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	10/03/2024

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

(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 the Investigation of Complaint IN00442989. Complaint IN00442989-State deficiencies related to the allegations are cited at R240 and R248. Survey date: October 3, 2024 Facility number: 009894 Residential: 115 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 9, 2024.	R 0000		
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on observation, interview and record review, the facility failed to ensure a resident was free from witnessed falls while staff was assisting the resident with Activities of Daily Living (ADL) care for 1 of 3 residents reviewed for assistance with ADLs. (Resident B) Finding includes: A document, titled "Intake Information," dated 9/10/24, indicated a complainant had concerns with Resident B having two witnessed falls while the facility staff was assisting her with ADLs. The clinical record for Resident B was reviewed on 10/3/24 at 11:15 a.m. The diagnoses included, but were not limited to, rheumatoid arthritis,	R 0240	***R240 Health Services – Deficiency*** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Resident B's fall on 9/4/2024 and 9/10/2024 were reviewed by Director of Nursing post fall and she had spoke with the POA regarding the falls. ·A post fall evaluation was completed after each fall to consider possible interventions to reduce the potential for future falls and injury. Resident B's care plan	10/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Camille Beeson	Regional Director of Operations	10/21/2024

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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	chronic atrial fibrillation, and hypertension. A nursing progress note, dated 9/4/24 at 4:10 p.m., indicated the resident was being assisted back to bed from the bathroom by an aide when she fell backwards while holding onto her walker and hit her head on the closet door. She had a small, raised area to her scalp. A document, titled "Preliminary Draft Notes of a Reported Incident for Licensed PAL," indicated the witnessed fall occurred on 9/4/24 at 3:15 p.m. Resident B was walking to her bed with her walker and a staff member. A second staff member was in the bathroom trying to plunge the toilet to make it stop overflowing. The first staff member walking behind the resident turned around due to the resident's toilet overflowing onto the floor and the resident fell backwards hitting her head on the closet door. She had a raised area to her scalp. A nursing progress note, dated 9/9/24 at 8:30 p.m., indicated the resident was assisted to the bedside commode by the CNA. The CNA indicated the resident was in the position to sit on the bedside commode when her buttocks hit the railing, and the commode tipped over onto the floor. The resident slid to the floor on her buttocks. A document, titled "Preliminary Draft Notes of a Reported Incident for Licensed PAL," indicated the witnessed fall occurred on 9/9/24 at 8:20 p.m. There was a witness to the fall, who was a staff member. The resident was assisted to the bedside commode by a CNA. The CNA indicated the resident was in position on the bedside commode to sit and her buttocks landed close to the railing of the bedside commode. The bedside commode tipped over onto the floor and the resident slid and landed onto her buttocks on the floor.		was updated post falls. ·Care Plan held via telephone with ED and DON with POA after both falls had occurred discussing the nature of each of the falls prior to state visit. **How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** ·Any resident has the potential to fall and therefore Wyndmoor has identified universal fall precautions applicable to residents. ·All fall risk evaluation is completed at the time of move in/admission, every 6 months or with change of condition. ·All facility falls reviewed Daily by Director of Nursing to identify nature of fall, ensure proper notifications were made and that possible interventions are considered. ·A Fall Monitoring Audit Tool has been implemented and the Executive Director and Director of Nursing will meet weekly to review all witnessed and unwitnessed falls. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?**	

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	A nursing progress note, dated 10/1/24 at 4:59 a.m., indicated the resident was total care for her ADL. She had a bedside commode, which she required extensive assist to stand and sit on the bedside commode times two persons. She had an unsteady gait. She was unable to lift her arms. She was not able to wash her face and underarms due to weakness. The resident's current service plan, dated 9/27/24, unsigned by her Power of Attorney (POA), indicated the resident had poor safety awareness and she required cues, reminders, and reassurance multiple times throughout each day. Her transfers required contact guard assist to maximum assist from staff. Her level of assistance varied day by day. The goal was she would be transferred in a safe manner to minimize her fall risk. She required physical assistance with wiping and pulling up and down her pants when toileting with one staff member. She required a wheelchair to go long distances. During an interview, on 10/3/24 at 11:43 a.m., Resident B was observed sitting in her recliner chair. She indicated the day she fell with her walker, her walker wheels tipped up and she fell backwards into the closet doors, then onto the floor. She had a knot on the left side of her head behind her left ear. She pointed to behind her left ear while indicating the area remained tender as of that day. The aides indicated they were not "paying attention" and that was why she fell while walking back from the bathroom. She had a second fall about a week later off her beside commode. She did not know how she fell off the commode because she had never fallen off her commode before. The aide was not "paying attention to me" and should not have fallen off		·Any resident has the potential to fall and therefore Wyndmoor has identified universal fall precautions applicable to residents. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. ·All fall risk evaluation is completed at the time of move in/admission, every 6 months or with change of condition. ·Residents who sustain a fall have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. ·All nursing staff educated on Wyndmoor Falls Management Policy and Post Fall Assessments on 10/16/2024. ·A Fall Monitoring Audit Tool has been implemented and will be reviewed weekly by the Director of Nursing and Executive Director for all witnessed and unwitnessed falls. The audit tool will be completed and reviewed weekly x 10 weeks or until the deficient practice does not recur. Ongoing fall monitoring will continue daily by the Director of Nursing. **How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place?**	

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	the commode. During a phone interview, on 10/3/24 at 12:41 p.m., Qualified Medication Aide (QMA) 1 indicated she was assisting the resident back to her bed and QMA 2 was in the bathroom. When QMA 2 flushed the toilet, it started overflowing water onto the floor and QMA 2 yelled out. When QMA 1 heard QMA 2 yell out, she turned around to see what she was yelling out for and when she did, the resident fell backwards into the closet doors and onto the floor. She had a raised area to the left side of her head. QMA 1 went to get a CNA to assist QMA 2 with picking her up off the floor and they placed her into the bed. During a phone interview, on 10/3/24 at 1:13 p.m., CNA 3 indicated she positioned Resident B in the center of the bedside commode before she started sitting her down. As the resident was sitting down, part of her buttocks landed on the handle of the bedside commode, and it tipped over onto the floor. The resident slid to the floor. A current policy, titled "Falls Management Policy," dated 1/1/2023 and provided by the ED on 10/3/24 at 11:37 a.m., indicated "...Definition of a Fall: a fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury...." This citation relates to Complaint IN00442989.		·A Fall Monitoring Audit Tool has been implemented and will be reviewed weekly by the Director of Nursing and Executive Director for all witnessed and unwitnessed falls. The audit tool will be completed and reviewed weekly x 10 weeks or until the deficient practice does not recur. Ongoing fall monitoring will continue daily by the Director of Nursing. ·The Executive Director will communicate daily with the Director of Nursing about results of such audits and will direct further action if required. **By what date will the systemic changes be implemented?** ·10/21/2024	
R 0248 Bldg. 00	410 IAC 16.2-5-4(f) Health Services - Deficiency Based on observation, interview and record review, the facility failed to ensure unlicensed staff did not move residents who have fallen prior	R 0248	***R248 Health Services – Deficiency*** **What corrective action(s) will**	10/21/2024

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	to being assessed by a licensed nurse for 1 of 3 residents being reviewed for a licensed nurse being available. (Resident B) Finding includes: A document, titled "Intake Information," dated 9/10/24, indicated a complainant had concerns with Resident B having two witnessed falls while the facility staff was assisting her with ADLs. The clinical record for Resident B was reviewed on 10/3/24 at 11:15 a.m. The diagnoses included, but were not limited to, rheumatoid arthritis, chronic atrial fibrillation, and hypertension. A nursing progress note, dated 9/4/24 at 4:10 p.m., indicated the resident was being assisted back to bed from the bathroom by an aide when she fell backwards while holding onto her walker and hit her head on the closet door. She had a small, raised area to her scalp. A fall incident report indicated a witnessed fall occurred on 9/4/24 at 3:15 p.m. The resident was checked for an injury, and she had a raised area to her scalp. The DON was notified on 10/4/24 at 3:25 p.m. A nursing progress note, dated 9/9/24 at 8:30 p.m., indicated the resident was assisted to the bedside commode by the CNA. The CNA indicated the resident was in the position to sit on the bedside commode when her buttocks hit the railing, and the commode tipped over onto the floor. The resident slid to the floor on her buttocks. The Director of Nursing (DON) was notified. A nursing progress note, dated 10/1/24 at 4:59 a.m., indicated the resident was total care for her		**be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Resident B's fall on 9/4/2024 and 9/10/2024 were reviewed by Director of Nursing post fall and she had spoke with the POA regarding the falls. ·Following the fall that occurred on 9/4/2024 the Director of Nursing was immediately called by the QMA prior to moving the resident and the Director of Nursing entered the post fall note the next day. ·Following the fall that occurred on 9/9/2024 the nurse on duty was called by the CNA prior to moving the resident. The LPN then instructed her to assist the resident off the floor following verbal assessment. The LPN then collected vitals and charted the incident. ·A post fall evaluation was completed after each fall to consider possible interventions to reduce the potential for future falls and injury. Resident B's care plan was updated post falls. ·Care Plan held via telephone with ED and DON with POA after both falls had occurred discussing the nature of each of the falls prior to state visit. **How will the facility identify other residents with the potential to be affected by the**	

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	ADL. She had a bedside commode, which she required extensive assist to stand and sit on the bedside commode times two persons. She had an unsteady gait. She was unable to lift her arms. She was not able to wash her face and underarms due to weakness. A fall incident report indicated the witnessed fall occurred on 9/9/24 at 8:20 p.m. There was a witness to the fall, who was a staff member. The resident was assisted to the bedside commode by a CNA. The CNA indicated the resident was in position on the bedside commode to sit and her buttocks landed close to the railing of the bedside commode. The bedside commode tipped over onto the floor and the resident slid and landed onto her buttocks on the floor. The resident's current service plan, dated 9/27/24, unsigned by her Power of Attorney (POA), indicated the resident had poor safety awareness and she required cues, reminders, and reassurance multiple times throughout each day. Her transfers required contact guard assist to maximum assist from staff. Her level of assistance varied day by day. The goal was she would be transferred in a safe manner to minimize her fall risk. She required physical assistance with wiping and pulling up and down her pants when toileting with one staff member. She required a wheelchair to go long distances. During an interview, on 10/3/24 at 11:43 a.m., Resident B was observed sitting in her recliner chair. She indicated the day she fell with her walker, her walker wheels tipped up and she fell backwards into the closet doors, then onto the floor. She had a knot on the left side of her head behind her left ear. She pointed to behind her left ear while indicating the area remained tender as of		**same alleged deficient practice and what corrective action will be taken?** ·Any resident has the potential to fall and therefore Wyndmoor has identified universal fall precautions applicable to residents. ·All fall risk evaluation is completed at the time of move in/admission, every 6 months or with change of condition. ·All facility falls reviewed Daily by Director of Nursing to identify nature of the fall, ensure proper notifications were made and that possible interventions are considered. ·A Fall Monitoring Audit Tool has been implemented and the Executive Director and Director of Nursing will meet weekly to review all witnessed and unwitnessed falls. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** ·Any resident has the potential to fall and therefore Wyndmoor has identified universal fall precautions applicable to residents. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury.	

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	that day. The aides indicated they were not "paying attention" and that was why she fell while walking back from the bathroom. She had a second fall about a week later off her beside commode. She did not know how she fell off the commode because she had never fallen off her commode before. The aide was not "paying attention to me" and should not have fallen off the commode. During a phone interview, on 10/3/24 at 12:41 p.m., Qualified Medication Aide (QMA) 1 indicated she was assisting the resident back to her bed and QMA 2 was in the bathroom. When QMA 2 flushed the toilet, it started overflowing water onto the floor and QMA 2 yelled out. When QMA 1 heard QMA 2 yell out, she turned around to see what she was yelling out for and when she did, the resident fell backwards into the closet doors and onto the floor. She had a raised area to the left side of her head. She and QMA 2 checked the resident out. She had a raised area to the left side of her head. QMA 1 went to get a CNA to assist QMA 2 with picking her up off the floor and they placed her into the bed. After a fall, the staff filled out the fall incident report. The next day, the DON was scheduled to work, and she wrote the fall notes in the resident's record. A nurse did not assess Resident B prior to the CNA and QMA 2 picking her up off the floor. During a phone interview, on 10/3/24 at 1:13 p.m., CNA 3 indicated she positioned Resident B in the center of the bedside commode before she started sitting her down. As the resident was sitting down, part of her buttocks landed on the handle of the bedside commode, and it tipped over onto the floor. The resident slid to the floor. She was not injured. CNA 3 called the nurse on duty on her walkie talkie to let her know the resident had		·All fall risk evaluation is completed at the time of move in/admission, every 6 months or with change of condition. ·Residents who sustain a fall have a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. ·All nursing staff educated on Wyndmoor Falls Management Policy and Post Fall Assessments on 10/16/2024. ·A Fall Monitoring Audit Tool has been implemented and will be reviewed weekly by the Director of Nursing and Executive Director for all witnessed and unwitnessed falls. The audit tool will be completed and reviewed weekly x 10 weeks or until the deficient practice does not recur. Ongoing fall monitoring will continue daily by the Director of Nursing. **How the corrective actions will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance programs will be put into place?** ·A Fall Monitoring Audit Tool has been implemented and will be reviewed weekly by the Director of Nursing and Executive Director for all witnessed and unwitnessed falls. The audit tool will be completed and reviewed weekly x 10 weeks or until the deficient practice does not recur. Ongoing fall monitoring will continue daily	

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	fallen. The nurse on duty told CNA 3 to pick the resident up off the floor and set her on the bedside commode because she was busy somewhere else in the facility, and she was not able to get to Resident B at that time. Resident B had to urinate, so CNA 3 picked her up without her being assessed by a nurse and sat her on the bedside commode. During an interview, on 10/3/24 at 3:10 p.m., the DON indicated the QMAs, and CNAs would fill out the fall event form after a fall occurred as a communication form. The next day the DON worked, she wrote the nursing progress note based off the fall event written by the QMA or CNA. The DON indicated if she was not in the facility, she was always available by phone. QMAs used their clinical judgement on whether they were able to get a resident up off the floor. If the resident did not complain of pain and there was no obvious deformity, then they were able to get the resident off the floor. They called and notified the DON, but not always before a resident was picked up off the floor. A current policy, titled "Falls Management Policy," dated 1/1/2023 and provided by the ED on 10/3/24 at 11:37 a.m., indicated "...Definition of a Fall: a fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury...When a fall occurs: 1. In Assisted Living: i. Assist the resident and assess the resident for injury and collect vitals. ii. Provide first aid as indicated. iii. Call 911 should the resident need to be sent out for further evaluation. iv. Notify the Nursing Director/nurse/designee. v. Notify the resident's physician/healthcare provider (HCP) for evaluation, care, and treatment if indicated and document in the resident record. vi. Notify the		by the Director of Nursing. ·The Executive Director will communicate daily with the Director of Nursing about results of such audits and will direct further action if required. **By what date will the systemic changes be implemented?** ·10/21/2024	

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	resident's family/responsible party and document in the resident record. vii. Document the resident fall/injuries, resident response...." This citation relates to Complaint IN00442989.			