STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET GALILEE AT THE WIGWAM	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 Intake IN00464232. Intake IN00464232- State deficiencies related to the allegations are cited at R0120. Survey dates: September 10 and 11, 2025 Facility number: 014706 Residential Census: 89 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2025.	R 0000		
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	R 0120	1 Employees 3, 5, 7, 8, 9, 10, 12, 13, 15, 17, and 18 have completed all deficient training.	10/11/2025

	least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, 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		2 All residents had the potential to be affected by this deficient practice. An audit of employee files has been completed by Business Office Manager. All employees who were identified in the audit have been assigned the required training through an approved education program and have completed them. 3 The Business Office Manager has been in-serviced on the regulations by the Executive Director. The Business Office Manager/Designee will conduct an audit of employee required training weekly times 4 weeks and monthly times 3 months. Staff who do not complete the assigned training will be removed from the schedule until completion. All new staff will not be permitted to work on the floor until the assigned trainings are complete. 4 Any variances identified will be corrected, and findings will be reported to the	

	inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure newly hired staff had 6 hours of dementia training within 6 months of hire for 12 of 19 employee records reviewed (Employees 3, 5, 7, 8, 9, 10, 12, 13, 15, 17, and 18). Findings include: Employee records were reviewed on 9/10/2025. The following concerns were identified: a. Employee 3, hired 7/22/2025 -lacked documented abuse education. b. Employee 5, hired 8/20/2025 - lacked documented abuse and dementia education. c. Employee 7, hired 8/20/2025 -lacked abuse education. d. Employee 8, hired 4/1/2025 -lacked abuse and dementia education. e. Employee 9, hired 7/22/2025 -lacked abuse education. f. Employee 10, hired 4/21/2025 -lacked abuse education. g. Employee 12, hired 5/30/2025 -lacked abuse		Quality Assurance Committee. QAPI committee will review the audit for 6 months. 5 Compliance date: October 11, 2025	

	education. h. Employee 13, hired 5/8/2025 -lacked abuse education. j. Employee 15, hired 9/3/2025 -lacked abuse and dementia education. k. Employee 17, hired 9/8/2025 - lacked abuse education. l. Employee 18, hired 8/5/2025 -lacked abuse education. m. Employee 19, hired 8/13/2025 -lacked abuse and dementia education.			

During an interview, on 9/11/2025 at 12:18 p.m., the Administrator indicated the facility's orientation process was as follows: New hires first met with the Business Office Manager and gave their log ins for the electronic education application; they complete their initial tax/benefit document The Administrator's part last 45 min -1 hour. The education included a slide presentation that covers abuse, resident rights, being on time, meeting resident needs, communication, and work ethics. The facilities policy gave the employees 30 days to complete part of the training, however it did not specify which parts. It did not specify which parts. The Administrator indicated the facility abided by state regulations for staff education.

A current policy, dated 4/2024, titled "Nursing Staff Development/Orientation & Inservice Education" was provided by the Administrator on 9/11/2025 at 11:29 a.m. The policy indicated the following:

" .... Procedure:

C. Provide in-service education sessions for all staff, coordinated by the Nursing Supervisor to include annual mandatory in-services as required by Gradant Management Solutions and

HFS/IDPH/State regulations.
...."

This citation relates to Intake IN00464232.

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Findings include:

Employee records were reviewed on 9/10/2025. The following concerns were identified:

a. Employee 3, hired 7/22/2025 -lacked documented abuse education.

b. Employee 5, hired 8/20/2025 - lacked documented abuse and dementia education.

c. Employee 7, hired 8/20/2025 -lacked abuse education.

d. Employee 8, hired 4/1/2025 -lacked abuse and dementia education.

e. Employee 9, hired 7/22/2025 -lacked abuse education.

f. Employee 10, hired 4/21/2025 -lacked abuse education.

g. Employee 12, hired

5/30/2025 -lacked abuse education.

h. Employee 13, hired 5/8/2025 -lacked abuse education.

j. Employee 15, hired 9/3/2025 -lacked abuse and dementia education.

k. Employee 17, hired 9/8/2025 - lacked abuse education.

l. Employee 18, hired 8/5/2025 -lacked abuse education.

m. Employee 19, hired 8/13/2025 -lacked abuse and dementia education.

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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 SIGNATUREVernatene Banks	TITLEExecutive Director	(X6) DATE10/02/2025