

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2014
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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
R000000	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey date: July 16, 2014</p> <p>Facility number: 013389 Provider Number: 013389 Aim Number: N/A</p> <p>Survey team: Lora Brettnacher, RN, TC Kewanna Gordon, RN</p> <p>Census bed type: Residential: 45 Total: 45</p> <p>Census by payor type: Other: 45 Total: 45</p> <p>Sample: 7`</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 7/21/14 by Brenda Marshall, RN/</p>	R000000	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.	
R000216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation			

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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	<p>shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure residents who self administered medications had a self-administration evaluation for 3 of 3 residents reviewed who self-administered medications (Resident #5, #2, and #1).</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 7/16/14 at 12:00 P.M. Resident #5 had diagnoses which included, but were not limited to, diabetes and hypertension. Resident #5's record indicated she administered her own medications. The record lacked documentation the facility had evaluated her ability to self administer medications.</p> <p>2. Resident #1's record was reviewed on 7/16/14 at 12:20 P.M. Resident #1 had a diagnoses which included, but were not limited to, a history of polio, diabetes,</p>	R000216	<p>1.Resident #5, #2, and #1 had self administrationof medication assessments completed which indicates they continue to be appropriate for self administration of medications.</p> <p>2.All residents who self administer mediations have the potential to be affected. The records for all residents who self administer medications were reviewed to ensure a current self administration ofmedication assessment was completed. All nurses were in-serviced on thefacility's policy on self administration of medications.</p> <p>3.As a measure of ongoing compliance the Nurse Director or designee will complete an audit monthly ongoing to ensure all residents that self administer medications have a current self administrationof medication assessment completed, (please see attachment A). Should a self administration of medication</p>	08/01/2014

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	<p>and hypertension. Resident #1's record indicated he administered his own medications. The record lacked documentation the facility had evaluated his ability to self administer medications.</p> <p>3. Resident #2's record was reviewed on 7/16/14 at 12:20 P.M. Resident #2 had a diagnosis which included, but was not limited to, stroke. Resident #2's record indicated she administered her own medications. The record lacked documentation the facility had evaluated her ability to self administer medications.</p> <p>During an interview on 7/16/14 at 2:00 P.M., the Director of Nursing indicated evaluations for the ability to administer medications had not been completed on Resident #5, #2, and #1. She indicated she was not aware of the requirement for the self administration evaluation and would make sure it was done in the future.</p>		<p>assessment be found inaccurate or missing, the assessment will be completed/updated immediately.</p> <p>4. As a measure of ongoing compliance the Administrator or designee will monitor and sign off on the said audit monthly ongoing. Based upon the monitored findings, the frequency of monitoring may be revised (i.e., increased or decreased) accordingly.</p>	