

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER WYNDMOOR SENIOR LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint #IN00182432.</p> <p>Complaint # IN00182432- Unsubstantiated due to lack of evidence.</p> <p>Survey date: November 4, 2015</p> <p>Facility number: 013389 Provider number: 013389 AIM number: N/A</p> <p>Census bed type: Residential: 48 Total: 48</p> <p>Census payor type: Other: 48 Total: 48</p> <p>Sample: 6</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 11/6/15 by 29479.</p>	R 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending November 4, 2015. Please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me. Respectfully, James Passwater Administrator</p>	
R 0273	410 IAC 16.2-5-5.1(f)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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Bldg. 00	<p>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.</p> <p>Based upon observation, interview and record review, the facility failed to ensure a beard restraint was worn by staff entering the kitchen for 1 of 2 kitchen observations. This deficient practice had the potential to affect 48 of 48 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>During the observation of luncheon service on 11/4/15 at 12:10 p.m., the Environmental Service Director was observed to enter the kitchen, obtain a plate of food, serve the plate of food to a resident in the dining room, then return back into the kitchen and begin to wash dishes at the dishwasher. The Environmental Service Director was observed with a full beard and was not wearing a beard restraint.</p> <p>The Dietary Manager, on 11/4/15 at 12:15 p.m., indicated she was not aware staff were to cover facial hair, when they entered the kitchen or served food to residents.</p> <p>On 11/4/15 at 12:30 p.m., the</p>	R 0273	<p>1.No residents were harmed. The staff member was immediately re-educated wearing a beard restraint when in the kitchen.</p> <p>2.All residents have the potential to be affected. All staff were in-serviced on the requirements for hair and beard restraints, (please see attachment A).</p> <p>3.As a measure of ongoing compliance the Dietary Manager or designee will complete observations three times weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure staff are wearing required hair restraints when in the kitchen, (please see attachment B).</p> <p>4.As a measure of quality assurance the Administrator or designee will monitor said audits monthly ongoing. Based on the monitored findings, the frequency of monitoring may be revised, (i.e., increased or decreased) accordingly.</p> <p>5.Completion date November 6, 2015.</p>	11/06/2015

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	<p>Administrator indicated the facility followed the Retail Food Establishment Sanitation Requirements and the facility policy was anyone who entered the kitchen or served residents food should wear a beard restraint, if they had facial hair.</p> <p>On 11/4/15 at 1:30 p.m., the Administrator provided a copy of the Retail Food Establishment Sanitation Requirements, Title 410 IAC 7-24, Effective November 13, 2004. Section 138 (a) indicated, "...food employees shall wear hair restraints, such as hats...beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting (1) exposed food; (2) clean equipment...."</p> <p>16.2-5-5.1(f)</p>			