...3. When to throw food away: a. Refrigerators do not stop the spoiling process. Leftover food can be kept for a few days but should be thrown out before they spoil...." This State Residential Finding was cited on 6/23/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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	R 0407	The following is the plan of correction for Wyndmoor of Portage regarding the statement of deficiencies dated September 23,2021. This plan of correction is	10/18/2021

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	protective equipment (PPE) not worn properly per CDC guidance. (Dietary Manger, CNA 1) Finding includes: Upon entering the facility on 9/23/21 at 9:35 a.m., the following was observed: - the Dietary Manger was observed in the kitchen without a mask. CNA 1 was assisting a resident out the door, both were unmasked. - In the lounge area, there were 2 residents walking side by side, unmasked. - Another resident was in the lounge area, asleep and unmasked. Interview with the Administrator in Training on 9/23/21 at 9:35 a.m., indicated all the residents have received the COVID-19 vaccine, and the staff and residents did not need to wear a mask. She was unaware that the guidance had changed related to vaccinated staff and residents still needed to wear a mask while indoors. The "Long Term Care Facilities Guidelines in Response to COVID-19 Infection Control Guidance in Long-Term Care Facilities", updated on 9/7/21, indicated "It is expected that COVID-19 infection prevention and control core principles be always adhered to and remain in place as long as the virus is present in epidemic levels. This standard operating procedure and Core Principles of Infection Control should be used in conjunction with all existing clinical and regulatory guidance to provide routine prevention measures to help contain and prevent the spread of COVID-19. Residents should wear a mask (cloth is acceptable) when they leave their rooms, and when HCP are delivering care within 6 feet. Fully vaccinated residents must continue to wear a mask while indoors."		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 staff was educated/in serviced on the updated rule change on September 7,2021 that all fully vaccinated residents must continue to wear a mask indoors / facility. Writer will ask residents for invite to meet with residents on the next scheduled resident council meeting to update all residents on the mask requirement in the facility. Management team will audit residents and staff twice daily to ensure mask requirement is followed by signing off check off sheet for 30days then weekly for 60days and will update staff and residents weekly with any changes made from the ISDH newsletters.	

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	This State Residential Finding was cited on 6/23/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			