STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF MARION, LLC	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 468253. Intake 468253 - State deficiencies related to the allegations are cited at R055, R119, R120, R246 and R304. Survey date: March 2, 2026 Facility number: 010682 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 11, 2026.	R 0000		
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4) (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:	R 0055	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The two residents affected both stated that they were ok	04/23/2026

	(1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, interview, and record review, the facility failed to protect a resident's right to privacy during the administration of insulin for 2 of 2 residents observed during insulin administration. (Resident E and Resident D) Findings include: During an observation of medication administration on 3/2/26 the following was observed: 1. At 11:59 a.m., QMA 5 administered Resident E's oral medication in the dining room and asked Resident E what her blood sugar was. QMA 5 returned to the medication cart on A hall and prepared 2 units of Lispro (fast acting insulin) via insulin pen. QMA 5 walked with Resident E from the dining room to an open common area across from the dining room. The resident sat in a facility chair, pulled the neckline of her shirt down, QMA 5 cleaned the resident's left deltoid area with an alcohol prep pad, and		receiving insulin in the locations noted. QMA 5 was immediately instructed to administered in private location or ensure she offer encourage a private location. • 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. Any resident who receives insulin has the potential to be affected by the alleged deficient practice no other residents were noted to be affected. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All nursing staff will attend a mandatory Inservice and receive a copy of updated policy for medication error, medication administration, PRN medication, Medication storage, Insulin administration, and 7 Rights of medication. All personnel will also be trained in the new training policy for new nursing staff. • 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;	

	injected the insulin into the resident's left deltoid muscle. QMA 5 indicated that Resident E had dialysis today and was unable to walk back to her room. Resident E indicated that she didn't mind receiving her medications in the dining room or the insulin in the common area. 2. At 12:18 p.m., QMA 5 assisted Resident D from the dining room in his wheelchair to the A hall medication cart. She drew up 6 units insulin aspart in a disposable insulin syringe. Resident D pulled up his shirt exposing his abdomen, QMA 5 cleaned his left lower abdominal area with an alcohol pad and injected the insulin. Resident D indicated that he didn't mind getting his insulin in the hall while staff and residents passed by. QMA 5 indicated that she had not asked Resident D if it was okay to give him his insulin in the hall, but she had asked him previously with prior injections. During an interview on 3/2/26 at 1:22 p.m. QMA 13 indicated she did not administer insulin in the dining room or common area. She took the residents back to their room or in a secluded area. The current policy, titled "Policy/Procedure - Insulin Pen," and provided by the		and Facility will audit all new nursing personnel training log daily until new nursing personnel are competent and feel comfortable doing their job responsibilities and duties prior to passing medications. The DON will audit weekly to ensure new nursing personnel have properly completed and signed off on new nursing personal training and offer more education if needed. • By what date the systemic changes will be completed. Facility will ensure 100% compliance by 4/23/2026.	

	Administrator on 3/2/26 at 2:26 p.m. did not address the privacy during insulin administration. This Citation relates to Intake IN00468253.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming	R 0119	• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident was sent out for ER evaluation and treatment, resident later returned to facility no adverse reactions noted. • 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 had the potential to be affected by the alleged deficient practice no other med errors 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.	04/23/2026

	policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide (QMA) received training and competency validation prior to independently passing medications, resulting in a medication error and the resident was sent to the hospital and admitted for observation. (QMA 7 and Resident B) Findings include: Resident B's clinical record was reviewed on 3/2/26 at 10:45 a.m. Diagnoses included pancreas transplant status, cognitive communication deficit,		All nursing staff will attend a mandatory Inservice where the personnel will sign and receive a copy of updated policy for medication error, medication administration, PRN administration, medication storage, insulin administration and 7 Rights of Medication. All personnel will also be trained in the new training policy for all new nursing staff. • 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; and Audit added new relias training for QMA and Nursing, if not completed prior to all staff inservice nursing/QMA staff will not be scheduled until training is completed. All new hires will receive new hire training on relias in addition to job specific training before working the floor. • By what date the systemic changes will be completed. Facility will ensure 100 % compliance by 4/23/2026.	

	hypertension, alcohol abuse, disorientation, other abnormal glucose, and psychotic disturbance. A Brief Interview for Mental Status (BIMS) assessment, dated 1/15/26, indicated he was moderately cognitively impaired. A late entry progress note, dated 2/24/26 at 8:15 a.m. and created on 2/25/26 at 8:49 a.m., indicated the resident possibly was given the wrong medication. He was in the dining room and answered questions properly. He was sent to a local hospital for an evaluation and treatment. A progress note, dated 2/24/26 at 1:17 p.m. indicated a follow-up call was made to the local hospital. The resident was being monitored, and labs and test results were within normal limits. A progress note dated 2/25/26 at 3:06 p.m., indicated the resident returned to the facility. He was alert, oriented, and voiced no complaints. A hospital history and physical report, dated 2/24/26, indicated he received Seroquel (antipsychotic), Celexa (antidepressant), primidone (anticonvulsant), metoprolol (treat high blood pressure), metformin (treat diabetes) and			

	Jardiance (treat diabetes) although he was not diabetic and did not take antipsychotics or beta-blockers (for blood pressure). He was sent to the hospital for generalized jerking movements that occurred for 15 to 30 seconds. When he was assessed, he was very somnolent (drowsy) but had not other complaints. The resident's Primary Care Physician (PCP) was contacted who indicated that the resident likely needed a skilled nursing facility for rehabilitation and was not safe for assisted living. Resident was started on Intravenous (IV) fluids. His urine showed glycosuria (high sugar). He was admitted to the medical/surgical/telemetry unit for observation. During an interview with QMA 7, on 3/2/26 at 12:44 p.m., she indicated that a week prior to the medication error, she completed 16 hours of general education within three days, which was her first week of work. She did not shadow anyone, watch anyone pass medications, and did not know the residents. On 2/24/26, the date of the medication error, was her first day working on the medication cart and QMA 9 worked on the other cart on the same hall. QMA 9 directed her to preset her medications and indicated presetting would assist			

	in passing two medication carts. QMA 7 did not feel comfortable with presetting her medications, as she had not preset her medications at her previous jobs. QMA 7 preset the medications and were in the top drawer of the medication cart with the resident's room numbers written on the medication cups. The CNAs brought Resident B to her cart, she didn't look correctly at the medication cup, and gave Resident B Resident C's medications. She realized about 30 minutes later when she was going to give Resident C medication and noticed that the medication with her room number was not in the cart. Approximately at that same time, someone called on the walkie talkie that Resident B was found unresponsive in the dining room. She reported the medication error to the nurse once she noticed it. They brought Resident B back to his room he was alert and oriented but confused and they were checking his blood pressure. She was educated on the 10 rights of medication today. During the interview with QMA 7, the Interim DON provided a teachable moment and an illustration poster titled "The 10 Rights Medication Administration". The teachable moment related to the			

	medication error indicated that the 10 rights of medication was reviewed and the preceptor was re-educated on the training procedures. The expectation going forward was that all nursing staff would complete on the floor training with a CNA and new staff would shadow a QMA for two days prior to completing medication pass. The preceptor would watch/observe until preceptor felt the QMA was competent to work independently. During an interview on 3/2/26 at 1:15 p.m. the Administrator indicated she didn't know that there was a 'glitch' in the training process. She let the former DON take care of the training. A new DON was hired and had experience from her previous job with training and would be changing the way nursing staff were trained. On 3/2/26 at 1:54 p.m., QMA 13 provided QMA 7's employee file. QMA 7's Job Specific Orientation form indicated she was hired on 2/13/26. She received orientation regarding medication pass, treatment administration, QMA documentation requirements, blood glucose testing, and blood pressures completed on 2/25/26 and was signed QMA 9 and QMA 7 on 2/26/26. QMA 7's timesheet indicated she worked			

	2/18/26, 2/19/26, 2/20/26, and 2/24/26. A current facility policy, titled "Medication & Treatments - Medication Error," and provided by QMA 13 on 3/2/26 at 1:54 p.m., indicated the following: "Policy Overview...Associates providing, assisting, or administering medication to residents are expected to follow the "7 Rights of Medication Administration" that include...right route...Policy Detail...1. The types of medication errors include...e. Incorrect Resident (i.e. administration to the wrong resident. 2...Associates are not to give any further medications until instructions are given by the nurse based on the nurse's professional judgement or in consultation with the physician...." This citation relates to Intake 468253.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,	R 0120	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	04/23/2026

	safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge		Resident E was monitored for adverse effects with non-noted. QMA 5 was immediately educated on proper insulin administration sites. • 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. Any resident who receives insulin has the potential to be affected by the alleged deficient practice no other residents were noted to be affected. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Effective immediately all nursing Inservice will be educated on insulin pen policy update and insulin injection diagram. DON will audit each shift insulin administration on a weekly basis • 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; and Administrator and DON will create an audit tool to ensure that all insulin administration	

	attendance by written signature. Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide (QMA) administered insulin via the correct route for 1 of 2 residents observed for insulin administration. (Resident E) Findings include: During a medication administration observation, on 3/2/26 at 11:59 a.m., QMA 5 administered Resident E's medication in the dining room and asked Resident E what her blood sugar was. QMA 5 returned to the medication cart on A hall and prepared 2 units of Lispro (fast acting insulin) via insulin pen. QMA 5 walked Resident E from the dining room to an open common area across from the dining room. The resident sat in a facility chair, pulled the neckline of her shirt down, QMA 5 cleaned the resident's left deltoid (muscle) area with an alcohol prep pad, and injected the insulin into the resident's left deltoid muscle. QMA 5 indicated that she would normally give insulin in the resident's lower abdomen or the meaty part of a resident's arm and pointed to the area below her shoulder on her arm. Some of the residents liked their		personnel properly follow the protocol with insulin administration as well as ensure staff are administering insulin in a private area. Audit tools will be monitored weekly by DON or designee. • By what date the systemic changes will be completed. Facility will ensure 100% compliance by 4/23/2026.	

	insulin in their thighs and one resident liked to have her insulin given in her upper abdomen. Resident E liked her insulin in her upper arm and depending on what type of shirt she wore, she would receive the insulin in her abdomen. During an interview on 3/2/26 at 1:22 p.m. QMA 13 indicated she administered insulin in the back of a resident's arm and in the resident's abdomen, not in the deltoid of the resident's arm. During an interview on 3/2/26 at 2:34 p.m. QMA 17 indicated she would administer insulin in the fatty tissue in the back of the resident's arm or abdomen or per resident's preference. She was unable to give Resident E insulin when she pulled the neckline of her shirt down just passed her shoulder and depending on the shirt Resident E wore, she would administer her insulin in her abdomen. On 3/2/26 3:48 p.m., the Interim DON provided QMA 5's Job Specific Orientation. QMA 5's hire date was 8/13/24 and the orientation did not address medication administration. A current facility policy, titled "Medication & Treatments - Medication Error," and provided by QMA 13 on 3/2/26 at 1:54 p.m. indicated the following: "Policy Overview...Associates			

	providing, assisting, or administering medication to residents are expected to follow the "7 Rights of Medication Administration" that include...right route...." A current facility policy, titled "Policy/Procedure - Insulin Pen," and provided by the Administrator on 3/2/26 at 2:26 p.m. indicated the following: "Policy Overview...Insulin is injected into the tissue just under the skin-otherwise known as the subcutaneous tissue...." This Citation relates to Intake 468253.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to ensure a	R 0246	• What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident F received their pain medication as prescribed and requested. The QMA notified the nurse of administration and nurse agreed to give the medication. • 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. Any resident who received PRN	04/23/2026

	Qualified Medication Aide (QMA) received permission from a licensed nurse prior to administering an as needed (PRN) medication for 1 of 10 medication administrations observed. (QMA 7) Findings include: During a medication administration observation with QMA 7 on 3/2/26 at 11:43 a.m., Resident F sat near the nurse's station and the medication carts on C hall. Resident F requested pain medication and indicated his pain level was an 8. QMA 7 prepared and administered a hydrocodone-acetaminophen 7.5 milligram (mg)/325 mg (opiate pain medication) pill to Resident F. As QMA 7 documented the administration in the resident's clinical record, QMA 9 approached the medication cart and indicated to QMA 7 to document that the nurse was notified. QMA 7 approached the nurse's desk and reported to the Interim DON that she gave Resident F a pain pill and his pain level was 8. The Interim DON acknowledged the reported medication administration. QMA 7 indicated she would normally ask the nurse prior to giving a PRN medication and she was unsure of the location of Resident F's pain.		medication could be affected by the alleged deficient practice. No other residents were noted to have been affected. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All nursing staff will attend a mandatory Inservice where the personnel will sign and receive a copy of updated policy for medication error, medication administration, PRN administration, medication storage, insulin administration and 7 Rights of Medication. All personnel will also be trained in the new training policy for all new nursing staff. New Relias training will be completed prior to all staff Inservice. Facility will ensure ALL staff reviewed and signed off on the Storage Medication Policy. All treatment carts will be properly always locked except when authorized personnel are present. • 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; and Facility will audit and monitor the PRN charting and enforce	

	During an interview on 3/2/26 at 2:34 p.m. QMA 17 indicated she would ask the nurse prior to administering a PRN medication, but did not document that the nurse gave her permission. A current facility policy, titled "Medications & Treatments - PRN," and provided by the Interim DON on 3/2/26 at 2:27 p.m. indicated the following: "...State Specific Requirement - PRN Procedures...IN...PRN medications may be administered by a Qualified Medication Aide (QMA) only upon authorization by a licensed nurse or physician..." This citation relates to Intake 468253.		the PRN policy. DON will audit PRN administration each shift to ensure that the deficient practice will not happen again. • By what date the systemic changes will be completed. Facility will ensure 100% compliance by 4/23/2026.	
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the	R 0304	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. Facility will ensure ALL staff reviewed and signed off on the Storage Medication Policy. All treatment carts will be properly always locked except when authorized personnel are present.	04/23/2026

	facility failed to store skin and wound treatments in a secure and sanitary manner for 1 of 3 medication carts observed. (A hall) Findings include: During an observation of medication administration with Qualified Medication Aide (QMA) 17 on A hall, a pink tackle box titled "Skin & Wound" sat on top of a medication cart. The contents of the tackle box included the following: a. Two packages of Puracol plus wound dressing b. A sterile specimen collection swab c. An open package of Xeroform (wound dressing) d. An opened package of hydrocolloid (wound dressing) e. Nonstick dressing f. Cotton tipped applicators g. Wound closure strips h. Sureprep wipes (skin protectant) i. Alcohol prep pads j. Abdominal pads k. Unpackaged disposable surgical mask lying on the		• 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 had the potential to be affected by the alleged deficient practice. The skin and wound storage containers were immediately locked up. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All nursing staff will attend a mandatory Inservice where the personnel will sign and receive a copy of updated policy for medication error, medication administration, PRN administration, medication storage, insulin administration and 7 Rights of Medication. All personnel will also be trained in the new training policy for all new nursing staff. New Relias training will be completed prior to all staff Inservice. Facility will ensure that All treatment carts will be properly always locked except when authorized personnel is present. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

	bottom of the tackle box. QMA 17 indicated that she was not sure if the tackle box was supposed to be there, but it normally sat on top of the treatment cart. A current facility policy, titled "Medication & Treatment - Storage," and provided by the Interim DON on 3/2/26 at 3:48 p.m. indicated the following: "...Policy Detail 1. Medications and treatments stored by the community are to be stored in designated locations that must be locked when not in use or when unattended...." This citation relates to Intake 468253.		program will be put into place; and Audit all treatment carts periodically and randomly to ensure that all medications are properly stored and all carts are locked. • By what date the systemic changes will be completed. Facility will ensure 100% compliance by 4/23/2026	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURECassandra L. Dixon	TITLE03/23/2026	(X6) DATE03/23/2026