

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 09/09/2026
NAME OF PROVIDER OR SUPPLIER WYNDMOOR OF MARION (IN), LLC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2452 W KEM RD, MARION, , 46952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 471723. Intake 471723 - State deficiencies related to the allegations are cited at R0052 and R0090. Survey dates: September 8 and 9, 2026 Facility number: 010682 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 16, 2026.	R 0000			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	R052	09/25/2026	

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

(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from neglect related to elopement for 1 of 4 residents reviewed for elopement (Resident C). This deficient practice resulted in Resident C leaving the facility without staff knowledge and being found by the police 0.5 miles from the facility at night. Findings include: Resident C's clinical record was reviewed on 9/8/26 at 11:21 a.m. Diagnoses included cerebral infarction due to embolism of an unspecified anterior cerebral artery (stroke) and cerebral infarction without residual deficits. A discharge summary from her previous long-term care facility, dated 8/3/26, indicated she had an order to wear a Wanderguard (wearable safety device) at all times for safety. A facility nursing move-in	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility will ensure that all residents remain independent and honor the residents' rights while reducing risk of elopement. 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. Every resident in house and every resident upon admission will receive a BIMS assessment to measure the resident cognitive ability. Upon completion of BIMS assessment if resident is found to have cognitive impairment, resident will be monitored elopement risk on going. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur. All staff Inservice on elopement risk and missing resident policy. All new admissions to facility will have two-hour check for first 72 hours of admission. Facility will perform BIMS assessment, elopement assessment and following results of assessments	
--	--	--

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

	screening/history assessment, dated 8/3/26, indicated she was alert to person, time, and situation. She had difficulty understanding others and difficulty being understood. She was aphasic, confused, and could become frustrated due to expressive aphasia and being unable to communicate. An 8/3/26 facility Wandering Risk Assessment indicated she was at risk for wandering. An 8/3/26 Senior Living Level of Care Evaluation indicated she was at risk for elopement. An interim service plan, dated 8/3/26, indicated she was cognitively impaired. She could not easily communicate with staff but understood staff. She transferred and ambulated independently without an assistive device. A nurse's note, dated 8/3/26 at 5:40 p.m., indicated she admitted to the facility on 8/3/26 at 1:00 p.m. She was alert and oriented to person, place, and time. She was pleasant and cooperative, ambulated independently, and was insulin dependent. She had expressive aphasia related to a recent stroke and was difficult to communicate with. She was oriented to her room, building, and mealtimes.		resident will be placed of elopement monitoring for safety. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Facility will create an audit tool to ensure that facility will monitor BIMS assessment and elopement assessments, so that this deficient practice will not occur again. By what date the systemic changes will be completed. 9/25/2026	
--	---	--	--	--

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

A nurse's note, dated 8/4/26 at 10:05 a.m., indicated she complained of pain and discomfort. She had allergies to a long list of medications and did not have an order for as needed (PRN) pain medication. Her complaints escalated to crying, and she threw herself on the floor, crying out that she needed help. She refused staff assistance off the floor and continued crying out for help. She then began exhibiting signs of seizure activity. Staff asked if she needed to go to the emergency room, and she nodded in agreement. An ambulance was called, and she was transported to a local hospital.

A nurse's note, dated 8/4/26 at 4:33 p.m., indicated she was admitted to the local hospital related to seizure activity.

A nurse's note, dated 8/5/26 at 9:15 a.m. (created 8/6/26 at 8:44 a.m.), indicated the DON spoke with hospital staff regarding Resident C returning to the facility and her safety in an assisted living setting. The hospital was to evaluate her ability to return due to her expressive aphasia.

A nurse's note, dated 8/5/26 at 12:44 p.m. (created 8/6/26 at 8:45 a.m.), indicated hospital staff said she was okay to return

to the facility at an assisted living level of care.

A nurse's note, dated 8/5/26 at 3:15 p.m., indicated she returned to the facility from the hospital.

A nurse's note, dated 8/5/26 at 6:01 p.m., indicated she had no complaints of pain or discomfort related to her hospitalization.

A nurse's note, dated 8/5/26 at 10:30 p.m. (created 8/6/26 at 11:55 a.m.), indicated Resident C left the facility on her own.

The facility received a call from the police reporting she was down the road near her old apartment. Police took her to the emergency room because they were unable to understand her speech. The nurse practitioner called the DON and indicated Resident C was admitted to the hospital until long term care placement was found.

A nurse's note, dated 8/5/26 at 11:00 p.m., indicated she was admitted to a local hospital by Nurse Practitioner 2 and was not to return to the facility per the DON. The hospital was to find another placement.

An emergency room provider report, dated 8/5/26, indicated Resident C was discharged from the hospital to a long term care facility on 7/1/26 and

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

returned to the hospital on 8/4/26 for possible seizure like activity. She was discharged earlier on 8/5/26 back to Wyndmoor Assisted Living. She managed to leave the facility unnoticed, walked through an individual's backyard, and was found sitting near a dumpster. EMS transported her to the hospital for possible altered mental status. On arrival, she exhibited expressive aphasia but followed commands. She had no facial drooping and appeared to comprehend questions, though her speech was difficult to understand due to dysarthria. It was unclear how she left the facility or what her intention was. She had repeatedly expressed a desire to leave her rehabilitation facility and previously required an emergency detention order. Given her debilitated condition and the fact that she left the assisted living facility without staff awareness, she was unsafe to return to that level of care and likely required a higher level of supervision. She was admitted for management of hyperglycemia, evaluation of elevated troponin, and an electroencephalogram to exclude ongoing or recurrent seizure activity.

A hospital history and physical, dated 8/5/26, indicated she presented after being found

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

wandering along Kem Road. She had been discharged earlier in the day after observation for seizure like activity and returned to her assisted living facility. The facility reported she was last seen around 8:30 p.m. during medication pass. Police were called at approximately 9:45 p.m. for a welfare check because she was sitting in front of the Kem Road Animal Hospital. Her speech was garbled and she seemed confused, so she was brought in for evaluation. She had a recent stroke with dysarthria. She could vocalize and give some history but could not explain why she left or where she was going. When asked if she had fallen, she said she could not remember. Bruising was noted on her bilateral upper extremities. She was pleasant, answered most questions appropriately, and moved all extremities.

A review of the resident sign in/sign out log sheet on 9/8/26 at 11:29 a.m. indicated Resident C had not signed herself out on 8/5/26.

During an interview on 9/8/26 at 1:34 p.m., QMA 4 indicated Resident C was agitated on 8/5/26 about receiving insulin. QMA 4 contacted the nurse on duty, who also could not

determine the cause of her agitation. Resident C became increasingly angry, went to her room, and slammed items. Staff checked on her, and she appeared okay. QMA 4 administered insulin between 8:00 p.m. and 8:30 p.m. and left the facility at 10:00 p.m. She did not know Resident C had left. The DON later texted her asking if she knew Resident C had left and when. QMA 4 stated Resident C was not alert and oriented and that she often could not communicate. QMA 4 attempted written communication; Resident C responded by writing a few numbers. She did not believe Resident C knew or could retain the door code to exit the building.

During an interview on 9/8/26 at 2:31 p.m., RN 12 indicated she arrived at work at 10:00 p.m. on 8/5/26. She received a call from the hospital at 10:30 p.m. indicating they found Resident C near the animal hospital. RN 12 did not know how long Resident C had been there before the call. She did not know whether anyone gave Resident C the door code or whether she had followed another resident out. Someone called the police believing the resident appeared confused. RN 12 contacted the DON after receiving the call. The nurse practitioner was at

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

FORM APPROVED

OMB NO. 0938-0391

	the hospital and reported Resident C was going to be admitted.			
--	--	--	--	--

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

During an interview on 9/8/26 at 3:22 p.m., Nurse Practitioner 2 indicated she was not involved in Resident C's care at the facility. Staff were uncertain about admitting her due to a new stroke, decreased abilities, and her desire to return to her apartment. She previously required rehabilitation and an emergency detention order and needed a locked unit. She later went to a long-term care facility. It was reported that Resident C followed someone out the door at Wyndmoor. The hospital notified Nurse Practitioner 2 because she worked in local facilities and might identify the patient. She recognized Resident C and stated she was supposed to be at Wyndmoor. Resident C was alert and coherent and had a conversation with her. A neighbor called for a welfare check because Resident C looked out of place; she was found near the Kem Road Animal Hospital and was unable to tell police where she was from. She likely arrived at the hospital around 10:15 p.m. Nurse Practitioner 2 believed she walked to the animal hospital and became fatigued. Resident C denied falling and had no injuries.

On 9/8/26 at 1:21 p.m., the route from the facility to the animal hospital was observed.

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

	The route had no sidewalks on the side of the road where both locations were situated. The path consisted of the facility parking lot, the driveway of an adjacent vacant business, a four-way stop, several homes with grassy yards and driveways, followed by a business driveway and the animal hospital. Street lighting was limited. During an interview on 9/9/26 at 9:21 a.m., the DON indicated that prior to admitting Resident C to Wyndmoor, she assessed her at the hospital. Resident C had a sitter and was not safe to return home, so she was denied admission to Wyndmoor. She went to a long-term care facility but was not appropriate there. The DON had concerns about admitting her. The day after admission, Resident C exhibited issues, including placing herself on the floor and showing seizure-like activity, prompting transfer to the hospital. The DON assessed her again and discussed her return with a physician, who indicated she was appropriate for assisted living. She was re-admitted. Around 9:30 p.m., Care Coordinator 3 called and said Resident C was found at the Kem Road Animal Hospital. The DON reviewed camera footage but did not see her exiting. Nurse Practitioner 2 advised			
--	---	--	--	--

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

she should not return. Resident C's friend said she had an apartment near the animal hospital and may have been trying to go there.

During an interview on 9/9/26 at 9:41 a.m., Care Coordinator 3 indicated Nurse Practitioner 2 called her at 10:34 p.m. on 8/5/26 stating Resident C arrived in the emergency room via police. At 11:03 p.m., she texted saying she was admitting her. At 11:04 p.m., she texted stating Resident C was found on Kem Road at 9:30 p.m. near a dumpster at the Kem Road Animal Hospital. Resident C had expressive aphasia and could not tell police anything. She told Nurse Practitioner 2 she followed someone out of the facility door. Care Coordinator 3 called the facility and spoke with RN 12, who said the hospital asked if they could send Resident C back and RN 12 told them she could not return. RN 12 was told in report that Resident C received medication around 8:30 p.m. and was not exit seeking at that time.

According to www.google.com/maps, reviewed on 9/9/26 at 10:02 a.m., the Kem Road Animal Hospital was 0.5 miles from the facility, approximately a 10 minute walk.

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

According to
www.wunderground.com/history/daily/us/in/marion, reviewed on 9/9/26 at 10:15 a.m., temperatures on 8/5/26 were as follows: 8:35 p.m., 75°F; 8:55 p.m., 74°F; 9:15 p.m., 74°F; 9:35 p.m., 73°F; 9:55 p.m., 72°F; 10:15 p.m., 72°F.

According to
www.timeanddate.com, reviewed on 9/9/26 at 10:18 a.m., sunset on 8/5/26 was at 8:09 p.m.

In a follow up interview on 9/9/26 at 10:20 a.m., Nurse Practitioner 2 indicated Resident C was wearing street clothes when she saw her in the hospital and had not yet been changed into a gown. She could not remember whether Resident C wore long or short sleeves, pants or shorts, or whether she had shoes. She recalled assessing her feet and did not remember them being dirty or suggestive of barefoot walking.

A current, undated facility policy titled "Resident Elopement," provided by the Administrator on 9/9/26 at 12:31 p.m., indicated: "Policy: This community seeks to provide each resident an environment in which he or she can feel valued and fulfill his or her purpose while experiencing feelings of safety, security, health, and wellbeing.

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

	Specifically, this community will ensure all residents identified as at risk for wandering and elopement are monitored and provided interventions necessary to keep them safe but as independent as possible, and if necessary, assist in placement to a secure unit within the community or at another location. Procedure ... 2. For residents determined to be at risk for elopement: a. Immediate interventions should be put in place that will allow the resident to remain independent and honor the resident's rights while reducing the risk of elopement ..." This citation relates to Intake 471723.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by	R 0090	R090	09/25/2026
			• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	

electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

- (A) epidemic outbreaks;
- (B) poisonings;
- (C) fires; or
- (D) major accidents.

If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.

(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

- (A) employee's full name; and
- (B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results

Facility will ensure that all unusual occurrences that directly threaten the welfare, safety, or health of residents, including but not limited to resident elopement, will be reported to ISDH and other appropriate authorities within twenty-four hours of becoming aware of occurrence.

- 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.

No other resident will be affected by deficient practice.

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

ED and DON go over 24 hours daily to determine whether incidents are classified as reportable occurrence. Facility will ensure that all unusual occurrences are reported within twenty-four hours to the proper authorities and proper details included within report.

- 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.

must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to accurately report an elopement to the State Agency for 1 of 1 facility reported incidents reviewed for elopement (Resident C).

Findings include:

A facility reported incident, dated 8/6/26, indicated the nurse practitioner working in the emergency room notified the DON that Resident C was admitted to the emergency room for altered mental status and for long term care placement. Prior to the incident, the resident was at the emergency room; the DON went to assess the resident for return and to clarify whether she was appropriate to return to an assisted living level of care. The emergency room doctor cleared the resident to return with no new orders or follow up orders. A follow up notation, added on 8/6/26, indicated the resident remained at the hospital and the nurse

ED and DON educated on proper reporting guidelines. Facility will create an audit tool to ensure that facility will monitor all unusual occurrences are reported within twenty-four hours to the proper authorities.

- By what date the systemic changes will be completed.

9/25/2026

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

FORM APPROVED

OMB NO. 0938-0391

practitioner was working on finding long term placement for the resident in a secured unit. The resident would not return to the assisted living facility.

Resident C's clinical record was reviewed on 9/8/26 at 11:21 a.m. Diagnoses included cerebral infarction due to embolism of an unspecified anterior cerebral artery (stroke) and cerebral infarction without residual deficits.

A nurse's note, dated 8/5/26 at 10:30 p.m. and created on 8/6/26 at 11:55 a.m., indicated Resident C left the facility on her own. The facility received a call from the police reporting she was down the road near her old apartment. The police took her to the emergency room because they were unable to understand what she was saying. The nurse practitioner called the DON and indicated Resident C was admitted to the hospital until long term care placement was found.

An emergency room provider report, dated 8/5/26, indicated Resident C was discharged from the hospital to a long term care facility on 7/1/26 and returned to the hospital on 8/4/26 for possible seizure like activity. She was discharged earlier on 8/5/26 back to Wyndmoor Assisted Living. She managed to leave the facility

unnoticed, walked through an individual's backyard, and was found sitting near a dumpster. EMS transported her to the hospital for possible altered mental status. On arrival, she exhibited expressive aphasia (inability to speak) but followed commands. She had no facial drooping and appeared to comprehend questions, though her speech was difficult to understand due to dysarthria. It was unclear how she left the facility or what her intention was. She had repeatedly expressed a desire to leave her rehabilitation facility and had previously required an emergency detention order. Given her debilitated condition and the fact that she left the assisted living facility without staff awareness, she was unsafe to return to that level of care and likely required a higher level of supervision. She was admitted for management of hyperglycemia (high blood sugar), evaluation of elevated troponin (indicates muscle damage), and an electroencephalogram (tests brain activity) to exclude ongoing or recurrent seizure activity.

A hospital history and physical, dated 8/5/26, indicated she presented after being found wandering along Kem Road. She had been discharged

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

earlier in the day after observation for seizure like activity and returned to her assisted living facility. The facility reported she was last seen around 8:30 p.m. during medication pass. Police were called at approximately 9:45 p.m. for a welfare check because she was sitting in front of the Kem Road Animal Hospital. Her speech was garbled and she appeared confused, so she was brought in for evaluation. She had a recent stroke with dysarthria. She could vocalize and provide some history but could not explain why she left or where she was going. When asked if she had fallen, she said she could not remember. Bruising was noted on her bilateral upper extremities. She was pleasant, answered most questions appropriately, and moved all extremities.

During an interview on 9/8/26 at 2:59 p.m., the Administrator indicated she was on vacation at the time of the incident and was not involved in the situation. She collaborated with the DON in completing the facility reported incident. She stated she read the facility reported incident and felt it was an accurate account of the incident. She indicated documenting "less was more."

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

FORM APPROVED

OMB NO. 0938-0391

During an interview on 9/9/26 at 9:21 a.m., the DON indicated that prior to admitting Resident C to Wyndmoor, she assessed her at the hospital. Resident C had a sitter and was not safe to return home, so she was denied admission to Wyndmoor. She went to a long term care facility but was not appropriate there. The DON had concerns about admitting her. The day after admission, Resident C exhibited issues, including placing herself on the floor and showing seizure like activity, prompting transfer to the hospital. The DON assessed her again and discussed her return with a physician, who indicated she was appropriate for assisted living. She was re admitted. Around 9:30 p.m., Care Coordinator 3 called and stated Resident C was found at the Kem Road Animal Hospital. The DON reviewed camera footage but did not observe her exiting the building. Nurse Practitioner 2 advised she should not return. Resident C's friend stated she had an apartment near the animal hospital and may have been trying to go there. The DON completed the facility reported incident with assistance from the Administrator. She stated she had been told to be discreet when reporting an incident.

A current, undated facility policy

titled "Resident Elopement," provided by the Administrator on 9/9/26 at 12:31 p.m., indicated: "Policy ... In conjunction with 410 IAC 16.2 5 1.3(g)(1), this community will ensure that all unusual occurrences that directly threaten the welfare, safety, or health of a resident, including but not limited to resident elopement, will be reported to the ISDH and other appropriate authorities within twenty four hours of becoming aware of the occurrence"

This citation relates to Intake 471723.

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 SIGNATURECassandra L. Dixon	TITLEexecutive director	(X6) DATE10/07/2026
---	-------------------------	---------------------