

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 07/20/2026	
NAME OF PROVIDER OR SUPPLIER SWEET GALILEE AT THE WIGWAM		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 JOHN STREET, ANDERSON, , 46016					
(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 Intakes 470421, 470666, and 470787. Intake 470421 - State deficiency related to the allegation is cited at R0027. Intake 470666 - State deficiency related to the allegation is cited at R0027. Intake 470787 - No deficiencies related to the allegations are cited. Survey date: July 17 and 20, 2026 Facility number: 014706 Residential Census: 74 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 23, 2026	R 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Sweet Galilee at the Wigwam respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.				

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

R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to inform a resident (Resident D) they had been given the wrong medications. Findings include: The clinical record for Resident D was reviewed on 7/17/26 at 9:53 a.m. Diagnoses included aphasia, cerebral infarction, cerebrovascular disease, anxiety, glaucoma, blind in both eyes, dementia, and depression. A progress note, dated 7/6/26 at 9:00 a.m., indicated the DON received a call from the facility to report a medication error involving Resident D during the morning medication administration pass. QMA 1 had given the resident another resident's medication. The DON called the Physician Assistant	R 0027	410 IAC 16.2-5-1.2(b) – Resident Rights R-Tag 027 The facility respectfully submits the following Plan of Correction. This Plan of Correction is intended to serve as the facility's allegation of compliance and does not constitute an admission of the alleged deficiency. The facility respectfully requests a desk review. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D was assessed immediately following the medication error by the Director of Nursing and the Physician Assistant. The Physician Assistant evaluated the resident, appropriate medical interventions were implemented, and the resident experienced no adverse effects related to the medication error. The resident was informed of the medication error by the Physician Assistant on July 7, 2026. The facility recognizes that the resident should have been notified immediately following the discovery of the	08/04/2026
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(PA) to report the incident. The progress note lacked any documentation of resident notification.

A PA progress note, dated 7/7/26 at 7:45 a.m. indicated the following: the resident was not initially aware she had taken the wrong medications and had not complained of any illness when checked.

During an interview, on 7/17/26 at 11:29 a.m., QMA 1 indicated on 7/6/26 during the morning medication administration pass, she gave Resident D medication meant for another resident. QMA 1 did not notify the resident of the medication error until the next day.

During an interview, on 7/20/26 at 10:20 a.m., Resident D indicated staff did not notify her of the medication error until the day after the incident. The resident was informed of the incident by the PA.

During an interview, on 7/20/26 at 11:01 a.m., the DON indicated neither she nor staff had informed Resident D of the medication error. The PA informed the resident of the incident on 7/7/26 when he came to assess the resident.

During an interview, on 7/20/26 at 11:12 a.m., LPN 2 (LPN for the PA) indicated the PA had

medication error. The facility has since established a process requiring immediate resident and/or responsible party notification following any medication error, unless clinically contraindicated.

2.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;

The Director of Nursing completed a retrospective review of all medication error reports and incident reports for the previous 90 days to determine whether residents and/or their responsible parties were notified in accordance with resident rights. Any identified documentation deficiencies were addressed immediately. No additional residents were identified who had not received appropriate notification.

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

The facility has implemented the following corrective measures:

- Medication Error and Resident Notification education has been

seen the resident on 7/7/26 and informed the resident the staff had been given the wrong medications on 7/6/26, during the morning medication pass. The PA was not available for interview during the survey.

During an interview, on 7/20/26 at 1:31 p.m., the DON indicated the facility did not have a policy to address medication errors or notification. The DON indicated the staff just went by the regulation. The DON indicated Resident D should have been informed of the medication error at the time of the incident.

No further information was provided.

This citation is related to Intakes 470421 and 470666.

implemented to ensure compliance with Indiana resident rights regulations.

- All licensed nurses, Qualified Medication Aides (QMAs), and medication administration staff received mandatory education on:
 - Resident Rights.
 - Immediate disclosure of medication errors to residents and/or their representatives.
 - Required physician/provider notification.
 - Required documentation of resident notification and follow-up.
 - Medication error reporting procedures.

4.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

The Director of Nursing or designee will audit 100% of all medication errors to verify:

- The resident was notified immediately upon discovery of the medication error.
- The responsible party was notified when applicable.

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

- The physician/provider was notified.
- Required documentation is complete.
- Appropriate resident assessments and follow-up were completed.

Audits will be conducted:

- Weekly for four (4) weeks.
- Bi-weekly for the following four (4) weeks.
- Monthly for two (2) additional months.

Audit findings will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. Any identified concerns will result in immediate corrective action, counseling, and re-education of staff.

**6. Date of Alleged Compliance
August 4,2026.**

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
SIGNATURE Darlene Adair

TITLE Executive Director

(X6) DATE 08/03/2026