STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF CASTLETON, LLC	8480 CRAIG ST, INDIANAPOLIS, , 46250

(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 466025, 466471, 466477 and 467145. Intake 466025-No deficiencies related to the allegations are cited. Intake 466471-State deficiencies related to the allegations are cited at R64 and R298. Intake 466477-No deficiencies related to the allegations are cited. Intake 467145-No deficiencies related to the allegations are cited. Survey date: April 14 and 15, 2026 Facility number: 009894 Residential Census: 115	R 0000		

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 21, 2026.			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure a resident's narcotic medication was free from loss or theft for 1 of 1 resident reviewed for missing narcotic medications. (Resident D) Findings include: During an interview, on 4/15/26 at 9:34 a.m., the Director of Nursing (DON) indicated QMA 4 had entered a physician's order to change Resident D's oxycodone-acetaminophen (a narcotic pain medication) 10/325 milligrams (mg) from three times a day to two times a day. There had not been a physician's order to change the	R 0064	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • A new order was obtained from pain management to replace the missing narcotics in question for resident D. • Resident D missed no doses of her scheduled narcotic. How will the facility identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken? • All residents that receive narcotics have the potential to be affected. • All medication administration records were audited and all narcotics immediately counted with no other residents found to have been affected. What measures will be	05/04/2026

	oxycodone-acetaminophen 10/325 mg from three times a day to two times a day. Qualified Medication Assistant (QMA) 4 should not have changed the physician's order. A handwritten controlled substance inventory tracker sheet had been placed in the shift-change narcotic tracking binder and started with the count of 60 pills. The original controlled substance inventory tracker sheet, sent by pharmacy, had not been found. QMA 4 and QMA 5 had not completed a narcotic count, of the cart for Resident D's medication, on 11/24/25. A narcotic count should be completed at any time a change in staffing occurred on a medication cart. A typed facility investigation indicated: On 11/25/25, QMA 6 reported to the Director of Nursing (DON) Resident D appeared to be missing narcotics. Resident D's physician order was changed, on 11/24/25, by QMA 4. Additionally, the narcotic sheet was missing and was replaced with a hand-written sheet. On 11/26/25, QMA 4 indicated she did not make the change to the physician's order and did not know anything about the discrepancy with the		put into place or why systemic changes the facility will make to ensure that the deficient practice does not recur? • In-service training scheduled with LPNs and QMAs regarding change of shift inventory on narcotics. • In-service training will continue to be scheduled quarterly to ensure new associates are appropriately trained. • A weekly Controlled Substance Audit Tool has been implemented to ensure narcotic count are reconciled on each shift change. • QMAs and LPNs are required to report missing narcotic reconciliation counts to DON or designee. • A formal reprimand will be issued to those clinical team members that do not follow the Community practice of counting narcotics at shift change. • In-service regarding narcotic counting on med carts will take place with LPNs and QMAs to re-train on change of shift inventory for narcotics. How will the corrective	

	medication. On 11/27/25, QMA 5 indicated she had the medication cart on 11/24/25 until noon and did not administer any narcotics to Resident D. QMA 4 took over the medication cart at noon and a narcotic count was not completed. The facility was able to determine 15 narcotic pills were missing for Resident D. A police report indicated on 12/5/25, a detective received an email from the Executive Director (ED) in reference to a medication theft as several tablets of prescription narcotic medication were missing/stolen from a resident at the facility. On 12/16/25, a detective spoke with the ED who explained, on 11/24/25, the facility discovered approximately 15 tablets of a resident's narcotic medication were missing. The QMAs assigned to the cart did not complete a count to verify the medications. There was video footage, but it did not capture what happened to the medication. The clinical record for Resident D was reviewed on 4/14/26 at 11:17 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and fibromyalgia.		action(s) be monitored to ensure the deficient practice will not recure, i.e. what quality assurance program will be put into place? • The weekly Controlled Substance Audit Tool (attached) will ensure that the deficient practice will not recur. The audit tool will be completed weekly X 3 months, then monthly thereafter. • By identifying those associates with failure to count, this will provide the opportunity for additional training.Additionally, this Audit Tool will help identify those associates that cannot follow facility policy, with the occurrence noted. By what date will the systemic changes be completed? • May 4, 2026	

	A physician's order, dated 11/21/25 and discontinued on 11/24/25, indicated to administer oxycodone-acetaminophen 10/325 milligrams three times a day. A physician's order, dated 11/25/25 and discontinued on 11/26/25, indicated to administer oxycodone-acetaminophen 10/325 mg two times a day. A physician's order, dated 11/26/25, indicated to administer oxycodone-acetaminophen 10/325 mg three times a day. A new prescription summary sent to the pharmacy, dated 12/16/25, indicated to dispense a four (4) day supply (12 tablets) of oxycodone-acetaminophen 10-325 mg. The note section indicated "Medication stolen from facility. Please fill 12/16/25". During a telephone interview, on 4/14/26 at 11:26 a.m., the pharmacy Director of Operations indicated 90 tablets of oxycodone-acetaminophen 10/325 mg had been delivered on 11/21/25, and the signed manifest indicated QMA 5 had signed for them. During an interview, on 4/15/26 at 9:21 a.m., the Executive			

	Director (ED) indicated she and the Regional Director completed an investigation of how many tablets of the oxycodone-acetaminophen 10/325 mg were left, compared to how many had been administered, and how many were delivered from the pharmacy. It had been determined 15 tablets were missing. The ED indicated she had filed a police report and notified the pain management clinic. A current facility policy, titled "Medications and Treatments Controlled Substances Count", dated as last revised on 5/2011 and received from the DON on 4/15/26 at 9:35 a.m., indicated "...Controlled substances should be counted at the end of each shift or when control of the medications keys is passed to another associate...an on-coming associate and an out-going associate should count each controlled substance and verify the amount of controlled substance remaining against the amount listed on the Controlled Substance Count Sheet ...The community or the pharmacy should supply Controlled Substance Counts Sheets for each controlled substance ...If the number of controlled substances counted matches the number listed on the Controlled Substance Count			

	Sheet, then each associate should sign the Controlled Substance/MAR Change of Shift Audit ...If there is a discrepancy, associates should immediately notify the nurse, Executive Director or designee ...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure controlled substance shift change audit forms were	R 0298	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were directly affected by the alleged deficient practice. • All narcotic sign-off logs were reviewed for missing signatures for counting and staff education provided. • A weekly Controlled Substance Audit Tool will be implemented to ensure narcotic counts are reconciled on each shift change and that all narcotics are counted between shifts. • In-service completed with LPNs and QMAs tor re-train on change of shift inventory for narcotics and counting requirement. How will the facility identify other residents having the potential to be affected by the deficient	05/04/2026

	completed to show the narcotic medications were reconciled in 2 of 2 medication carts reviewed for narcotic medications. (medication cart 1 and medication cart 2) Findings include: 1. During a review of the medication cart 1 controlled substance change of shift audit inventory tracker sheet, on 4/14/25 at 3:09 p.m., the form did not contain signatures to indicate the narcotic medications were reconciled on 3/26/26, 3/27/26, 3/28/26, 3/29/26, 3/30/26, 3/31/26, 4/1/26, 4/2/26, 4/3/26, 4/4/26, 4/5/26, 4/6/26, 4/7/26, 4/8/26, 4/9/26, 4/10/26, 4/11/26, 4/12/26, 4/13/26 and 4/14/26. There were 80 signatures missing from the dates listed above. During a review of the medication cart 1 controlled substance change of shift audit inventory tracker sheet, on 4/14/25 at 3:10 p.m., the form did not contain signatures to indicate the narcotic medications were reconciled on 3/27/26, 3/28/26, 4/1/26, 4/2/26, 4/6/26, 4/8/26, 4/9/26, 4/10/26, 4/11/26, 4/13/26 and 4/14/26. There were 21 signatures missing from the dates listed above. During an interview, on 4/15/26		practice and what corrective action will be taken? • All narcotic sign-off logs were reviewed for missing signatures for counting and staff education provided. • In-service training for all LPN and QMA staff will be on-going to prevent the deficient practice from recurring. What measures will be put into place or why systemic changes the facility will make to ensure that the deficient practice does not recur? • In-service training was scheduled with LPNs and QMAs regarding change of shift inventory on narcotics. • In-service training will be scheduled quarterly on going to ensure new and existing associates fully understand the expectation of the Community. • A weekly Controlled Substance Audit Tool will be implemented to ensure narcotic counts are reconciled on each shift change and that all narcotics are counted between shifts. • QMAs and LPNs are	

	at 9:34 a.m., the Director of Nursing (DON) indicated a narcotic count should be completed at any time a change in staffing occurred on a cart. During an interview, on 4/15/25 at 9:04 a.m., QMA 2 indicated before taking over a medication cart, a count of the narcotics in the lock box should be completed with the off going and oncoming staff member. The count of controlled substances in the locked box should be the same as the controlled substance inventory tracker sheet in a binder on the cart. During an interview, on 4/15/26 at 8:58 a.m., QMA 3 indicated when beginning and leaving a shift, a narcotic count should be completed and documented on the shift-change controlled substance inventory tracker sheet. A current facility policy, titled "Medications and Treatments Controlled Substances Count", dated as last revised on 5/2011 and received from the DON on 4/15/26 at 9:35 a.m., indicated "...Controlled substances should be counted at the end of each shift or when control of the medications keys is passed to another associate...an on-coming associate and an out-going associate should count each controlled substance		encouraged to immediately report if a narcotic count does not occur on a shift. How will the corrective action(s) be monitored to ensure the deficient practice will not recur ,i.e. what quality assurance program will be put into place? • The weekly Controlled Substance Audit Tool (attached)will ensure that the deficient practice will not recur. The audit tool will be completed weekly X 3 months, then monthly thereafter. • By identifying those associates with failure to count, this will provide the opportunity for additional training. Additionally, this Audit Tool will help identify those associates that cannot follow facility policy. By what date will the systemic changes be completed? • May 4,2026	

	and verify the amount of controlled substance remaining against the amount listed on the Controlled Substance Count Sheet ...The community or the pharmacy should supply Controlled Substance Counts Sheets for each controlled substance ...If the number of controlled substances counted matches the number listed on the Controlled Substance Count Sheet, then each associate should sign the Controlled Substance/MAR Change of Shift Audit ...."			

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 SIGNATURECaryl Houghton	TITLEExecutive Director	(X6) DATE05/01/2026