STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR ASSISTED LIVING LLC	1465 EAST CROSSING BLVD, TERRE HAUTE, , 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00463604. Complaint IN00463604 - State deficiencies related to the allegations are cited at R0091. Survey date: August 11 and 12, 2025 Facility number: 013389 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 22, 2025.	R 0000	Administrator never received an email to notify me the results of investigation were posted. On 9/3/25 Administrator checked Gateway to see why or if it had been posted. Regarding the incident on June 30th, the administrator did ask any dietary staff that was working that witnessed the incident to provide a written statement. Only one staff member turned in a statement. Both residents were assessed by the nurse after wards and neither one had any marks on them. Administrator interviewed Resident C after dinner and he gave his statement of what happened, Resident G was also interviewed and had no memory of the incident after dinner. Plan of Correction: Since the incident the dining room has been monitored by a member of management or the charge nurse or designee if she is called away for an emergency. This will be our ongoing practice. A witness form has been created and will be given to anyone (resident or staff) that is present to	

			fill out in their own words for any future incidents.	
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the Administrator failed to complete a thorough investigation of a resident-to-resident physical altercation for 1 of 1 incidents reviewed (Residents C and G) Findings include: A facility reported incident, dated 7/1/25, indicated, on 6/30/25 at 4:48 p.m., Resident C and Resident G were sitting at a table in the dining room when	R 0091	Administrator never received an email to notify me the results of investigation were posted. On 9/3/25 Administrator checked Gateway to see why or if it had been posted. Regarding the incident on June 30th, the administrator did ask any dietary staff that was working that witnessed the incident to provide a written statement. Only one staff member turned in a statement. Both residents were assessed by the nurse after wards and neither one had any marks on them. Administrator interviewed Resident C after dinner and he gave his statement of what happened, Resident G was also interviewed and had no memory of the incident after dinner. Plan of Correction: Since the incident the dining room has been monitored by a member of management or the charge nurse or designee if she is called away for an emergency. This will be our ongoing practice. A witness form has been created and will be given to anyone (resident or staff) that is present to fill out in their own words for any future incidents.	09/03/2025

Resident G took all the silverware. Resident C was seated at the table with Resident G. Staff asked Resident G to give Resident C a set of silverware and she gave it to him. Resident G then took the silverware back and smacked his arm and said for him to not to take her silverware. Resident C then smacked Resident G's arm. Resident G then smacked Resident C on the side of his head. Staff stepped in and separated the two residents.

1. A clinical record review for Resident C was completed on 8/11/25 at 11:09 a.m. Diagnoses included dementia, communication disorder, and depression. The resident's Level of Service Assessment/Evaluation, dated 5/28/25, included that the resident was disoriented to the point of no longer able to function independently three or more days a week or part of every day for a seven day period. He had a diagnosis of dementia and/or significant memory loss combined with behaviors including but not limited to wandering, requiring directions or reminding and continuous daily cues.

2. A clinical record review for Resident G was completed on 8/12/25 at 10:38 a.m. Diagnoses included dementia and depression. The resident's

Level of Service Assessment/Evaluation, dated 8/6/25, included that she was always disoriented and performed repetitive behaviors. She had a dementia diagnosis and/or significant memory loss combined with behaviors including but not limited to wandering, requiring directions or reminding and continuous daily cues.

During an interview on 8/11/25 at 1:07 p.m., the Administrator indicated she had not witnessed the incident on 6/30/25, but had been told about it by staff. She indicated she was unsure if there had been documentation of assessments being completed following the incident.

Review of information provided by the Administrator on 8/11/25 at 2:10 p.m., as the investigation of the incident, contained one employee statement written by Dietary Aide 3. The Administrator indicated, at that time, she had some written notes she took after speaking with Residents C and G, but had been unable to find them. The electronic health record and resident's paper chart lacked documentation regarding the incident.

Dietary Aide 3's, undated, written statement included that he had witnessed Resident C

and Resident G get into a fight over silverware. He had explained to Resident G that the silverware belonged to the kitchen, and Resident C needed some silverware. Resident G gave Resident C a set of silverware and then said "hey that's mine," and Resident C indicated, "No, it's mine." Dietary Aide 3 indicated he believed Resident C hit first, but both the resident's exchanged some "punches and slaps."

During a telephone interview on 8/11/25 at 3:38 p.m., Dietary Aide 4 indicated when she had arrived in the middle of lunch service on 6/30/25, she observed Resident C seated at a table and Resident G had sat down with him. She observed Resident G gather all the silverware on the table and the staff ask her to provide some for Resident C which she did. She observed Resident G strike Resident C on his arm and Resident C then tried to kick Resident G, but staff had intervened. The Administrator had not asked her for her statement following the incident or spoke with her about it.

During an interview on 8/12/25 at 10:21 a.m., Resident E indicated she had been in the dining room on 6/30/25, when Resident C and Resident G had gotten into a fight. She indicated Resident C was standing and

doing his "stupid little dance thing" and reached out and smacked Resident G in the face. She was not asked by staff or the administrator about what she had observed.

During an interview on 8/12/25 at 11:20 a.m., Resident F indicated she was sitting in the lobby with a full view of the dining room on 6/30/25. Resident C was observed standing up and then Resident G stood up. She observed Resident G grabbing at something in Resident C's hands and yelling at him. Resident C then smacked Resident G in the face and pushed at her. Resident G then began to smack at Resident C when staff broke the two of them up. She was not asked about the incident from any staff member or the Administrator.

During an interview on 8/11/25 at 2:00 p.m., Dietary Aide 3 indicated he had taken Resident C's order on 6/30/25, and Resident C indicated he had no silverware. Dietary Aide 3 asked Resident G, who had all the silverware, if she would give Resident C some silverware. Resident G then tried to take the silverware back from Resident C. Resident C smacked Resident G's arm and she then kicked him. Resident C then punched her in the face on her left cheek. Resident G

yelled and backed up. Another staff member stepped in and told Resident G to stop. Dietary Aide 3 had reported the incident to the Administrator and had been clear that Resident C had punched Resident G in the face.

A written statement by the Administrator was provided on 8/11/25 at 3:20 p.m. She indicated she had re-written a statement from her memory of her written notes from the day of the incident, 6/30/25, that she had been unable to locate. The statement included that she had come in as Resident G made contact with the side of Resident C's head. It had not been very hard from what she had seen. There were several staff members around helping with dinner and staff separated Resident C and Resident G. She had stayed in the dining room with Resident C during his meal. She had asked staff to submit a statement, and Dietary Aide 3 was the only one who turned one in to her. Both families were notified of the incident and staff were to monitor the dining room during meals going forward.

A current facility policy, undated, titled, "Abuse Prohibition Reporting and Investigation," provided by the Administrator on 8/12/25 at 11:00 a.m., included the following: "Policy It is the policy of this facility allegation of

abuse will be communicated to, and thoroughly investigated by, the correct authority.....8. The facility administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations and for assuring that all policies and procedures are followed...If resident abuse, or suspicion of abuse, is reported:...10. Residents will be questioned about the nature of the incident and their statements placed in writing. 11. Investigation will be conduced {SIC} to assure other residents have not been affected by the incident or inappropriate behavior and the results documented. 12. Statements will be taken including, but not limited to, Facts and Observations by involved employees...by witnessing employees....by witnessing non-employees...."

This citation relates to Complaint IN00463604.

Based on interview and record review, the Administrator failed to complete a thorough investigation of a resident-to-resident physical altercation for 1 of 1 incidents reviewed (Residents C and G)

Findings include:

A facility reported incident, dated 7/1/25, indicated, on

6/30/25 at 4:48 p.m., Resident C and Resident G were sitting at a table in the dining room when Resident G took all the silverware. Resident C was seated at the table with Resident G. Staff asked Resident G to give Resident C a set of silverware and she gave it to him. Resident G then took the silverware back and smacked his arm and said for him to not to take her silverware. Resident C then smacked Resident G's arm. Resident G then smacked Resident C on the side of his head. Staff stepped in and separated the two residents.

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2. A clinical record review for Resident G was completed on

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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