STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD POINTE SENIOR LIVING	6235 STERLING CREEK RD, PORTAGE, , 46368

(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 467622. Intake 467622 - State deficiencies related to the allegations are cited at R0240 and R0241. Unrelated deficiency is cited. Survey dates: March 23 & 24, 2026 Facility number: 012396 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/30/26.	R 0000	**The following is the Plan of Correction for Windward Pointe Senior Living in regards to the Statement of Deficiencies from survey completed on 3/24/2026. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance	R 0240	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient**	04/20/2026

	with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure residents who had fallen were assessed and/or assessed timely after the fall by a licensed nurse for 3 of 3 residents reviewed for falls. (Residents B, F, and C) The facility failed to ensure a resident with a change of status that required an intervention, was assessed timely by a licensed nurse and failed to ensure the notification of the Nurse Practitioner (NP) was followed up on causing a delay in treatment for 1 of 5 residents reviewed for assessments. (Resident C). The facility also failed to ensure a licensed nurse was informed of a resident's refusal of insulin by QMA's who were not certified to administer insulin and the licensed nurse was not informed of the refusal of Mounjaro (glucagon-like peptid-1 and glucose-dependent inslinotropic polypeptide) by QMA's, for 1 of 3 residents who required insulin and 1 of 1 resident who received Mounjarno. (Resident C) Findings include: 1. Resident B's record was reviewed on 3/24/26 at 12:31 p.m. The diagnoses included,		**practice?** Residents B, F, and C were immediately reviewed by the Director of Nursing (DON) to ensure current condition, safety, and care needs are appropriately addressed and assessments are up to date. Any identified gaps in documentation or follow-up were corrected in the medical record. Staff involved received immediate re-education on: - Timely nurse assessment requirements post-fall and with change in condition - Notification protocols for nurse and provider - Medication refusal procedures **2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit will conducted by no later than 4/20/26 by the DON/designee of: - All falls within the last 30 days to ensure a licensed nurse completed timely assessments - All changes in condition to ensure proper nurse notification and provider follow-up - All medication refusals/held medications to ensure nurse notification and documentation	

	but were not limited to, dementia. An unwitnessed fall incident, dated 1/17/26 at 1:43 a.m., indicated QMA 1 was notified by the safety video company the resident might have been on the floor. QMA 1 entered the apartment and the resident was observed in bed and had stated she had not fallen. The video was watched and the resident was observed sitting on the corner of the bed after she returned from the bathroom and slid off the bed onto the floor. She had hit a plastic storage container as she slid from the bed. A minor scratch was observed on the left hip to the buttocks. The resident denied pain or discomfort. The Health Director was notified on 1/17/26 at 1:38 a.m. (sic). There was no documentation the Health Director had completed an assessment after the fall. A Nurse's Progress Note, dated 1/17/26 at 9:17 a.m., indicated the resident had no apparent injuries. During interviews on 3/24/26 at 12:57 a.m., the Director of Nursing (DON) indicated there had been no assessment after the fall by a nurse until 9:17 a.m. The Executive Director (ED) indicated she thought they had 24 hours to assess the		- All residents receiving insulin or high-risk medications to verify proper administration and escalation Corrective actions include reeducation for all nurses and QMA on: - Timely nurse assessment requirements post-fall and with change in condition - Notification protocols for nurse and provider - Medication refusal procedures **3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** We have implemented the following systemic changes to be in place by 4/20/26: Policy & Process Reinforcement: - Reinforced policy requiring immediate licensed nurse assessment following all falls and changes in condition - Reinforced requirement that QMA/CNA staff must notify a licensed nurse immediately for falls, change in condition, and medication refusals or held medications Staff Education: - All nursing staff, QMA’s, and CNA’s were re-educated on scope of practice, timely assessment requirements, and	

	resident after a fall. 2. Resident F's record was reviewed on 3/24/26 at 1:03 p.m. The diagnoses included, but not limited to, vascular dementia. A Progress Note, written by QMA 1, dated 1/23/26 at 5:08 a.m., indicated she was notified by the safety video company the resident may have been on the floor. QMA 1 entered the room and observed the resident in bed. QMA 1 then watched the video and observed the resident walking back to the bed from the bathroom using the wheelchair as a walker. She then missed the bed and fell to her knees and was able to get herself up and into bed. A small purplish bruise was observed on the left knee and she complained of her left knee hurting. An "as needed" medication was given and no further assistance was required. The ED, Hospice and Power of Attorney were made aware. The fall occurred on 1/23/26 at 4:10 a.m. A Progress Note, completed by QMA 2, dated 1/23/26 at 9:44 a.m., indicated the resident continued on 72 hour fall charting with no signs of pain or concerns noted. A Progress Note, completed by Nurse 3, dated 1/23/26 at 10:39 p.m., indicated a 72 hour fall		provider notification expectations - New hires will receive this education during orientation **4. How will the corrective actions be monitored to ensure the deficient practice will not recur (Quality Assurance)?**	

	charting and the resident voiced no pains or discomfort. There was no assessment completed by a licensed nurse after the fall until 1/23/26 at 10:39 p.m. A Progress Note, completed by QMA 1 and dated 4:15 a.m. on 2/27/26, indicated the safety video company notified the facility the resident my have been on the floor. QMA 1 entered the room and observed the resident sitting in the wheelchair. The video was viewed and the resident was observed out of bed without the use of her wheelchair. She fell between her bed and closet. There were no visible injuries. She complained about a headache and QMA 1 was unable to determine if she had hit her head during the fall. Hospice was notified and the on call nurse had instructed the QMA to administer an as needed medication and the hospice nurse would be in to assess the resident. The fall occurred at 3:40 a.m. There was no assessment from the hospice nurse provided when requested from the facility. A Progress Note, dated 2/27/26 at 8:42 a.m., written by Nurse 4, indicated there was no injury from the fall. The range of motion remained at baseline		The facility will implement the following Quality Assurance measures: Audits: - DON/designee will complete weekly audits x4 weeks, then monthly audits x3 months on falls, change in condition documentation, and medication refusals Audit Tracking: - Results will be documented on an audit tool and reviewed for trends QAPI Oversight: - Findings will be reviewed at monthly QAPI meetings - Any identified trends will result in additional staff education, policy revision if needed, and progressive discipline if non-compliance continues Sustainability: - Continued monitoring will remain in place until 100% compliance is achieved and maintained	

	and there was no complaints of pain or discomfort. 3. Resident C's record was reviewed on 3/24/26 at 8:18 a.m. The diagnoses included, but not limited to, diabetes mellitus and right below the knee amputation. a) A Progress Note, dated 3/18/26 at 1:34 a.m., written by QMA 1, indicated the resident had fallen in the bathroom and stated her leg had given out and she fell. She denied hitting her head and had no complaints of pain. She indicated she had a headache and felt dizzy before she had fallen. The blood sugar had been obtained at 98 (normal 70-99). The DON was made aware. The time of the fall was at 1:16 a.m. A Progress Note, written by Nurse 5, dated 3/18/26 at 1:13 p.m., indicated there had been no injuries from the fall. The resident denied pain or discomfort. b) A Progress Note, written by QMA 2, dated 2/20/26 at 10:01 a.m., indicated the resident reported that her left lower leg was red, warm to the touch and "bubbly". The QMA, "observed what the resident was saying". A communication form was sent to the Nurse Practitioner and the QMA was awaiting a response.			

	The Progress Notes had not indicated the nurse on duty had been informed of the change in condition at the time of the concern or the notification to the NP had been followed up on. A Progress Note, written by Nurse 5, dated 2/20/26 at 5:05 p.m., indicated the left lower leg was red and warm with a closed blister that measured approximately 2 centimeters (cm) by 2 cm. A cool compress was applied and the Nurse Practitioner was faxed for an order for an antibiotic and wound care. The DON was notified. There was no documentation the notification to the NP had been followed up on. A Progress Note, written by Nurse 5, dated 2/21/26 at 9:17 a.m., indicated the NP was notified about the left leg blister. The facility was awaiting a response. There was no further follow up with the NP about the concerns with the left leg and no further assessments of the left leg. A Progress Note, written by QMA 2, dated 2/23/26 at 10:44 a.m., indicated a new order had been received from the NP for an antibiotic for 10 days and an order for Home Health to evaluate and treat the blister on			

	the left leg. A Progress Note, written by QMA 2, dated 2/26/26 at 11:15 a.m., indicated the left lower extremity was warm to touch and red. The resident's family were transferring the resident to the hospital. A Progress Note, written by QMA 1, dated 2/27/26 at 1:21 a.m., indicated the resident had been admitted to the hospital for cellulitis of the left lower extremity. During an interview on 3/24/26 at 10:47 a.m., the Director of Nursing indicated the nurse should have been informed of the change of condition. The staff were to follow up on all faxes prior to the ending of the shift. c) A Physician's Order, dated 11/4/25, indicated lantus insulin 10 units was to be administered at bedtime. The insulin was to be not be given if the blood sugar was less than 110. The Medication Administration Record (MAR), dated 1/2026, indicated on 1/17/26 QMA 2 (not certified to administer insulin) held the bedtime lantus per the Physician's Orders. On 1/24/26, QMA 1 (not certified to administer insulin) documented the bedtime lantus had been refused. There was no			

	documentation that indicated the nurse had been notified of the held and refused insulin. d) A Physician's Order, dated 11/14/25, indicated Mounjaro 2.5 milligrams (mg) per 0.5 milliliters (ml) pen was to be injected weekly. The MAR, dated 2/206, indicated the Mounjaro had not been administered on 2/2/26 due to a new prescription was required. The MAR was signed by QMA 3. A Progress Note, written by Nurse 5, dated 2/3/26 at 1:26 p.m., indicated the NP had sent a new prescription to the Pharmacy. A Physician's Order, dated 2/3/26, indicated Mounjaro 2.5 mg was to be administered weekly. The MAR, dated 2/206, indicated on 2/9/26, QMA 2 signed that the Mounjaro had not been administered. There was no documentation by QMA 2 or the nurse that indicated the reason the Mounjaro had not been administered. A Progress Note, dated 3/6/26 at 12:55 a.m., QMA 1 indicated the resident had decided she was unable to afford the			

	Mounjaro at this time. The NP was notified per fax. There was no documentation the licensed nurse and/or DON had been notified of the refusal. There was no documentation or follow up with the NP in regards to the fax. The MAR, dated 3/2026, indicated by QMA 2, the Mounjaro had not been administered on 3/12/26 and 2/19/26. The resident had not wanted to pay the high co-pay. There was no documentation from a licensed nurse. There was no documentation the Physician had been notified. During an interview on 3/24/26 at 10:22 a.m., the ED indicated the facility policy for refusing the medications had not been followed and the QMA's should have notified the nurse. An undated facility policy for medication refusal, received from the ED as current on 3/24/26 at 10:22 a.m., indicated The refusal and potential effects of not taking the medication will be evaluated and documented by a licensed nurse. If the staff member assisting with the medication was not a licensed nurse, the refusal will be reported to a licensed nurse at the time of the refusal. The licensed nurse will evaluate the			

	resident's condition in regard to the refused medications and documented in the resident's health record. A community staff member will notify the resident's physician of the medication refusal and must be documented in the health record by the licensed nurse. A facility fall management policy, dated 5/15/23, and received from the ED as current, indicated if the resident had hit their head or is suspected to have hit their head, do not move the resident and call 911. An undated QMA job description, received from the ED as current on 3/24/26 at 9 a.m., indicated the QMA was to observe residents for changes in physical, emotional mental, or behavioral condition, unusual symptoms, accidents, injuries, or unusual occurrences and report promptly to a licensed nurse. This citation relates to Intake 467622.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised	R 0241	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident C was immediately reviewed by the Director of	04/20/2026

	by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure an injectable non-insulin medication was administered by a licensed nurse and staff failed to administer and hold an insulin as ordered by the Physician, for 1 of 3 residents reviewed for insulin administration. (Resident C) Finding includes: Resident C's record was reviewed on 3/24/26 at 8:18 a.m. The diagnoses included, but not limited to, diabetes mellitus. a) A Physician's Order, dated 11/14/25, indicated Mounjaro (glucagon-like peptid-1 and glucose-dependent inslinotropic polypeptide) was to be given subcutaneously (injected into the the fatty tissue layer of the skin) weekly. The Medication Administration Record (MAR), dated 1/2026, indicated the Mounjaro was administered by QMA 3 on 1/12/26 and 1/19/26. During an interview on 3/24/26		Nursing (DON) to ensure current condition, safety, and medication management needs were appropriately addressed. Staff involved were immediately re-educated on QMA scope of practice, injectable medication administration requirements, proper documentation of held/refused medications, and requirement for nurse notification. DON to complete a full medication review of Resident C. The physician/Nurse Practitioner will be notified of missed and undocumented insulin doses and improper administration of Mounjaro by non-licensed staff before 4/20/26 **2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The DON/designee will conducted a facility-wide audit by 4/20/26 including: - All residents receiving injectable medications (insulin and non-insulin) - All MARs for the last 30 days to identify missed or held medications, lack of documentation for omissions,	

	at 9:35 a.m., the Director of Nursing indicated she thought a trained QMA could give the Mounjaro since it was a medication for diabetes. The Indiana QMA Scope of Practice, located at web address www.in.gov, and reviewed on 3/23/26 at 7 p.m., indicated a QMA could administer prescribed medication which they have been trained to administer. The Indiana Department of Health QMA - Insulin Administration Education Module, dated 1/2025, indicated, QMA's must have additional training to administer insulins. QMA's are not allowed to administer other injectable, non-insulin medications to treat diabetes. b) A Physician's Order, dated 11/4/25, indicated lantus 10 units was to be administered daily at bedtime. The lantus was not to be given if the blood sugar was less than 110. The MAR, dated 2/2026, indicated the lantus had not been administered at 8:00 p.m. on: 2/1/26 with a blood sugar of 115.		and administration by unauthorized staff - All residents with diabetes management orders Corrective actions taken include: - Immediate correction of any identified documentation gaps - Verification that all injectable medications are administered by appropriately licensed personnel - Physician/NP notification for any missed or improperly administered medications - Re-education of any staff identified with non-compliance - Update of care plans as needed **3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The facility has implemented the following systemic changes to be in place by 4/20/26: Policy Reinforcement: - Only licensed nurses may administer non-insulin injectable medications - QMA’s may only administer insulin if properly trained and permitted per Indiana regulations - All held or refused medications must be documented and reported to a licensed nurse	

	2/3/26 with a blood sugar of 143. 2/11/26 with a blood sugar of 112. 2/12/26 with a blood sugar of 119. 2/16/26 with a blood sugar of 117. 2/17/26 with a blood sugar of 116. There was no documentation that indicated why the lantus had not been administered. The lantus was administered at 8:00 p.m. on 2/18/26 with a blood sugar of 89. An undated facility policy for medication refusal, received from the ED as current on 3/24/26 at 10:22 a.m., indicated The refusal and potential effects of not taking the medication will be evaluated and documented by a licensed nurse. A community staff member will notify the resident's physician of the medication refusal and must be documented in the health record by the licensed nurse. During an interview on 3/24/26 at 10:22 a.m., the ED indicated the facility policy for refusing the medications had not been followed.		immediately Staff Education: - Mandatory re-education for all QMA's and nursing staff on Indiana QMA Scope of Practice, injectable medication administration rules, and documentation standards **4. How will the corrective actions be monitored to ensure the deficient practice will not recur (Quality Assurance)?** The facility will implement the following Quality Assurance measures: Audits: - Weekly audits x4 weeks, then monthly audits x3 months of MAR accuracy, medication omissions, and proper staff administering injectable medications Audit Tracking: - Results will be documented and trended to identify patterns or concerns QAPI Oversight: - Findings will be reviewed during monthly QAPI meetings - Any identified trends will result in additional staff education, policy revisions if needed, and progressive discipline for continued non-compliance Sustainability:	

	This citation relates to Intake 467622.		- Monitoring will continue until 100% compliance is achieved and maintained	
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure medications were destroyed properly by a licensed nurse and another nurse, QMA, or pharmacist , related to a controlled pain medication,	R 0298	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident F's medication record was immediately reviewed by the Director of Nursing (DON) to ensure accuracy, safety, and compliance with physician orders. The physician was notified regarding the inappropriate destruction of hydrocodone-acetaminophen and lack of discontinuation order. The Controlled Drug Record was audited and QMA 1 and QMA 4 received immediate re-education on controlled substance handling and destruction requirements, requirement for a licensed nurse to be present during medication destruction, and verification of physician orders prior to discontinuation and destruction. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/20/2026

hydrocodone-acetaminophen 5-325 milligrams (ml), being destroyed by two QMA's. (Resident F, QMA 1 and QMA 4)

Finding includes:

Resident F's record was reviewed on 3/24/26 at 1:03 p.m. The diagnoses included, but not limited to, vascular dementia.

A Physician's Order, dated 7/15/25, indicated hydrocodone-acetaminophen 5-325 mg, one tablet could be administered every eight hours for pain.

The Controlled Drug Record, dated 7/21/25 to 1/12/26, indicated 46 tablets of the hydrocodone-acetaminophen 5-325 mg had been destroyed by QMA 1 and QMA 4 on 1/17/26. There was no licensed nurse as a witness to the destruction of the medication.

There was no Physician's Order to discontinue the medication.

During an interview on 3/24/26 at 1:40 p.m., the Executive Director (ED) indicated the QMAs had not realized that a licensed nurse must witness the destruction of medications. The hydrocodone came up in the computer system as being discontinued though the

taken?

The DON/designee will conducted a facility-wide audit including:

- All medication destruction logs to ensure proper witnessing and documentation
- All medications listed as discontinued in the system to verify valid physician orders

Corrective actions include:

- Immediate reconciliation of any discrepancies identified
- Physician notification for any medications improperly discontinued or destroyed
- Re-education of any staff identified with non-compliance

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

The facility has implemented the following systemic changes to be in place by 4/20/26:

Policy Reinforcement:
- Controlled substances must be destroyed by a licensed nurse and a second authorized witness (nurse, QMA, or pharmacist)
- Verification of a valid physician order prior to medication discontinuation and destruction

	medication had not been discontinued. During an interview on 3/24/26 at 2:19 p.m., the ED indicated QMA 1 and QMA 4 had been re-educated on destroying medications and other QMA's at the facility had not been re-educated. The Indiana QMA Scope of Practice indicated the QMA could prepare and administer medications they were trained to administer. The facility drug disposal policy, dated 11/23/25 and received from the ED as current, indicated discontinued or expired medications were to be destroyed by the nurse and a second staff member (nurse, QMA or pharmacy representative).		System Safeguards: - Requirement for nurse review of all discontinued medications prior to removal from inventory Staff Education: - All QMA's and nursing staff to be re-educated on controlled substance policies, Indiana QMA Scope of Practice, and proper medication destruction procedures **4. How will the corrective actions be monitored to ensure the deficient practice will not recur (Quality Assurance)?** The facility will implement the following Quality Assurance measures: Audits: - Weekly audits x4 weeks, then monthly audits x3 months on controlled substance destruction logs, presence of licensed nurse witness, and physician orders for discontinued medications Audit Tracking: - Audit results will be documented and trended to identify patterns or concerns QAPI Oversight: - Findings will be reviewed during monthly QAPI meetings - Any identified trends will result in additional staff education, policy revisions if needed, and progressive discipline for	

			continued non-compliance Sustainability: - Monitoring will continue until 100% compliance is achieved and maintained	

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 SIGNATUREKristin Pawlak	TITLEExecutive Director	(X6) DATE04/13/2026