STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

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 Complaints IN00455898, IN00457870 and IN00461002. Complaint IN00455898-No deficiencies related to the allegations are cited. Complaint IN00457870-No deficiencies related to the allegations are cited. Complaint IN00461002-State deficiencies related to the allegations are cited at R217 and R240. Unrelated deficiencies are cited at R297. Survey dates: July 14 and 15, 2025 Facility number: 009894 Residential: 114 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review was completed on July 25, 2025.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation	R 0217	**R 217** What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Care plans for Residents A, B and C were not signed by the resident or the representative. Care plans have been reviewed and updated by DON. Care plan meetings with the resident or their representative will be set to have these plans reviewed and signed. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?	08/12/2025

	indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure services plans were reviewed, discussed, and signed by the resident or the resident's representative for 3 of 3 residents reviewed for service plans. (Resident B, C and D) Findings include: 1. The clinical record for Resident B was reviewed on 7/14/25 at 1:00 p.m. The diagnoses included, but were not limited to, rheumatoid arthritis, chronic atrial fibrillation, and hypertension. A service plan and two untitled documents, dated 3/10/25 and 6/6/25, was addressed to Resident B's family member and attached to the service plan. During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated the facility was attempting to get the Power of Attorney to sign the service plan. There was no signature from the resident's legal representative on the		All residents with care plans have the potential to be affected by the deficiency. All care plans will be reviewed to ensure that appropriate signatures are on all care plans. New/updated care plans will reviewed 30 days after care plan meeting as follow up to ensure signatures are in place. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Care plans for each resident are updated every six months or as needed. The scheduling of care plans will be done by Medical Record Manager. A recurring 30-day follow up audit has been added to the care plans to ensure that signatures and	

	service plan to indicate she had participated in the development of the service plan. During an interview, on 7/15/25 at 10:16 a.m., Resident B's family member indicated she had never signed a service plan, nor had she participated in the discussion of the service plan. She had never received a copy of the service plan. 2. The clinical record for Resident C was reviewed on 7/14/25 at 1:27 p.m. The diagnoses included, but were not limited to, bipolar disorder, borderline personality disorder, post-traumatic stress disorder, and anxiety disorder. A service plan and an untitled document, dated 6/12/25, indicated the facility was attempting to get Resident C to sign the service plan. During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated there was no signature from the resident on the service plan to indicate she had participated in the development of the service plan. 3. The clinical record for Resident D was reviewed on 7/14/25 at 2:01 p.m. The diagnoses included, but were not limited to, edema, malaise, adult maltreatment, and malignant neoplasm of thyroid		reviews are in place. The facility has put in place electronic signature system to ensure that signatures for resident representatives are captured for all care plans. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur, ie what quality assurance programs will be put in place? A Care Plan Review tool has been implemented and will be reviewed monthly by the DON and ED to ensure care plans are being reviewed by the resident or their representative and the signatures are captured appropriately. By what date will the systemic changes be implemented? 8/12/2025	

	gland. A service plan and an untitled document, dated 7/2/25, indicated the facility was attempting to get Resident D's family member to sign the service plan. During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated there was no signature from the resident's responsible party or Resident D to indicate they had participated in the development of the service plan. All three of the residents' service plans had a document attached. The untitled document had a place for the date, indicated the letter was from the facility, and had the resident's name or the name of the resident's representative in the "to" section. The form indicated "Enclosed please find a copy of the updated Personal Service Plan for your loved one. We review the Personal Service Assessment and Personal Service Plan upon move in, and with any condition change, also routinely at the 6-month intervals. I am happy to discuss the changes, if any, on this new Personal Service Plan if you have any questions or concerns. If so, you may contact me at the community to arrange a conference at your convenience. Please sign the			

Personal Service Plan where indicated on the last page of the document. Use the enclosed self-addressed envelope to the return the assessment to my attention. Thank you for your prompt response." The document was signed by the Director of Nursing (DON).

A current facility policy, titled "Service Plan Process Policy," dated 5/1/19 and provided by the Director of Nursing on 7/15/25 at 2:20 p.m., indicated "...The resident and/or their responsible party may participate in the development of the resident's service plan...Upon initial review and subsequent changes, members of the community care team that contributed to the service plan, including the ED [Executive Director] or designee, or nurse and the resident/legally responsible party should sign the service plan...."

This citation relates to Complaint IN00461002.

Based on interview and record review, the facility failed to ensure services plans were reviewed, discussed, and signed by the resident or the resident's representative for 3 of 3 residents reviewed for service plans. (Resident B, C and D)

Findings include:

1. The clinical record for

Resident B was reviewed on 7/14/25 at 1:00 p.m. The diagnoses included, but were not limited to, rheumatoid arthritis, chronic atrial fibrillation, and hypertension.

A service plan and two untitled documents, dated 3/10/25 and 6/6/25, was addressed to Resident B's family member and attached to the service plan.

During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated the facility was attempting to get the Power of Attorney to sign the service plan. There was no signature from the resident's legal representative on the service plan to indicate she had participated in the development of the service plan.

During an interview, on 7/15/25 at 10:16 a.m., Resident B's family member indicated she had never signed a service plan, nor had she participated in the discussion of the service plan. She had never received a copy of the service plan.

2. The clinical record for Resident C was reviewed on 7/14/25 at 1:27 p.m. The diagnoses included, but were not limited to, bipolar disorder, borderline personality disorder, post-traumatic stress disorder, and anxiety disorder.

A service plan and an untitled

document, dated 6/12/25, indicated the facility was attempting to get Resident C to sign the service plan.

During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated there was no signature from the resident on the service plan to indicate she had participated in the development of the service plan.

3. The clinical record for Resident D was reviewed on 7/14/25 at 2:01 p.m. The diagnoses included, but were not limited to, edema, malaise, adult maltreatment, and malignant neoplasm of thyroid gland.

A service plan and an untitled document, dated 7/2/25, indicated the facility was attempting to get Resident D's family member to sign the service plan.

During an interview, on 7/15/2025 at 1:50 p.m., the Executive Director indicated there was no signature from the resident's responsible party or Resident D to indicate they had participated in the development of the service plan.

All three of the residents' service plans had a document attached. The untitled document had a place for the date, indicated the letter was from the

	facility, and had the resident's name or the name of the resident's representative in the "to" section. The form indicated "Enclosed please find a copy of the updated Personal Service Plan for your loved one. We review the Personal Service Assessment and Personal Service Plan upon move in, and with any condition change, also routinely at the 6-month intervals. I am happy to discuss the changes, if any, on this new Personal Service Plan if you have any questions or concerns. If so, you may contact me at the community to arrange a conference at your convenience. Please sign the Personal Service Plan where indicated on the last page of the document. Use the enclosed self-addressed envelope to the return the assessment to my attention. Thank you for your prompt response." The document was signed by the Director of Nursing (DON). A current facility policy, titled "Service Plan Process Policy," dated 5/1/19 and provided by the Director of Nursing on 7/15/25 at 2:20 p.m., indicated "...The resident and/or their responsible party may participate in the development of the resident's service plan...Upon initial review and subsequent changes, members of the community care team that contributed to the service plan,			

	including the ED [Executive Director] or designee, or nurse and the resident/legally responsible party should sign the service plan...." This citation relates to Complaint IN00461002.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview and record review, the facility failed to ensure personal care was provided for a resident based upon her individual preferences according to her service plan for 1 of 3 residents reviewed for assistance with activities of daily living. (Resident B) Findings include: During an interview, on 7/15/25 at 10:16 a.m., Resident B's family member showed cell phone videos for the dates of 7/11/25, 7/12/25 and 7/13/25, which showed the personal care being provided to Resident B in the morning before getting her out of bed for the day. The following were observed in the videos for these dates and	R 0240	**R 240** What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident B’s care plan has been updated to reflect that Resident B is to receive peri-care daily and bed baths twice a week. Staff has been instructed on the proper way to administer peri-care and bed baths. Facility has ordered basins, washcloths and towels in order to provide bed baths	08/12/2025

	times: On 7/11/25 at 8:34 a.m., CNA 1 entered Resident B's apartment. The resident was lying in bed with her night clothes on. CNA 1 sat Resident B up on the side of the bed, then left, and came back with a washcloth. CNA 1 had the resident wipe her face. While the resident was wiping her face, CNA 1 placed a clean pull up and a pair of sweatpants on the resident and pulled them up to her knees. No soap bubbles were observed on the washcloth. CNA 1 then used the same washcloth and wiped under the resident's arms, then applied deodorant on her. She stood the resident up at the side of the bed with her walker and pulled the new pull up and sweatpants over the pull up she already had on, then she walked the resident to her recliner. CNA 1 did not change or check to see if the previous brief in place needed changed from the night before nor did she give the resident any peri care. On 7/12/25 at 9:40 a.m., CNA 1 entered Resident B's apartment and sat the resident up on the side of the bed. CNA 1 left, then came back with a washcloth, which did not have any soap bubbles on it. She wiped the resident under her underarms, under her breast and back, then wiped across her chest and		How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All residents who receive bed baths and peri-care have the potential to be affected. All care plans will be reviewed and updated to ensure preferences are indicated. Staff trained on the appropriate way to administer bed baths and peri-care. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recure? DON will ensure that daily shower assignment	

	down her back. She placed the resident's dress on her. She did not apply any deodorant or wash her face. She stood the resident up and pulled her pull up down to her knees. She took the same washcloth used to wipe the top parts of the resident's body, then wiped the resident's rectal area, then immediately wiped the resident's labia area in a backward to forward wipe. She pulled the same pull up back up from her knee area, then walked the resident to her recliner with her walker. On 7/13/25 at 9:56 a.m., CNA 1 and an unidentified female staff member entered the resident's apartment and sat the resident up on the side of the bed. The resident's night shirt was removed. A pull up was placed over the resident's feet and her pajama pants and then pulled up to her knees. CNA 1 left and came back with a washcloth without any soap bubbles on it. She wiped the washcloth under the resident's underarms and breasts, then across her chest and down her back. CNA 1 wiped the resident's rectal area with the same washcloth, then immediately wiped her labia area in a backward to forward swipe. She removed the old pull up by tearing it and pulling it off the resident, then she pulled the new brief up. She and the other unidentified female staff		sheets are signed off by the caregiver to make sure care plans are being followed as written. A weekly audit tool will be implemented for DON and ED to review signed shower task sheets. All nursing staff educated on Facility policy on “Incontinence Care”. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie, what quality assurance programs will be put into place? Staff will be held accountable for shower task sheets not signed. Monthly review audit with outside companies that provide bed baths and showers to be done to ensure resident preferences are being met.	

	member walked the resident to her recliner. The resident's face was not washed, and she did not get any deodorant applied. During an interview, on 7/15/25 after the videos were reviewed, the family member indicated Resident B's care plan was supposed to have been changed to indicate she would receive a bed bath every day, which included her feet and legs being washed. She discussed and showed the Executive Director (ED) the previous videos of Resident B not getting bathed appropriately and was told the care plan would be updated to include a daily bath with her legs and feet being washed. A facility document, titled "Personal Service Plan," dated 3/10/25, indicated the shower section of the service plan was updated, on 6/6/25, and indicated per the family request the facility staff would perform peri care on the resident every day in addition to the resident's showers from her private aide. During an interview, on 7/15/25 at 11:27 a.m., the ED indicated she had seen the previous videos of Resident B's personal care not completed appropriately. Resident B's service plan was updated by the Director of Nursing (DON) to indicate personal care would be		When will be the systemic changes be implemented? 8/12/2025	

	provided daily. She did not know the staff was not providing care according to the service plan. During an interview, on 7/15/25 at 11:39 a.m., the DON indicated Resident B did not have a private aide at this time. The facility staff should give Resident B a complete bed bath two times a week in place of showers and on the other days of the week a partial bed bath. She was not aware this was not happening. The resident had to have a bed bath instead of a shower because she was not safe to be in the shower. Therapy had completed a shower evaluation and determined she was not safe to be placed in the shower, so a complete bed bath was to be completed twice a week. A current facility policy, titled "Incontinence Care," dated as revised January 2015 and provided by the Director of Nursing on 7/15/25 at 2:20 p.m., indicated "...Help the resident remove and place soiled incontinence product in a plastic bag for removal from the apartment...Encourage resident to clean perineal area in a front to back motion, offer to help, provide assistance as needed 7. Encourage residents to dry the perineal area (wiping in a front to back motion), offer to help, provide assistance as needed...Assist resident with			

putting on clean adult incontinence product and re-dressing as needed...."

This citation relates to Complaint IN00461002.

Based on observation, interview and record review, the facility failed to ensure personal care was provided for a resident based upon her individual preferences according to her service plan for 1 of 3 residents reviewed for assistance with activities of daily living. (Resident B)

Findings include:

During an interview, on 7/15/25 at 10:16 a.m., Resident B's family member showed cell phone videos for the dates of 7/11/25, 7/12/25 and 7/13/25, which showed the personal care being provided to Resident B in the morning before getting her out of bed for the day. The following were observed in the videos for these dates and times:

On 7/11/25 at 8:34 a.m., CNA 1 entered Resident B's apartment. The resident was lying in bed with her night clothes on. CNA 1 sat Resident B up on the side of the bed, then left, and came back with a washcloth. CNA 1 had the resident wipe her face. While the resident was wiping her face, CNA 1 placed a clean pull up and a pair of sweatpants

	on the resident and pulled them up to her knees. No soap bubbles were observed on the washcloth. CNA 1 then used the same washcloth and wiped under the resident's arms, then applied deodorant on her. She stood the resident up at the side of the bed with her walker and pulled the new pull up and sweatpants over the pull up she already had on, then she walked the resident to her recliner. CNA 1 did not change or check to see if the previous brief in place needed changed from the night before nor did she give the resident any peri care. On 7/12/25 at 9:40 a.m., CNA 1 entered Resident B's apartment and sat the resident up on the side of the bed. CNA 1 left, then came back with a washcloth, which did not have any soap bubbles on it. She wiped the resident under her underarms, under her breast and back, then wiped across her chest and down her back. She placed the resident's dress on her. She did not apply any deodorant or wash her face. She stood the resident up and pulled her pull up down to her knees. She took the same washcloth used to wipe the top parts of the resident's body, then wiped the resident's rectal area, then immediately wiped the resident's labia area in a backward to forward wipe. She			

	pulled the same pull up back up from her knee area, then walked the resident to her recliner with her walker. On 7/13/25 at 9:56 a.m., CNA 1 and an unidentified female staff member entered the resident's apartment and sat the resident up on the side of the bed. The resident's night shirt was removed. A pull up was placed over the resident's feet and her pajama pants and then pulled up to her knees. CNA 1 left and came back with a washcloth without any soap bubbles on it. She wiped the washcloth under the resident's underarms and breasts, then across her chest and down her back. CNA 1 wiped the resident's rectal area with the same washcloth, then immediately wiped her labia area in a backward to forward swipe. She removed the old pull up by tearing it and pulling it off the resident, then she pulled the new brief up. She and the other unidentified female staff member walked the resident to her recliner. The resident's face was not washed, and she did not get any deodorant applied. During an interview, on 7/15/25 after the videos were reviewed, the family member indicated Resident B's care plan was supposed to have been changed to indicate she would receive a bed bath every day, which included her feet and legs			

	being washed. She discussed and showed the Executive Director (ED) the previous videos of Resident B not getting bathed appropriately and was told the care plan would be updated to include a daily bath with her legs and feet being washed. A facility document, titled "Personal Service Plan," dated 3/10/25, indicated the shower section of the service plan was updated, on 6/6/25, and indicated per the family request the facility staff would perform peri care on the resident every day in addition to the resident's showers from her private aide. During an interview, on 7/15/25 at 11:27 a.m., the ED indicated she had seen the previous videos of Resident B's personal care not completed appropriately. Resident B's service plan was updated by the Director of Nursing (DON) to indicate personal care would be provided daily. She did not know the staff was not providing care according to the service plan. During an interview, on 7/15/25 at 11:39 a.m., the DON indicated Resident B did not have a private aide at this time. The facility staff should give Resident B a complete bed bath two times a week in place of showers and on the other days of the week a partial bed bath.			

	She was not aware this was not happening. The resident had to have a bed bath instead of a shower because she was not safe to be in the shower. Therapy had completed a shower evaluation and determined she was not safe to be placed in the shower, so a complete bed bath was to be completed twice a week. A current facility policy, titled "Incontinence Care," dated as revised January 2015 and provided by the Director of Nursing on 7/15/25 at 2:20 p.m., indicated "...Help the resident remove and place soiled incontinence product in a plastic bag for removal from the apartment...Encourage resident to clean perineal area in a front to back motion, offer to help, provide assistance as needed 7. Encourage residents to dry the perineal area (wiping in a front to back motion), offer to help, provide assistance as needed...Assist resident with putting on clean adult incontinence product and re-dressing as needed...." This citation relates to Complaint IN00461002.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles,	R 0297	**Deficiency R 297** What corrective action(s) will be accomplished for those	08/12/2025

	and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a resident's narcotic pain medication was available for 1 of 1 resident reviewed for pharmacy services. (Resident C) Findings include: A facility reported incident, dated 7/8/25, indicated on the afternoon of 7/7/25 Resident C reported to the Executive Director (ED) she was out of her Oxycodone-Acetaminophen (a narcotic pain medication) 10/325 mg (milligrams). The ED called the pharmacy regarding the medication and was told a refill was sent in the tote on 7/1/25, when the resident still had 23 pain pills left in her present supply. The facility started an investigation. The clinical record for Resident C was reviewed on 7/14/25 at 1:27 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, chronic obstructive pulmonary disease, major depressive disorder,		residents found to have been affected by the alleged deficient practice? Resident C reported missing narcotics 7/7/25 – it was found that the narcotics were allegedly sent to the community by pharmacy on 7/1/25. Guardian Pharmacy stated medications were delivered – however, the medications did not appear on the manifest. A police report was filed with narcotic detective Stephen Jones of IMPD. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?	

	post-traumatic stress disorder, osteoarthritis, anxiety disorder, and borderline personality disorder. The facility investigation included, but was not limited to, An untitled typed document, undated, indicated, on 7/7/25, Resident C came to the ED's office and told her she had not received her pain pills. The ED called the pharmacy, who told the ED they had sent the pain pills to the facility on 7/1/25. On 7/1/25, QMA (Qualified Medication Aide) 2 received a tote of medications from the pharmacy at 8:12 p.m., and Resident C's medication was in the tote he received. LPN 3 and the ED checked the narcotic book and the narcotic drawer and discovered there was no narcotic sheet in the narcotic book or narcotic medication in the cart for Resident C's Oxycodone/Acetaminophen 10/325 mg. On 7/7/25, the ED called the pharmacy and spoke to a technician who confirmed the confirmation sheet on the receipt of the medication was not returned to the pharmacy. On 7/7/25, after the ED rechecked all the medication carts and found the medication was not in the facility, she called the pharmacy and spoke to the		Any resident who has narcotics delivered by Guardian Pharmacy has the potential to be affected. Nurses that accept the medications delivered by Guardian Pharmacy have been instructed to not accept the delivery of medications if the tote has the seal broken prior to delivery. Deliveries of medications will no longer be accepted at the front of the building – rather the delivery person will have to deliver the medications to the nurses station, giving the nurse time to reconcile the medications delivered to the manifest. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur. The facility will no longer accept pharmaceutical deliveries if the seal is broken on the tote.	

president of the pharmacy, who indicated the pharmacy had done a thorough search for the medication and it was not at the pharmacy.

On 7/8/25, the ED spoke to the pain management group which Resident C went to, to get her pain medications filled and was informed the prescription for the pain medication was sent to the pharmacy on 7/1/25, after her appointment with the doctor at the clinic. The resident's next pain medication prescription would be ordered with her next appointment on 8/1/25.

An "Order Summary Report" dated 7/14/25, indicated, on 7/1/25, the resident had an order for Oxycodone-Acetaminophen 10 mg, one tablet every six hours for pain related to chronic pain syndrome.

A "Delivery Sheet" dated 7/1/25, indicated QMA 2 signed he received 120 tablets of Oxycodone/Acetaminophen for Resident C.

A pharmacy manifest, dated 7/1/25 at 8:16 p.m., indicated Resident C's prescription number, which was her Oxycodone/Acetaminophen, was in the tote QMA 2 signed for and accepted on 7/1/25.

During an interview, on 7/14/25 at 11:22 a.m., Resident C

Deliveries will be made in the nurses station so the nurse has time to inventory and reconcile what is received vs what is on the manifest.

A security camera will be installed in the nurses station to safeguard against missing narcotics.

How will the corrective actions be monitored to ensure the alleged deficient practice will not recur, ie what quality assurance programs will be put into place?

Nurse receiving medications will notify the DON of any missing medications.

Facility will implement a narcotic delivery tool of delivered narcotics. This will be done daily to reconcile delivered narcotics against the narcotic book and med cart. DON will check delivery tool weekly to ensure metrics

	indicated she had gone to the ED to tell her she had not had any narcotics since 7/1/25. The ED told her QMA 2, signed in four sheets of her Oxycodone, but the medication was not found. She had been going through physical withdrawal, since she had not had her medication. She had the shakes, had vomited once, and had diarrhea uncontrollably, since she had not had her medication. She had to have a police report by Wednesday for her pain management appointment, or they would not refill her pain pill prescription. During an interview, on 7/14/25 at 11:27 a.m., the ED indicated Resident C came to her and indicated she was out of pain medication. She called the pharmacy and found out they had delivered the medication on 7/1/25. During an interview, on 7/14/25 at 3:31 p.m., QMA 2 indicated he worked the evening of 7/1/25. The delivery man from the pharmacy delivered the medications. He went up to the lobby and checked the medications in with the delivery man. After he went over the medications to ensure all the medications were in the tote box, he signed for the medications. He kept a copy of the papers, and the delivery person took the originals. He		are being met. By what date will the systemic changes be implemented? 8/12/2025	

separated the medications for each unit, then he delivered the medications to each unit, and put them in the appropriate residents' drawers and narcotic boxes.

During an interview, on 7/15/25 at 1:12 p.m., the president of the pharmacy indicated the procedure to deliver medications to the facility was the delivery person was to take the tote to the unit. The nurse broke the seal on the tote. The licensed person checked off all the medications in the tote and signed the delivery sheets, then the driver brought the original copies back to the pharmacy and the facility kept the yellow copies. She was told the driver had already broken the seal on the tote prior to QMA 2 arriving at the lobby to check off the medication. She indicated this was not the proper procedure. She did not know the drivers were not delivering the medication totes to the units and were checking off medications in the front lobby of the facility. She indicated four cards of Resident C's Oxycodone/Acetaminophen were delivered on 7/1/25. The pain medication script was written on 7/1/25, from the pain management group. It was filled and sent out the same day. She indicated the resident's name, or medication would not appear on the medication manifest to

show it had been delivered because it was scanned incorrectly.

Based on interview and record review, the facility failed to ensure a resident's narcotic pain medication was available for 1 of 1 resident reviewed for pharmacy services. (Resident C)

Findings include:

A facility reported incident, dated 7/8/25, indicated on the afternoon of 7/7/25 Resident C reported to the Executive Director (ED) she was out of her Oxycodone-Acetaminophen (a narcotic pain medication) 10/325 mg (milligrams). The ED called the pharmacy regarding the medication and was told a refill was sent in the tote on 7/1/25, when the resident still had 23 pain pills left in her present supply. The facility started an investigation.

The clinical record for Resident C was reviewed on 7/14/25 at 1:27 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, chronic obstructive pulmonary disease, major depressive disorder, post-traumatic stress disorder, osteoarthritis, anxiety disorder, and borderline personality disorder.

	The facility investigation included, but was not limited to, An untitled typed document, undated, indicated, on 7/7/25, Resident C came to the ED's office and told her she had not received her pain pills. The ED called the pharmacy, who told the ED they had sent the pain pills to the facility on 7/1/25. On 7/1/25, QMA (Qualified Medication Aide) 2 received a tote of medications from the pharmacy at 8:12 p.m., and Resident C's medication was in the tote he received. LPN 3 and the ED checked the narcotic book and the narcotic drawer and discovered there was no narcotic sheet in the narcotic book or narcotic medication in the cart for Resident C's Oxycodone/Acetaminophen 10/325 mg. On 7/7/25, the ED called the pharmacy and spoke to a technician who confirmed the confirmation sheet on the receipt of the medication was not returned to the pharmacy.			

On 7/7/25, after the ED rechecked all the medication carts and found the medication was not in the facility, she called the pharmacy and spoke to the president of the pharmacy, who indicated the pharmacy had done a thorough search for the medication and it was not at the pharmacy.

On 7/8/25, the ED spoke to the pain management group which Resident C went to, to get her pain medications filled and was informed the prescription for the pain medication was sent to the pharmacy on 7/1/25, after her appointment with the doctor at the clinic. The resident's next pain medication prescription would be ordered with her next appointment on 8/1/25.

An "Order Summary Report" dated 7/14/25, indicated, on 7/1/25, the resident had an order for Oxycodone-Acetaminophen 10 mg, one tablet every six hours for pain related to chronic pain syndrome.

A "Delivery Sheet" dated 7/1/25, indicated QMA 2 signed he received 120 tablets of Oxycodone/Acetaminophen for Resident C.

A pharmacy manifest, dated 7/1/25 at 8:16 p.m., indicated Resident C's prescription number, which was her

Oxycodone/Acetaminophen, was in the tote QMA 2 signed for and accepted on 7/1/25.

During an interview, on 7/14/25 at 11:22 a.m., Resident C indicated she had gone to the ED to tell her she had not had any narcotics since 7/1/25. The ED told her QMA 2, signed in four sheets of her Oxycodone, but the medication was not found. She had been going through physical withdrawal, since she had not had her medication. She had the shakes, had vomited once, and had diarrhea uncontrollably, since she had not had her medication. She had to have a police report by Wednesday for her pain management appointment, or they would not refill her pain pill prescription.

During an interview, on 7/14/25 at 11:27 a.m., the ED indicated Resident C came to her and indicated she was out of pain medication. She called the pharmacy and found out they had delivered the medication on 7/1/25.

During an interview, on 7/14/25 at 3:31 p.m., QMA 2 indicated he worked the evening of 7/1/25. The delivery man from the pharmacy delivered the medications. He went up to the lobby and checked the medications in with the delivery man. After he went over the

medications to ensure all the medications were in the tote box, he signed for the medications. He kept a copy of the papers, and the delivery person took the originals. He separated the medications for each unit, then he delivered the medications to each unit, and put them in the appropriate residents' drawers and narcotic boxes.

During an interview, on 7/15/25 at 1:12 p.m., the president of the pharmacy indicated the procedure to deliver medications to the facility was the delivery person was to take the tote to the unit. The nurse broke the seal on the tote. The licensed person checked off all the medications in the tote and signed the delivery sheets, then the driver brought the original copies back to the pharmacy and the facility kept the yellow copies. She was told the driver had already broken the seal on the tote prior to QMA 2 arriving at the lobby to check off the medication. She indicated this was not the proper procedure. She did not know the drivers were not delivering the medication totes to the units and were checking off medications in the front lobby of the facility. She indicated four cards of Resident C's Oxycodone/Acetaminophen were delivered on 7/1/25. The pain medication script was

	written on 7/1/25, from the pain management group. It was filled and sent out the same day. She indicated the resident's name, or medication would not appear on the medication manifest to show it had been delivered because it was scanned incorrectly.			

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