STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON AT SOUTHPORT THE	7212 US HWY 31 S, INDIANAPOLIS, , 46227

(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 Intake IN00464350. Intake IN00464350 - State deficiencies related to the allegations are cited at R304. Survey date: August 27, 2025 Facility number: 003283 Residential Census: 40 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed September 2, 2025.	R 0000		
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present.	R 0304	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of The Wellington at	08/28/2025

All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.

Based on observation, interview, and record review, the facility failed to ensure an unsupervised medication cart was locked for 1 of 3 random medication cart observations. A resident opened the top drawer of a medication cart and took two medications that were not his. (Resident B, Resident C)

Findings include:

During a tour of the memory care unit from, 8/27/25 at 8:18 a.m. until 8:32 a.m., observed the following:

- At 8:18 a.m., Qualified Medication Aide (QMA) 1 walk off the memory care unit with a small cup of medication. The medication cart was around a corner, in the hall, in front of the memory care dining room. The medication cart was locked. On the top of the cart, observed a Lantus Solostar insulin pen (long acting insulin) 100 unit/milliliter (ml) with approximately 1.8 ml remaining in the pen and a Lispro kwik pen (rapid acting insulin) 100 units/ml with approximately 0.6 ml remaining in the pen. Neither pen had a needle attached but a

Southport as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

What corrective action(s) will be accomplished for those residents found to

	31 gauge/5 millimeter sealed safety pen needle was sitting on the cart with the insulin pens. - At 8:25 a.m., QMA 1 returned to the memory care unit and indicated the insulin pens should have been locked in the medication cart. - At 8:28 a.m., CNA 1 walked onto the memory care unit and indicated she had been off the unit taking a meal cart back to the kitchen. There was no staff on the unit from 8:18 a.m. until 8:25 a.m. - At 8:30 a.m., QMA 1 walked off the memory care unit with a small cup of medication. The medication cart was left unlocked. CNA 1 was in the dining room and not in line of site of the medication cart. - At 8:31 a.m., QMA 1 walked back onto the memory care unit and indicated she should have locked the medication cart before leaving it unsupervised.		have been affected by the deficient practice? How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? What measures will be put into or what systemic changes the facility will make to ensure that the deficient practice does not recur? How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will put into place? By the date the systemic changes will be completed.	

During an interview on 8/27/25 at 8:40 a.m., Resident B indicated he remembered opening the top drawer of a medication cart to find his cigarettes. He saw a cup of medication that he thought was his and picked up the medication and swallowed two pills. Resident B did not have any adverse effects from the pills.

During an interview on 8/27/25 at 8:50 a.m., Licensed Practical Nurse (LPN) 1 indicated Resident B opened the top drawer of an unsupervised, unlocked medication cart looking for cigarettes and took Resident C's pregabalin (prescription controlled substance used to help calm overactive nerves in the body) and metoprolol tartrate (prescription medication used to treat high blood pressure) out of a medication cup. The medication cart should have been locked.

The clinical record for Resident B was reviewed on 8/27/25 at 9:32 a.m. The diagnoses included, but were not limited to, traumatic brain injury, general anxiety disorder, and seizures.

R 304

1 Residents B and C are receiving
their correct medications.

2 The Community reviewed each
resident’s record to determine which residents, if any, could be affected by
the alleged deficient practice.

3 QMA 1 has been given corrective
corrections. In addition, an in-service will be conducted with nursing staff to
educate on proper medication storage/ locking of unsupervised medication carts.

4 The Executive Director or designee
will audit medication carts two times a week x 4 weeks, and then monthly
thereafter.

5 Systemic changes: 8/8/2025

A progress note, dated 8/25/25 at 9:32 a.m., indicated Resident B was looking for his cigarettes and went into the medication cart and took medication.

The clinical record for Resident C was reviewed on 8/27/25 at 9:51 a.m. The diagnoses included, but were not limited to, epilepsy, cerebral infarct, and dysphagia.

The current Physician's orders indicated:

- Pregabalin 100 milligram (mg) capsule, give one capsule orally three times daily.

- Metoprolol tartrate 25 mg tablet, give one tablet orally twice daily.

On 8/27/25 at 10:32 a.m., the Administrator provided a copy of a resident incident report, dated 8/25/25. A review of the incident report indicated on 8/25/25 at 8:30 a.m., Resident B was looking for his cigarettes and opened the medication cart and took Resident C's pregabalin capsule and a metoprolol tablet.

On 8/27/25 at 10:32 a.m., the Administrator provided a copy of an undated facility policy, titled Medication Distribution, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the community to ensure the proper storage of

	medications. This citation relates to Intake IN00464350. Based on observation, interview, and record review, the facility failed to ensure an unsupervised medication cart was locked for 1 of 3 random medication cart observations. A resident opened the top drawer of a medication cart and took two medications that were not his. (Resident B, Resident C) Findings include: During a tour of the memory care unit from, 8/27/25 at 8:18 a.m. until 8:32 a.m., observed the following:			

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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