STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR ASSISTED LIVING LLC	1465 EAST CROSSING BLVD, TERRE HAUTE, , 47802

(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 a State Residential Licensure Survey. Survey dates: February 4 and 5, 2026 Facility number: 013389 Residential Census: 114 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 17, 2026.	R 0000		
R 0050	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(t)(1-10) (t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of	R 0050	When the oversight of the quarterly reports was brought to the BOM attention, the facility immediately sent out the last quarterly reports. The regulations and policy were reviewed by the Administrator and BOM. An audit tool was developed and will be used each quarter to track the quarterly statements sent out by the BOM and will be double checked by the Administrator to ensure they are completed by the	02/23/2026

	personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a		deadline listed on the audit tool. This will be our own going practice throughout the year,	

	system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate. Based on interview and record review, the facility failed to ensure the residents and or residents' representatives were receiving quarterly financial			

	statements for 1 of 5 residents reviewed for financial statements. Findings include: During a confidential interview, on 2/4/26 at 10:30 a.m., the resident indicated she had never received quarterly financial statements from the facility. She indicated the facility managed her money and she often had no idea how much money was in her account. Resident requested to remain anonymous. During an interview, on 2/4/26 at 1:45 p.m., the Business Office Manager (BOM) indicated she did not send quarterly statements to residents or their representatives. She indicated if a resident requested the statement, then she would print them out and give them to the resident. During an interview, on 2/4/26 at 1:47 p.m., the Administrator indicated they would print out statements if they were requested by the resident or representative, but they had not been sending them out unless requested. During an interview, on 2/4/26 at 2:08 p.m., the BOM indicated she had been in the position for 3 years and did not know she needed to send out quarterly			

	financial statements. On 2/4/26 at 2:03 p.m., the Administrator provided an undated document, titled, "Management of Personal Funds," and indicated it was the policy currently being used by the facility. The policy indicated, " ...5). An individual financial record shall be available per quarterly statements (and upon request) to the resident or his/her legal representative ...." Based on interview and record review, the facility failed to ensure the residents and or residents' representatives were receiving quarterly financial statements for 1 of 5 residents reviewed for financial statements. Findings include: During a confidential interview, on 2/4/26 at 10:30 a.m., the resident indicated she had never received quarterly financial statements from the facility. She indicated the facility managed her money and she often had no idea how much money was in her account. Resident requested to remain anonymous. During an interview, on 2/4/26 at 1:45 p.m., the Business Office Manager (BOM) indicated she did not send quarterly statements to residents or their			

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R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately	R 0304	A secure medication room and medication cart policy/procedure was developed. On going in-services will be held with nursing staff each month throughout the year and with new hires. Pharmacy was contacted and medication	02/23/2026

	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 facility failed to ensure narcotic medications were stored under double locks for 3 of 3 medication rooms reviewed. Findings include: 1. During a continuous observation, on 2/4/26 from 2:04 p.m. to 2:12 p.m., Qualified Medication Aide (QMA) 7 administered medications to three residents on the first floor of the building. A locked medication room was observed with an unlocked medication cart inside, with additional keys sitting on top of it, in the first floor medication room. One resident received hydrocodone/acetaminophen (narcotic pain medication). The hydrocodone/acetaminophen was observed stored in a roll of plastic packets in the bottom drawer of the unlocked medication cart. There was locked compartment contained in the bottom drawer. At the same time, QMA 7 indicated the locked compartment was the narcotic drawer, however, the		carts with larger narcotic boxes were ordered. Nursing staff will be educated on the proper way to secure the med carts and keys per the new policy / procedure. The Director of Nursing and / or Administrator will conduct random audits throughout the year for ensuring staff is following the policy/procedure for keeping the med carts locked inside the medication room.	

rolled packets did not fit in the locked compartment. They stored morphine (narcotic pain medication) and other bottles they were able to fit in the locked compartment. They stored all other narcotics in the bottom drawer, which did not have a secondary lock. QMA 7 was observed to leave the medication room to administer medications to three residents. She returned to the room between each resident and after the last resident. Each time she entered the medication room she unlocked the room with a key worn on a lanyard. Each time she left the medication room, the medication cart was left unlocked, with keys on top of it.

2. During an observation, on 2/4/26 at 2:18 p.m., QMA 7 was observed preparing medications for a resident on the second floor medication room. QMA 7 unlocked the medication room with a key worn on a lanyard. The medication cart was unlocked with keys laying on top of it when QMA 7 entered the medication room. Narcotic medications were observed stored in the bottom drawer, without a secondary lock. There was a locked compartment in the bottom drawer. At the same time, QMA 7 indicated the same types narcotics were stored in the locked compartment, and

	the rolled packets of narcotic medications were stored in the bottom drawer, without a secondary lock. When QMA 7 left the medication room, the medication cart was left unlocked with keys laying on top of it. 3. During an observation, on 2/4/26 at 2:18 p.m., QMA 7 was observed preparing medications for a resident in the third floor medication room. QMA 7 unlocked the medication room with a key worn on a lanyard. The medication cart was unlocked with keys laying on top of it when QMA 7 entered the medication room. Narcotic medications were observed stored in the bottom drawer, without a secondary lock. There was a locked compartment in the bottom drawer. At the same time, QMA 7 indicated the same types narcotics were stored in the locked compartment, and the rolled packets of narcotic medications were stored in the bottom drawer, without a secondary lock. When QMA 7 left the medication room, the medication cart was left unlocked with keys laying on top of it. During an interview, on 2/4/26 at 2:28 p.m., QMA 7 indicated three nurses had access to the medication room, in addition to herself, this shift. QMA 7			

counted the narcotic medications with staff at the beginning and end of her shift.

During an interview, on 2/4/26 at 2:40 p.m., the Director of Nursing (DON) indicated there were two locks on the door of the medication rooms, which she thought was sufficient for a double lock. The DON confirmed QMA 7 and three nurses had access to the medication rooms this shift. They were not able to fit all of the rolled packets that contained narcotic medications in the locked compartments, so they stored some of them in the bottom drawer of the medication cart.

During an interview, on 2/4/26 at 2:48 p.m., the Administrator indicated she thought having two locks on the medication room door was sufficient for a double lock. The Administrator verified QMA 7 and three nurses had access to the medication rooms this shift.

On 2/4/26 at 2:48 p.m., the Administrator provided a policy titled, "Medication Administration," dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, "...Guidelines for Medication Administration...18. During routine administration of medications, take the

medication cart to the doorway of the resident's room. Position the cart within visual range. Always lock the medication cart before leaving it out of visual range. Never leave the narcotic box/drawer or medication room unlocked...."

Based on observation, interview, and record review, the facility failed to ensure narcotic medications were stored under double locks for 3 of 3 medication rooms reviewed.

Findings include:

1. During a continuous observation, on 2/4/26 from 2:04 p.m. to 2:12 p.m., Qualified Medication Aide (QMA) 7 administered medications to three residents on the first floor of the building. A locked medication room was observed with an unlocked medication cart inside, with additional keys sitting on top of it, in the first floor medication room. One resident received hydrocodone/acetaminophen (narcotic pain medication). The hydrocodone/acetaminophen was observed stored in a roll of plastic packets in the bottom drawer of the unlocked medication cart. There was locked compartment contained in the bottom drawer. At the same time, QMA 7 indicated the locked compartment was the narcotic drawer, however, the

rolled packets did not fit in the locked compartment. They stored morphine (narcotic pain medication) and other bottles they were able to fit in the locked compartment. They stored all other narcotics in the bottom drawer, which did not have a secondary lock. QMA 7 was observed to leave the medication room to administer medications to three residents. She returned to the room between each resident and after the last resident. Each time she entered the medication room she unlocked the room with a key worn on a lanyard. Each time she left the medication room, the medication cart was left unlocked, with keys on top of it.

2. During an observation, on 2/4/26 at 2:18 p.m., QMA 7 was observed preparing medications for a resident on the second floor medication room. QMA 7 unlocked the medication room with a key worn on a lanyard. The medication cart was unlocked with keys laying on top of it when QMA 7 entered the medication room. Narcotic medications were observed stored in the bottom drawer, without a secondary lock. There was a locked compartment in the bottom drawer. At the same time, QMA 7 indicated the same types narcotics were stored in the locked compartment, and

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	medication cart to the doorway of the resident's room. Position the cart within visual range. Always lock the medication cart before leaving it out of visual range. Never leave the narcotic box/drawer or medication room unlocked...."			

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 SIGNATUREValaurie Nesbit	TITLEAdministrator	(X6) DATE02/24/2026