STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/08/2026

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 Investigation of Intakes 469853, 469861, 469994, 469999 and 470049. Intake 469853-State deficiencies related to the allegations are cited at R241. Intake 469861-State deficiencies related to the allegations are cited at R241. Intake 469994-State deficiencies related to the allegations are cited at R64. Intake 469999-No deficiencies related to the allegations were cited. Intake 470049-No deficiencies related to the allegations were cited. Survey dates: June 4, 5 and 8, 2026 Facility number: 009894 Residential: 111	R 0000		

	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 16, 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 residents' narcotic medication was kept safe and secure for 3 of 3 residents reviewed for misappropriation of property. (Resident C, D and E) Findings include: An email, dated 5/29/26, from a primary care provider indicated three (3) residents over the past few months had negative drug screens and had controlled substances prescribed for them. The facility had requested routine controlled substance refills which were processed. The prescriptions were verified by the pharmacy as being	R 0064	**Plan of Correction, Intake 469994, R064** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Narcotic count sheets for resident D are in the resident's cart and show all medications where given as ordered and initialed by the nurses. The resident and family was also interviewed by the department of health surveyor and confirmed that the resident was getting her narcotics. • The narcotic count sheets in question for resident E were also accounted for and show the resident was administered their hydrocodone in January and February. Further documentation shows the narcotic was d/c'd on February 3rd and we have a destruction sheet for	06/26/2026

	delivered to the facility for the three (3) residents and signed for by a facility staff member. The concern was facility staff and Director of Nursing (DON) requested controlled substance refills for medications which appeared the residents were not receiving based on inconsistent drug screens and personal reports from the residents. The controlled substances for the three (3) residents were ordered on an as needed (PRN) basis. The standard practice for PRN controlled substance medications was to only request a refill when the supply was gone. This was not the case with the three (3) residents narcotic medications. The medications were being refilled more often. 1. The clinical record for Resident C was reviewed on 6/5/26 at 1:15 p.m. The diagnoses included, but were not limited to, anxiety disorder, hypertension, and hyponatremia. Resident C had an order for hydrocodone (a controlled substance pain medication) 7.5/325 mg (milligram) written on 2/9/26, to administer one tablet orally every six hours as needed for pain with 120 pills prescribed each month. Resident C had a prescription		the remainder of the medication.The last day the narcotic was administered was 2/2/26 so the drug screen would have been negative on 3/16/26. • Narcotic count sheets for resident C were unable to be accounted for the months noted. • Facility has implemented a weekly Controlled Substance Audit Tool.The use of this tool is to ensure narcotic counts are reconciled on each shift change and that all narcotics are counted between shifts. • Facility is having pharmacy send a weekly report to the Executive Director and the Regional Director.This report is called the Monthly Controlled Drug Report.Pharmacy will update this report weekly with the narcotics that are sent each week to the building. • The facility will audit this sheet to ensure that the orders are in the system and medications are accounted for. How the facility will identify other residents	

	sent to the pharmacy which was filled on 3/5/26, 4/15/26 and 5/19/26. Resident C had a negative urine drug screen for hydrocodone on 4/30/26 and 5/13/26. The Electronic Medication Administration Record (EMAR) did not contain documentation to show Resident C had any hydrocodone 7.5/325 mg tablets administered in April 2026 or May 2026. There was no narcotic log sheets found for the hydrocodone prescriptions filled on 3/5/26, 4/15/26 or 5/19/26, to verify the narcotic pill count or the amount of medication administered. Resident C told the physician, on her 5/27/26 visit, she was not receiving her pain medication. 2. The clinical record for Resident D was reviewed on 6/5/26 at 1:37 p.m. The diagnoses included, but were not limited to, major depressive disorder, vascular dementia, type II diabetes mellitus, and hypertension.		having the potential to be affected by the same deficient practice and what corrective action will be taken: • All residents who are prescribed narcotics had the potential to have been affected by the alleged deficient practice. Upon immediate audit no additional concerns were noted. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: • Weekly Controlled Substance Audit will ensure counts are completed and narcotics are entered in the EMAR. The audit will continue weekly x 6 months then monthly thereafter. • Facility is working with the primary care provider to discontinue the ordering of large counts ofPRN narcotics. By limiting the pill counts – we can better determine if a diversion is occurring. • In-service training for all LPN and QMA staff on Handling Controlled	

	Resident D had an order for hydrocodone 5/325 mg, written on 2/9/26, to administer one tablet orally every six hours as needed for pain with 120 pills prescribed each month. Resident D had a prescription sent to the pharmacy which was filled for more than 12 months. Resident D had a negative drug screen for hydrocodone on 12/10/25 and 4/3/26. The EMAR did not contain documentation to show Resident D had any hydrocodone 5/325 mg tablets administered in March 2026 or April 2026. There was one dose documented as administered on 5/7/26. 3. The clinical record for Resident E was reviewed on 6/5/26 at 1:52 p.m. The diagnoses included, but were not limited to, acute kidney failure, generalized anxiety disorder, mild cognitive impairment, and dysphasia. Resident E had an order to administer a hydrocodone 5/325 mg tablet orally every eight hours as needed for pain.		Substances has been done.This also covered the proper documentation and disposal of narcotics. • Weekly audit of the pharmacy monthly controlled drug report is completed to ensure delivery of the medication and that the order is in the system. The audit will continue weekly X 6 months then monthly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: • Weekly Controlled Substance Audit will ensure counts are done and narcotics are entered in the EMAR. The audit will continue weekly x 6 months then monthly thereafter. • Weekly audit of the pharmacy monthly controlled drug report is completed to ensure delivery of the medication and that the order is in the system. The audit will continue weekly X 6 months then monthly thereafter.	

	Resident E had prescriptions which were filled, every week during the month of November 2025, with a total of 21 tablets per prescription. Resident E had a prescription, written in December 2025, for 84 tablets. Resident E also had prescriptions written on 1/7/26, 1/26/26 and 2/2626, for 90 tablets each. Resident E had a negative urine drug screen for hydrocodone on 3/16/26. The EMAR did not contain documentation to show Resident E had any hydrocodone 5/325 mg tablets administered in January 2026, and only a few doses in early February 2026. During an interview, on 6/5/26 at 11:15 a.m., the DON indicated she had a very strong suspicion it was the QMA who had stolen these missing narcotics. During an interview, on 6/5/26 at 11:37 a.m., the Nurse Practitioner (NP) from the primary care provider indicated residents who received controlled substances were on a pain contract with this provider. The residents were subject to drug screen testing. Resident C's hydrocodone was		By what date the systemic changes will be completed: June 26, 2026	

	discontinued on 3/16/26, but she continued to get hydrocodone refills every month until it was discovered her hydrocodone had been discontinued. The hydrocodone came up missing, and the resident had negative drug screens on 4/30/26 and 5/13/26. During an interview, on 6/8/26 at 12:52 p.m., the Regional Executive Director indicated the controlled substance orders were entered into the computer and then after the medication order had been sent to the pharmacy, the order was deleted out of the computer by QMA 6. The pharmacy still sent the controlled substance medication to the facility. The controlled substance medications and the narcotic count sheet then went missing. The Regional Executive Director "believed" QMA 6 took the narcotics and the narcotic count sheets. QMA 6 was involved in the last two narcotic investigations. The facility could not prove QMA 6 took the narcotics and QMA 6 had a negative urine test. QMA 6 had clocked in at 7:00 a.m., on one of the days, and the medication was deleted and by 7:06 a.m., that day. During an interview, on 6/8/26 at 1:30 p.m., the DON indicated she found the narcotic count			

	sheets for Resident E, but the narcotic count sheets for Residents C and D were missing. Whoever took the narcotics must have taken the count sheets with them. During an interview, a confidential interviewee indicated the DON had loaned her computer login username and password to several agency staff members to use when they worked to chart and sign off medications. These agency staff members had even used her login credentials when she was on leave. She was on leave from 1/22/26 through 4/1/26. She indicated she had asked the DON several times to stop using her login credentials for all the agency staff members, but she continued to do it. She had received a telephone call from the Regional Executive Director, Executive Director, and DON, on 6/5/26, regarding residents' narcotic medications missing and why she had deleted Resident C's hydrocodone orders on 4/15/26 and 5/21/26. She indicated she had no idea how to "strike out medications" on the computer. She "believed" someone else had "struck out the orders" using her credentials, which made it look like she did it. During an interview, a confidential interviewee			

	indicated she used a login credential which was the same for all the agency staff members. It was the name of QMA 6. She did not know she was using another staff member's login credentials until last week. The confidential interviewee continued to use the login credentials because the word "agency" popped up in the corner of the Electronic Medication Administration Record (EMAR) and she thought this was a login assigned for agency staff members to use. The DON had given her the login credentials when she started working there. On Saturday 6/6/26, the DON called her and told her she had her own login credentials now and she needed to stop using the other login credentials. During an interview, a confidential interviewee indicated she used a login credential used by all agency staff members. She did not know it was a staff member's login credential until one day last week. She did not know the login belonged to a staff member. The DON gave her the login credentials when she first started working there. During an interview, a confidential interviewee indicated the DON had given a staff members computer login			

	credentials to the agency staff members to sign into the computer to pass their medications and chart. A current facility policy, titled "Medications & Treatments - Unused Medication Disposal/Return to Resident/Legally Responsible Party or Pharmacy", dated 5/1/23 and received from the DON on 6/5/26 at 10:32 a.m., indicated " ...Discontinued and Unused Controlled Substances: When a resident is living in the community ...unused and discontinued controlled substances should be disposed of Properly at the community within seven days ...." This citation relates to Intake 469994.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.	R 0241	**Plan of Correction , Intake 469853 and 469861, R 241** **The community disputes the finding of a Health Services – Offense 410 IAC 16.2-5-4(e)(1) which stated “the facility failed to ensure a resident did not receive controlled substance medications which were not ordered by the physician”.** What corrective action(s) will be	06/26/2026

	Based on interview and record review, the facility failed to ensure a resident did not receive controlled substance medications which were not ordered by the physician for 1 of 4 residents reviewed for physician's orders. (Resident B) Resident B was sent to the emergency room for altered mental status and tested positive for controlled substance medications which were not ordered by the physician. Findings include: An email from a hospital, dated 5/22/26, indicated Resident B was admitted to the hospital, on 5/15/26, with complaints of altered mental status. The hospital had a strong concern about a medication error which had occurred at her assisted living facility. When she was admitted to the hospital, she tested positive for benzodiazepines (a class of central nervous system depressants which slow down brain activity) and opiates (a class of drugs often used for severe pain relief). These medications were confirmed to be lorazepam (a medication used to treat anxiety), hydromorphone (a highly potent synthetic opioid prescribed to treat moderate-to-severe pain) and morphine metabolites (the metabolites in which the liver		accomplished for those residents found to have been affected by the deficient practice: • The facility requests an IDR for this deficiency. • The facility questions the validity of the tox screen at the hospital and questions why it wouldn't have been run again. • The community has no hydromorphone onsite and has not in years. This clearly shows that the facility did not administer this medication. • The facility does have other residents that take lorazepam and morphine but there were no narcotic discrepancies noted on their counts or administration. • The resident's husband does not take any of the listed medications that the hospital stated the resident tested positive for. • The residents EMAR was audited, and her picture is visible to ensure the right resident. How the facility will identify other residents having the potential to be affected by the same	

	metabolizes morphine into). None of these were documented on her medication list as medications she was ordered. Multiple attempts to reach the director of nursing had been unsuccessful. The clinical record for Resident B was reviewed on 6/4/26 at 1:15 p.m. The diagnoses included, but were not limited to, vascular dementia, anxiety disorder, chronic atrial fibrillation, and localized edema. The physician's orders dated May 2026, for Resident B did not include any physician's orders for benzodiazepines, hydromorphone or morphine medications. The emergency room progress note, dated 5/15/26, indicated there was a concern for polypharmacy contributing to Resident B's altered mental status change due to discrepancies between the assisted living facility medication list and the medication pack. A urine drug screen, dated 5/15/26, indicated Resident B tested positive for a benzodiazepine of lorazepam and for opiates medications of hydromorphone and morphine. During a telephone interview, on 6/4/26 at 10:56 a.m., a Nurse Practitioner from the hospital		deficient practice and what corrective action will be taken: • All residents who are prescribed narcotics had the potential to have been affected by the alleged deficient practice. Upon immediate audit no additional concerns were noted. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: • On-going training with LPN and QMA staff will occur regarding medication and treatment general guidelines. • In-service training for all LPN and QMA staff on Handling Controlled Substances and Medication &Treatment-GeneralGuidelines for Medication Administration/Assistanc e has been completed.This also covered the proper documentation and disposal of narcotics. • Resident pictures are in the EMAR to ensure safe administration. • Shift change must include inventory on	

	indicated she had attempted to reach the Director of Nursing (DON) to inform her Resident B had tested positive for benzodiazepines and two opiates, which she was not prescribed. She did not receive any calls back. Her supervisor reached out to the DON and notified her Resident B had tested positive for medications she was not prescribed. The DON had acknowledged she understood the seriousness of the information and indicated she was going to investigate to determine how the resident had received the opiates and benzodiazepines she tested positive for on the drug screen. A facility investigation into how Resident B obtained the benzodiazepine and two opiates without a prescription and tested positive on a urine drug screen was requested on 6/4/26. By the end of the exit conference, on 6/8/26, an investigation regarding Resident B's positive urine drug test was not provided. During a telephone interview, on 6/4/26 at 11:20 a.m., Resident B's Power of Attorney (who was also a physician) indicated the only way she believed Resident B would have had opiates in her system and a positive urine drug screen was if the nursing staff had administered Resident B's		narcotics. • Weekly Controlled Substance Audit will ensure counts are completed and narcotics are entered in the EMAR. The audit will continue weekly x 6 months then monthly thereafter. • Director of Nursing understands that all clinical phone calls must be returned or referred to another clinician.Additionally, front desk associates understand that urgent clinical calls must be routed to the Executive Director if they are told calls are not being returned. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; • Weekly Controlled Substance Audit will ensure counts are completed and narcotics are entered in the EMAR. The audit will continue weekly x 6 months then monthly thereafter. • It is our goal that we partner with area physician and hospitals	

	husband's medications to her in error. During an interview, on 6/8/26 at 11:15 a.m., the Director of Nursing indicated there had not been any hydromorphone in the facility since 2021. She had no idea how Resident B tested positive for the three drugs on her drug urine test. During a telephone interview, on 6/8/26 at 1:15 p.m., a Social Worker from the hospital indicated Resident B was not administered any benzodiazepines or opiates during her treatment in the emergency room. Her toxicology urine drug screen indicated she tested positive for lorazepam, hydromorphone and morphine. A facility policy related to medication errors was not provided. This citation relates to Intakes 469853 and 469861.		and that legitimate concerns are addressed.By responding promptly to telephone calls, we can correct perceived errors or request that tests be re-administered, if needed. By what date the systemic changes will be completed: • June 26, 2026.	

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 SIGNATURECamille Beeson	TITLERDO	(X6) DATE06/29/2026