PRINTED: 05/05/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING			04/16/2025	
NAME OF PROVIDER OR SUPPLIER  WYNDMOOR ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
R 0000							
Bldg. 00	This visit was for a State Residential Licensure Survey.			000			
	Survey dates: April 15 and 16, 2025						
	Facility number: 013389						
	Residential Census: 112						
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5.  Quality review completed on April 23, 2025						
R 0407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance						
Bldg. 00	intection Control -	Noncompliance					
	Based on record review and interview, the facility failed to ensure that immunizations had been documented as completed for 4 of 6 residents reviewed for immunizations (Residents 184, 108, 148, and 212).  Findings include:  1. Resident 184's record was reviewed on 4/15/25 at 1:08 p.m. The profile indicated the resident had been admitted to the facility on 9/24/21, for diagnoses which included, but were not limited to, hyperlipidemia (a condition where there are abnormally high levels of fats in the blood) and hypertension (high blood pressure).  An informed consent document, dated 9/14/21, indicated the resident had given his consent to		R 0407		On admission Residents sign a consent or declination to recei their flu vaccination and this is placed in their chart. During ou annual Flu clinic Resident are offered their annual flu vaccina if they consented during admission a new consent is not needed. If they declined during admission and decline every y during the flu vaccination of flu vaccinat will be obtained and placed in chart. (see attached form) If the have consented to flu vaccination past years but decline in curyear a declination form will be filled out and placed in their ch	ve ur ation, ot g ear c a ion their ey tion rrent	05/01/2025
		nt had given his consent to influenza (flu) vaccine.			Same process of declinations be followed when a Pneumoni		

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

Valaurie Nesbit

TITLE

Administrator

(X6) DATE 05/01/2025

Any definency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/16/2025			
NAME OF PROVIDER OR SUPPLIER WYNDMOOR ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE			
	A physician's order, resident could have fall, if not allergic to An informed conser indicated the resider receive the pneumo.  The record lacked do had ever received a A physician's order, resident could have unless contraindicated.  2. Resident 108's reat 2:18 p.m. The received a diagnoses that includiabetes (a chronic does not regulate bloom and transient ischem interruption of bloom stroke-like symptom hours).  An informed conser indicated the resider	at document, dated 9/14/21, at had given his consent to mia vaccine.  ocumentation that the resident pneumonia vaccine.  dated 12/27/22, indicated the the pneumonia vaccine,		vaccination is declined. The Director of Nursing will design nurse to audit all records for proper documentation during immunization clinic., and she perform a second audit in all records to ensure proper documentation is in place. The double check audit will ensure missed required documentation	Flu will e no		
	The record lacked d	ocumentation that the resident nual flu vaccine after 10/19/22.					
		dated 12/26/22, indicated the the annual flu vaccine, every peggs.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	e survey pleted 6/2025				
NAME OF PROVIDER OR SUPPLIER WYNDMOOR ASSISTED LIVING LLC			1465 E	STREET ADDRESS, CITY, STATE, ZIP COD 1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
	indicated the reside receive the pneumo	ocumentation that the resident							
	A physician's order,	pneumonia vaccine.  dated 12/26/22, indicated the the pneumonia vaccine, ed.							
	During an interview, on 4/15/25 at 1:48 p.m., the Director of Nursing (DON) indicated that the facility used an outside vendor that would come to the facility to provide the vaccines for the residents. The residents had likely not come down								
	from their apartments to get the vaccines, on the day they were offered, or had declined to receive them. She was not able to find any signed vaccine declination documentation for the residents.								
	provided a documer "Pneumococcal Dis and indicated it was used by the facility.								
	delayed10. If the contraindicated or r appear on the "Imm Resident 148's reco 2:00 p.m. The profidiagnoses included,	vaccine is medically efused, the information must unization Record.""3. rd was reviewed on 4/15/25 at le indicated the resident but were not limited to,							
	levels), hypertensio	metabolic disorder gh blood glucose [sugar] n (elevated blood pressure), tive pulmonary disease							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/16/2025	
NAME OF PROVIDER OR SUPPLIER  WYNDMOOR ASSISTED LIVING LLC			1465 E	ADDRESS, CITY, STATE, ZIP COD AST CROSSING BLVD E HAUTE, IN 47802	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	(COPD - a group of	lung diseases that block difficult to breathe).			
	The facility census to the facility on 12.	indicated the resident admitted /30/24.			
	Review of immuniz documentation that vaccine for 24/25 fl	the resident received her flu			
		nt form for the flu vaccine on of the resident's refusal to ine.			
	A physician order, dated 12/23/24, indicated to administer an annual flu vaccine 0.5 cc (cubic centimeter) IM (intermuscular) every fall if not allergic to eggs.				
	During an interview, on 4/15/25 at 2:33 p.m., the Director of Nursing (DON) indicated she thought Resident 148 had received her flu vaccine at the doctor's office. The DON indicated the flu clinic had already been completed prior to the resident admitting to the facility.				
	Resident 148 indica the flu vaccine but of was not offered the year and was not aw already been conduct 4. Resident 212's re at 1:25 p.m. Census	t, on 4/15/25 at 2:50 p.m., ted that she would always get did not get it this year. She flu vaccine by the facility this ware that a flu clinic had cted before she was admitted. cord was reviewed on 4/15/25 information indicated the ed to the facility on 4/21/17.			
		dated 12/26/22, indicated the the annual flu vaccine, every eggs.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		B. WING	_	04/16/2025		
NAME OF T	DOMINED OF CLIPPLIES		STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			1465	EAST CROSSING BLVD		
WYNDMOOR ASSISTED LIVING LLC			TERF	RE HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION  An undated consent form indicated the resident		TAG	DEFICIENCY	DATE	
		consent to be administered				
	the flu shot.	consent to be administered				
	the Hu shot.					
	The resident's imm	unization record indicated she				
		thot on 10/24/23. The record				
	lacked documentati	ion the resident received or				
	declined a flu shot	for the 2024-2025 flu season.				
	During an interview	v, on 4/15/25 at 2:05 p.m.,				
	_	outside service provider came				
		vaccines the resident probably				
		to get her shot. The DON was				
		locumentation the resident was				
	offered the flu shot and refused. The consent in					
	the resident's chart was probably an old consent form.  On 4/15/25 at 2:18 p.m., the DON provided an					
		titled, "Annual Influenza				
		edure," and indicated it was the				
		ing used by the facility. The				
	1	Procedure4. Written consent				
		will not be required prior to				
		ne influenza vaccine, if a				
		igned upon or after admission				
		ring stay at the facility.				
		annual immunization program				
		resident/responsible party in				
	early October announcing our annual influenza program. If the resident or responsible party declined to participate in the program, the facility will attempt to contact him/her annually in an attempt to re-educate on the program and determine if the party will now consent to the vaccination. All attempts and resulting					
		ns will be documented in the				
		ecord6. Residents admitted				
		1st and April 1st shall also be				
	vaccinated as indicated."			1	1	

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CENTERS FOR MEDICARE & MEDICARD SERVICES							B 110. 0736-037
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING <u>00</u>		COMPLETED			
			B. WING			04/16/2025	
NAME OF PROVIDER OR SUPPLIER WYNDMOOR ASSISTED LIVING LLC				STREET ADDRESS, CITY, STATE, ZIP COD 1465 EAST CROSSING BLVD TERRE HAUTE, IN 47802			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE

State Form Event ID: 1YM011 Facility ID: 013389 If continuation sheet Page 6 of 6