

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER WYNDMOOR OF CASTLETON, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Intakes 470049, 470633, 470769, and 470910. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Intakes 469853, 469861, 469994 completed on June 8, 2026. Intake 470049-No deficiencies related to the allegations are cited. Intake 470633-No deficiencies related to the allegations are cited. Intake 470769-State deficiencies related to the allegations are cited at R241 and R349. Intake 470910-State deficiencies related to the allegations are cited at R241 and R349. Intake 469853-Not corrected.	R 0000		

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	Intake 469861-Not corrected. Intake 469994-Not corrected. Survey dates: August 11 and 12, 2026 Facility number: 009894 Residential: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 14, 2026.			
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. 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	R 0241	Plan of Correction, Intake 470769 and 470910, R241 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	08/28/2026

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, 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		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 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	
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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. 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		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 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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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 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.

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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 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

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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 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.

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

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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 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

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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 treatment performed. Associates should sign the paper copy MAR/MOR/Treatment Administration Record (TAR) with their full signature/title and initial each medication administered/assisted or follow the electronic MAR procedure as required...."

The American Diabetes Association's about Diabetes,

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	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 citation relates to Intakes 470769 and 470910.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated	R 0349	Plan of Correction, Intake 470769 and 470910, R349	08/28/2026

with that responsibility. The records must be as follows:

- (1) Complete.
- (2) Accurately documented.
- (3) Readily accessible.
- (4) Systematically organized.

Based on interview and record review, the facility failed to ensure the clinical record was completed and accurately documented for 2 of 3 residents reviewed for clinical records. (Resident B and C)

Findings include:

1. 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.

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 on 8/11/26.

The Medication Administration Record (MAR), for June 2026, included holes (missing medication administrations) for several different medications throughout the month.

The MAR, for July 2026,

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

- A daily audit has been established to ensure that the MAR does not have any holes. Any LPN or QMA will found to have not documented appropriately will be expected to correct the issue and document this in Point Click Care.
- LPN and QMA training include proper documentation when a resident is sent out. This will be double checked by the Executive Director each morning.

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 living at the community have the potential to be affected by the same deficient practice.
- Daily audit on documentation of those residents sent out to the hospital.

included holes for several different medications throughout the month.

The MAR, for August 2026, included holes for several different medications from 8/1/26 to 8/11/26.

The clinical record did not contain documentation explaining a rationale for the missed medication administrations.

During an interview, on 8/11/26 at 1:59 p.m., QMA (Qualified Medication Aide) 7 reviewed the MAR and indicated the June, July, and August MAR had several holes. When medications were not administered, documentation would be completed on the MAR or a progress note to reflect the reason.

During an interview, on 8/12/26 at 11:55 a.m., the Executive Director (ED) indicated it was the expectation the nurses would document medication administration at the time the medication was administered, medications which were refused would be documented in a nurses' note and the MAR would not have holes.

2. The clinical record for Resident C was reviewed on 8/12/26 at 10:35 a.m. The diagnoses included, but were

- A daily audit by the DON or ADON on holes in the MAR.
- LPN and QMA team will be held accountable for any undocumented medication administrations.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

- Daily audit of documentation of residents sent out to the hospital.
- Daily audit by DON and ADON to address holes in the MAR.

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:

- In-service training for all LPN and QMA staff on proper charting and documentation.
- Daily audit of holes in the MAR, with DON and ADON addressing deficiencies. Audit will be done daily for 120 days

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not limited to epilepsy and recurrent seizures, conversion disorder (a seizure disorder) with seizures or convulsions, post traumatic seizures, localization-related symptomatic epilepsy and epileptic syndromes with complex partial seizures.

A facility concierge daily shift log and checklist, dated 6/15/26, indicated Resident C was sent out to the hospital.

The clinical record did not contain documentation of Resident C going out the hospital or why he went to the hospital.

During an interview, on 8/11/26 at 1:59 p.m., Unit Manager (UM) 4 indicated staff should document any time a resident was sent to the hospital.

During an interview, on 8/11/26 at 1:59 p.m., Qualified Medication Aid (QMA) 3 indicated staff should make a progress note any time a resident was sent to the hospital.

During an interview, on 8/12/26 at 12:27 p.m., the Executive Director (ED) indicated the facility did not have a policy on documentation, but it was the expectation if a resident went to the hospital for a seizure, staff should document it in the clinical

and weekly thereafter.

By what date the systemic changes will be completed:

- August 28, 2026

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record.

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...Documentation of medications administered/assisted, or treatments administered/assisted, should occur promptly after the resident has taken the medication or the treatment performed. Associates should sign the paper copy...with their full signature/title and initial each medication administered/assisted or follow the electronic MAR procedure as required...."

This citation relates to Intakes 470769 and 470910.

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) DATE08/28/2026