

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>08/12/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>WYNDMOOR OF CASTLETON, LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>8480 CRAIG ST, INDIANAPOLIS, , 46250 |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                          | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION...                                | (X5)<br>COMPLETION<br>DATE                      |
| R 0000                                                         | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Intakes 469853, 469861, 469994 completed on June 8, 2026. This visit was in conjunction with the Investigation of Intakes 470049, 470633, 470769, and 470910.</p> <p>Intake 469853-Not corrected.</p> <p>Intake 469861-Not corrected.</p> <p>Intake 469994-Not corrected.</p> <p>Intake 470049-No deficiencies related to the allegations are cited.</p> <p>Intake 470633-No deficiencies related to the allegations are cited.</p> <p>Intake 470769-State deficiencies related to the allegations are cited at R241 and R349.</p> <p>Intake 470910-State deficiencies related to the</p> | R 0000                                                                               |                                                                 |                                                 |

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|        | <p>allegations are cited at R241 and R349.</p> <p>Survey dates: August 11 and 12, 2026</p> <p>Facility number: 009894</p> <p>Residential: 108</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on August 14, 2026.</p>                                                                                                                                                                                                                                                                                                                                                                                 |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |            |
| R 0064 | <p>Residents' Rights- Noncompliance</p> <p>410 IAC 16.2-5-1.2(hh)</p> <p>(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.</p> <p>Based on observation, interview and record review, the facility failed to ensure procedures were in place and followed to ensure medication was kept safe and secure for 2 of 2 medication carts and 1 of 1 resident reviewed for medication storage. (Cart 1, Cart 2, Resident B)</p> | R 0064 | <p><b>Plan of Correction Audit, Intake 469853, 469861 and 469994, R064</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> <li>• Proper narcotic counts between shifts can affect any resident. The Community has hired a new Director of Nursing and Assistant Director of Nursing to ensure appropriate pr procedures are being followed. This includes the monitoring of the change-of-shift audit log for controlled substances.</li> </ul> | 08/28/2026 |

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|  | <p>Findings include:</p> <p>1. The controlled substance storage and counting logs were reviewed on 8/11/26 at 11:20 a.m.</p> <p>a. The controlled substance change-of-shift audit log for medication cart 1, dated 6/29/26 through 7/5/26, indicated two (2) nurses did not sign the controlled substance count on any date from 6/29/26 through 7/5/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on any shift for the entire week.</p> <p>The controlled substance change-of-shift audit log for medication cart 1, dated 7/13/26 through 7/19/26, indicated two (2) nurses did not sign the controlled substance count on 7/15/26, 7/16/26, 7/18/26, and 7/19/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on 7/13/26, 7/14/26, 7/15/26, 7/16/26, 7/18/26, and 7/19/26.</p> <p>The controlled substance change-of-shift audit log for medication cart 1, dated 7/20/26 through 7/26/26, indicated two (2) nurses did not sign the</p> |  | <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> <li>All residents who are prescribed narcotics have the potential to be affected by the deficient practice. Proper shift change audits ensures that all medications are accounted for.</li> </ul> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>By hiring a new Director of Nursing and Assistant Director of Nursing, we can ensure that appropriate med cart counts are being done. The DON or ADON will run a daily audit on the med carts to ensure that counts are done between shift changes.</li> <li>In-service training for all LPNs and QMAs will be done to address the importance of counting controlled substances.</li> </ul> |  |
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|  | <p>controlled substance count on 7/23/26, 7/24/26, and 7/26/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on 7/20/26 through 7/24/26.</p> <p>The controlled substance change-of-shift audit log for medication cart 1, dated 7/27/26 through 8/2/26, indicated two (2) nurses did not sign the controlled substance count on 7/27/26, 7/30/26, 8/1/26, and 8/2/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on any shift for the entire week. All the non-signature columns were blank.</p> |  | <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> <li>• A daily audit tool will be implemented daily by the DON or ADON to ensure controlled substances are counted between shifts and any discrepancies noted.</li> <li>• Audit will be done daily for 120 days and thereafter for 4 months.</li> </ul> <p>By what date the systemic changes will be completed:</p> <ul style="list-style-type: none"> <li>• August 28, 2026</li> </ul> |  |
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The controlled substance change-of-shift audit log for medication cart 1, dated 8/3/26 through 8/9/26, indicated there was no documentation of the count being completed or the number of controlled substance cards present on 8/4/26 for any shift, 8/5/26 for the night shift, 8/6/26 for the night shift, 8/7/26 for the day shift, 8/8/26 for the day shift, and a signature was missing for a second nurse on 8/7/26 for the night shift and 8/9/26 for the night shift.

b. The controlled substance change-of-shift audit log for medication cart 2, dated 7/13/26 through 7/19/26, indicated two (2) nurses did not sign the controlled substance count on any date from 7/13/26 through 7/19/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on any shift for the entire week.

The controlled substance change-of-shift audit log for medication cart 2, dated 7/20/26 through 7/26/26, indicated two (2) nurses did not sign the controlled substance count on 7/20/26, 7/23/26, and 7/24/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual

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|  | <p>count of controlled substances were not indicated on any shift for the entire week. All the non-signature columns were blank.</p> <p>The controlled substance change-of-shift audit log for medication cart 2, dated 7/27/26 through 8/2/26, indicated two (2) nurses did not sign the controlled substance count on 7/27/26, 7/30/26, 7/31/26, 8/1/26, and 8/2/26. The number of controlled substances, number of controlled substance sheets, and the accuracy of the actual count of controlled substances were not indicated on any shift for the entire week. All the non-signature columns were blank.</p> <p>During an observation and interview, on 8/11/26 at 11:24 a.m., Unit Manager 4 indicated she had not completed the controlled substance count sheet at the beginning of her shift on medication cart 1. Eighteen (18) controlled substances (17 in the cart and 1 in the refrigerator) were counted during the observation. The last documented count on the sheet was 20 on 8/10/26 for the 7a-7p shift line. She indicated she had removed 2 medications earlier in her shift and would document it at the end of her shift. She indicated it was difficult to complete the current count</p> |  |  |  |
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sheets for the frequent dates the nurses on the unit worked 8 hours instead of 12. The sheets were supposed to be completed with 2 nurses at shift change, and all the columns should be filled out.

During an interview, on 8/11/26 at 12:58 p.m., QMA (Qualified Medication Aide) 2 indicated the nurses were supposed to count the controlled substances together every time they changed shifts, both were to sign, and each column should be filled out. If the count was incorrect, the off-going nurse would correct the problem before leaving so the count would be correct as the new nurse took over.

2. The clinical record for Resident B was reviewed on 8/11/26 at 10:18 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depressive episodes, and autistic disorder.

A physician order, dated 3/11/26 and discontinued 7/15/26, indicated to inject Mounjaro (a glp medication for diabetes) subcutaneously (the fatty layer just under the surface of the skin), in the evening every Monday for diabetes mellitus. Instructions indicated the medication could be held in Resident B's refrigerator in her

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room.

A physician order, dated 7/15/26, indicated to inject Mounjaro subcutaneously every Thursday for diabetes mellitus.

During an interview, on 8/12/26 at 10:54 a.m., Pharmacist 5 indicated Resident B's Mounjaro with a quantity of 4 pens was last delivered to the facility on 7/15/26.

The medication administration record (MAR), dated July 2026, indicated Resident B received a dose of Mounjaro on 7/16/26 and 7/30/26. The MAR, for August 2026, indicated Resident B had not received any doses of Mounjaro. The resident should have 2 pens left from the shipment on 7/15/26.

During an observation and interview, on 8/12/26 at 9:41a.m., QMA 3 searched in the medication storage refrigerator and the refrigerator in Resident B's room and indicated they could not find Resident B's Mounjaro injection pens.

During an observation and interview, on 8/12/26 at 11:11 a.m., the Executive Director (ED) searched in the medication storage refrigerator and the refrigerator in Resident B's room and indicated she could not find Resident B's Mounjaro injection

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|  | <p>pens.</p> <p>The clinical record indicated late entries was added related to the administration of Mounjaro on 7/23/26 and 8/6/26 after the start date of the survey.</p> <p>A facility plan of correction, dated 6/26/26, indicated the facility had implemented a weekly controlled substance audit tool. The use of this tool was to ensure controlled substance counts were reconciled each shift change, and all controlled substances were counted between shifts to reduce the risk of diversion and protect the residents' property.</p> <p>A staff education document, titled "Handling of Controlled Substances-General Reminders, Part 1," undated and provided by the Executive Director (ED) upon entrance with the plan of correction, indicated "...Shift Change Counts: 1. A physical inventory of all controlled drugs is made at the change of each shift by two licensed nurses and is documented on an audit record...Both nurses must look at and verify the narcotic book count AND the number of doses in the blister pack/container. A. There must always be TWO sets of eyes on the book and the medication, no exceptions...." The ED indicated</p> |  |  |  |
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|        | <p>all staff had been educated on and received a copy of this document by 6/26/26.</p> <p>A current facility policy, titled "Medication &amp; Treatments Controlled Substance Count," dated 5/1/19 and provided by the ED on 8/11/26 at 2:07 p.m., indicated "...An on-coming associate and an out-going associate should count each controlled substance and verify the amount of controlled substances remaining against the amount listed...."</p> <p>A current facility policy, titled "Resident Rights," dated 1/8/25 and provided by the ED on 8/11/26 at 11:00 a.m., indicated "...The facility shall exercise reasonable care for the protection of residents' property from loss and theft ...."</p> <p>This deficiency was cited on 6/8/26. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> |        |                                                                                |            |
| R 0241 | <p>Health Services - Offense</p> <p>410 IAC 16.2-5-4(e)(1)</p> <p>(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</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | R 0241 | <p><b>Plan of Correction Audit, Intake 469853, 469861 and 469994, R241</b></p> | 08/28/2026 |

premises or on call as follows:

(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.

Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the physician for 2 of 3 residents reviewed for medication administration. (Resident C and B) This deficient practice resulted in Resident C not receiving anti-seizure medications with an increase in seizure activity requiring hospital transport and Resident B not receiving a medication used to improve blood sugar control with continued uncontrolled blood sugar levels and elevated HgA1C levels.

Findings include:

1. During an interview, on 8/11/26 at 11:33 a.m., Resident C indicated staff either did not administer or was delayed in administering his seizure medications. He often did not receive his morning medications until 1:30 p.m.

The clinical record for Resident C was reviewed on 8/12/26 at 10:35 a.m. The diagnoses included, but were not limited to, epilepsy, recurrent seizures,

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

- Regarding Resident B - Injections have been moved to night shift on Thursdays so that one LPN is responsible for administering and charting this. Pharmacy is aware of this change in the medication.
- Resident B will keep medication in her refrigerator so that it is specific to her.
- Clinical team will have an in-service to train them on the importance of Resident C's seizure medication.
- In-service with pharmacy to re-train on ordering refill prescriptions to ensure there is not a lag in medications being administered.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- All residents who are prescribed medications

conversion disorder (a seizure disorder) with seizures or convulsions, post traumatic seizures, and epileptic syndromes with complex partial seizures.

a. A physician's order, dated 10/22/24, indicated to administer three (3) tablets of levetiracetam (an antiseizure medication) 500 milligrams (mg) three (3) times a day for seizures. This medication order was revised, on 7/28/26, to be unsupervised with self-administration. It was not unsupervised self-administration prior to the revision.

The Medication Administration Record (MAR), dated June and July 2026, indicated levetiracetam was not administered on 6/8/26 at 4:00 p.m., on 6/11/26 at 4:00 p.m., on 6/15/26 at 8:00 a.m., on 7/5/26 at 8:00 a.m., on 7/6/26 at 8:00 a.m. and 4:00 p.m., and on 7/7/26 at 8: 00 a.m.

b. A physician's order, dated 4/13/26, indicated to administer one (1) tablet of lacosamide (an antiseizure medication) 100 mg twice a day for recurrent seizures. This medication order was revised, on 7/28/26, to be unsupervised with self-administration. It was not unsupervised self-administration prior to the revision.

have the potential to be affected by the deficient practice. Upon an 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 will be completed on charting and administering medications as ordered by the physician.
- Weekly audits will be implemented to ensure medication refills are ordered in a timely manner.

How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place :

- Daily report will be done on holes in the MAR:
- Weekly audit to ensure

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The Medication Administration Record (MAR), dated June and July 2026, indicated lacosamide was not administered on 6/11/26 at 4:00 p.m., on 6/15/26 at 8:00 a.m. and 4:00 p.m., on 6/16/26 at 8:00 a.m. and 4:00 p.m., on 7/7/26 at 8:00 a.m., and on 7/13/26 at 4:00 p.m. On 7/6/26, one dose was documented as administered at 1:00 p.m.

A progress note, dated 6/29/26, indicated staff went to answer Resident C's call light and the resident was face down. Staff went to call 911, came back, and the resident was having a seizure with upper extremity movement lasting about 1 minute. Resident C was taken to the emergency room.

A progress note, dated 7/7/26 at 9:17 a.m., indicated Resident C was sitting in the lobby on the couch when he started having a seizure. He had 4 of them back-to-back. After he came out of the seizure, he was still out of it so he was sent to the emergency room.

According to the documentation in the clinical record, Resident C did not receive his lacosamide until 1:00 p.m. on 7/6/26 and did not receive his second dose. He also did not receive his 8:00 a.m. dose on 7/7/26, so he went 20 hours without a dose of lacosamide. He also did not

medication refill requests are sent. Audit will be done weekly for 4 months.

By what date the systemic changes will be completed:

- August 28, 2026

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receive his 8:00 a.m. dose of levetiracetam on 7/5/26, either dose on 7/6/26, and did not receive his 8:00 a.m. dose on 7/7/26. Resident C then had 4 seizures in the morning on 7/7/26 and had to go to the emergency room.

A progress note, dated 7/20/26, indicated Resident C had a seizure in the lobby. He had a total of three (3) before and was sent to the emergency room.

During an interview, on 8/11/26 at 12:33 a.m., the Executive Director (ED) indicated the staff charted the lacosamide administration on the controlled drug log paper instead of the medication administration record since it had to be signed out.

During an observation and interview, on 8/12/26 at 11:01 a.m., Resident C's paper chart was reviewed. There was no controlled drug log for levetiracetam.

During an interview, on 8/12/26 at 11:15 a.m., Qualified Medication Aid (QMA) 3 indicated levetiracetam was not a controlled substance and staff would chart the administration on the medication administration record.

During an interview, on 8/12/26 at 10:57 a.m., Pharmacist 5

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indicated if a resident missed doses of lacosamide, the resident would have a higher onset of seizures. It would not be good if they were having additional seizures.

During an interview, on 8/11/26 at 1:59 p.m., Unit manager (UM) 4 indicated the resident could have more seizures if he was missing doses of his antiseizure medications. If staff did not chart the medications as administered, then they did not give them.

2. During an interview, on 8/11/26 at 10:59 a.m., Resident B indicated a nurse was to administer her daily insulin injection and weekly Mounjaro injection (a dual GIP/GLP-1 receptor agonist used to improve blood sugar control). She did not refuse the Mounjaro injections.

During an interview, on 8/12/26 at 9:18 a.m., the Licensed Social Worker for Resident B's primary care provider indicated they had received a telephone call from the pharmacist regarding concerns Resident B had not received the weekly Mounjaro injections as ordered by the physician. Resident B's blood glucose levels were out of control and the HgA1C (a blood test which measured average blood glucose levels over the past two to three months) was

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OMB NO. 0938-0391

elevated. Resident B had reported to the primary care physician during a visit, in July 2026, she had not received the weekly Mounjaro injection at the facility.

The clinical record for Resident B was reviewed on 8/11/26 at 10:18 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depressive episodes, and autistic disorder.

A service plan, dated 2/18/26, indicated Resident B had diabetes and required assistance with blood glucose monitoring and insulin injections. Resident B had chronic conditions which required specific care. Staff were to coordinate services with pharmacy, laboratory, doctors and/or non-facility providers, as well as ensure Resident B received all treatments as ordered.

A physician order, dated 3/11/26 and discontinued 7/15/26, indicated to inject Mounjaro (a glp-2 medication for diabetes) subcutaneously (into the fatty layer just under the surface of the skin), in the evening every Monday for diabetes mellitus. Instructions indicated the medication could be stored in Resident B's refrigerator in their room.

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A physician order, dated 7/15/26, indicated to inject Mounjaro subcutaneously every Thursday for diabetes mellitus.

The Medication Administration Record, dated 6/1/26 to 8/11/26, indicated Resident B's weekly Mounjaro injections had not been administered on 6/9/26, 6/22/26, 6/29/26, 7/23/26, and 8/6/26. The MAR lacked a nurse's signature to indicate it had been administered.

The clinical record lacked documentation of medication administration refusals, or an explanation of why the medication had not been administered.

The clinical record indicated late entries was added related to the administration of Mounjaro on 7/23/26 and 8/6/26 after the start date of the survey.

During an interview, on 8/11/26 at 1:59 p.m., QMA (Qualified Medication Aide) 7 reviewed the medication administration record and indicated it appeared the Mounjaro had not been administered. When medications were not administered, documentation in the clinical record would reflect the reason.

Resident B's HgA1C (a blood test to measure average blood sugar level in last 3 months)

levels were received from Resident B's primary care provider office, on 8/12/26 at 10:04 a.m., and indicated Resident B's HgA1C on 12/10/25 was 7.8%-High; on 3/23/26 was 8.5%-High, and on 7/6/26 was 9%-High.

The clinical record documentation of Resident B's blood glucose levels was reviewed and indicated from 6/1/26 to 8/11/26, her blood sugar was tested twice a day and 33 of the blood glucose checks resulted in readings between 200 and 355.

During an observation and interview, on 8/12/26 at 9:41a.m., QMA 3 searched in the medication storage refrigerator and the refrigerator in Resident B's room and could not locate Resident B's Mounjaro injection pens. QMA 3 indicated they were an agency nurse and did not work at the facility often. It was possible the medication could be stored somewhere else.

During an observation and interview, on 8/12/26 at 11:11 a.m., the Executive Director (ED) searched in the medication storage refrigerator and the refrigerator in Resident B's room and could not locate the Mounjaro injection pens. The ED indicated LPN 8 was responsible for ensuring

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medications were re-ordered. LPN 8 was not in the facility, but she (ED) would call LPN 8 to find out if Resident B's medication was ordered and if it would be expected in the pharmacy delivery on third shift (8/12/26).

During an interview, on 8/12/26 at 10:54 a.m., Pharmacist 5 indicated Resident B's Mounjaro with a quantity of 4 pens was last delivered to the facility on 7/15/26. A refill request had not been received from the facility since the last delivery on 7/15/26.

The clinical record indicated Resident B's next scheduled dose of Mounjaro was 8/13/26.

A current facility policy, titled "Medication & Treatment-General Guidelines for Medication Administration/Assistance," last revised 1/2/23 and received from the ED on 8/11/26 at 11:00 a.m., indicated "...Document medications administered or assisted with on the Medication Administration Record (MAR)/Medication Assistance Record/Medication Observation Record ...Documentation of medications administered/assisted, or treatments administered/assisted, should occur promptly after the resident has taken the medication or the

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|  | treatment performed.<br>Associates should sign the<br>paper copy<br>MAR/MOR/Treatment<br>Administration Record (TAR)<br>with their full signature/title and<br>initial each medication<br>administered/assisted or follow<br>the electronic MAR procedure<br>as required...." |  |  |  |
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The American Diabetes Association's about Diabetes, Understanding A1C: What it Measures and Why It Matters, dated 1995-2026, and retrieved on 8/12/26 at 12:45 p.m., at <https://diabetes.org/about-diabetes/a1c> indicated, "...The A1C test can be used to diagnose diabetes or help you know how your diabetes treatment plan is working...Your A1C results can be used to Diagnose prediabetes or diabetes...Your A1C offers a big picture of how your blood glucose has been over time. This allows you and your healthcare team to talk about if changes to your treatment plan are needed. These could be changes to your eating plan, physical activity, emotional support, or the medications you take...Reaching your A1C target is one way to lower your risk of developing diabetes complications...For most people living with diabetes, an A1C of 7% or less is the recommended target...."

This deficiency was cited on 6/8/26. The facility failed to implement a systemic plan of correction to prevent recurrence.

This citation relates to Intakes 470769 and 470910.

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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<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURECaryl Houghton | TITLEExecutive Director | (X6) DATE08/28/2026 |
|-------------------------------------------------------------------------------------------|-------------------------|---------------------|