STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/19/2026

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 Intakes 468899, 469051, and 469758. Intake 468899 - No deficiencies related to the allegations are cited. Intake 469051 - State deficiencies related to the allegations are cited at R0243 and R0301. Intake 469758 - No deficiencies related to the allegations are cited. Survey dates: May 15, 18, and 19, 2026 Facility number: 014706 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	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.	

	Quality review completed May 22, 2026.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure mediations were given as ordered by the physician for 2 of 3 residents reviewed for medication administration. (Residents D and G) Findings include: 1. During a medication administration observation on 5/18/26 at 12:00 p.m., QMA 1 dialed up 15 units of Novolin N (intermediate-acting insulin) insulin instead of the 15 units of Novolog (rapid acting insulin) as indicated per orders for sliding scale use. Resident D	R 0243	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. Resident D did not have any adverse effects as resident D received correct administration of insulin. 2. Resident G did not have any adverse effects from alleged deficient practice. Discontinued medication was removed and destroyed at time of medication event. 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; 1. All residents that receive medication administration had the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	06/02/2026

	recognized the incorrect insulin and stopped QMA 1. The clinical record for Resident D was reviewed on 5/18/26 at 2:38 p.m. Diagnoses included diabetes mellitus and stage 3 chronic kidney disease. Current orders included blood glucose checks at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 10:00 p.m., (dated 9/7/23), Novolin N 100 units/ml flex pen, 40 units subcutaneously every morning and inject 10 units subcutaneously at bedtime, (dated 12/12/25), and Novolog 100 unit/ml flex pen, inject per sliding scale three times daily, (dated 4/28/25). 2. During an interview on 5/15/26 at 3:00 p.m., QMA 4 indicated, on 4/6/26 during the night shift, he administered clonazepam (anti-seizure/sedative) to Resident G. QMA 4 indicated he did not check the order prior to administration because he knew the resident and felt comfortable that he knew the resident's medication. QMA 4 had not been aware that the medication had been discontinued. Review of the March 2026 Medication Administration Record on 5/18/26 at 10:43 a.m. indicated an order for clonazepam 0.5 mg tablets, one-half tablet by mouth three		1. The Director of Nursing or designee educated nursing staff on June 01, 2026, 5 rights for medication administration and medication administration policy. 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 1. The Director of Nursing or designee: will audit medication administration by use of an audit tool (1) Once weekly for the first month then (2) Two times a monthly for (6) months. Audits will be reported monthly to the QAPI Committee. By what date the systemic changes will be completed. 06/02/2026	

	times daily as needed, dated 8/20/25 and discontinued on 3/24/26. During an interview, on 5/18/26 at 11:34 a.m., LPN 5 indicated she had identified the medication error on 4/7/26 when she arrived for the day shift. LPN 5 indicated staff knew they should verify the resident, medication, route and time of administration prior to giving medications. The clinical record for Resident G was reviewed on 5/19/26 at 10:43 a.m. Diagnoses included hypertension, anxiety disorder, hypercholesterolemia, diabetes mellitus, and gastro-esophageal reflux disease. A current policy, dated 3/2022, titled "Medication Management, Administration, & Storage (Indiana and Ohio Only)" was provided by the Regional Clinical Consultant on 5/18/26 at 11:25 a.m. The policy indicated the following: " .... Policy .... A.Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA. 1. Rights of Medication Administration: All medication			

	will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation." .... 4. Documentation: At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name b. Name of Medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment...." This citation relates to Intake 469051.			

R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review and interview, the facility failed to ensure insulin pens were labeled and dated according to residential regulation and facility policy. This deficient practice had the potential to affect 3 of 3 residents reviewed for medication administration. (Residents D, E, and F) Findings include:	R 0301	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practices. Medication labels were corrected to ensure completeness and accuracy. A licensed professional from ELP Pharmacy conducted a review of all medication carts and systems on 6.1.26 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; Residents that received medication administration have the potential to be affected by alleged deficient practice What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	05/28/2026

	1. During a medication administration observation on 5/18/26 at 12:00 p.m., QMA 1 dialed up 15 units of Novolin N (intermediate-acting insulin) insulin instead of the 15 units of Novolog (rapid acting insulin) as indicated per orders for sliding scale use. Resident D recognized the incorrect insulin and stopped QMA 1. The insulin pens lacked the resident's name, date the pen was put into use and end usage date. The clinical record for Resident D was reviewed on 5/18/26 at 2:38 p.m. Diagnoses included diabetes mellitus and stage 3 chronic kidney disease. Current orders included blood glucose checks at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 10:00 p.m., (dated 9/7/23), Novolin N (intermediate-acting insulin) 100 units/ml flex pen, 40 units subcutaneously every morning and inject 10 units subcutaneously at bedtime, (dated 12/12/25), and Novolog (rapid acting insulin) 100 unit/ml flex pen, inject per sliding scale three times daily, (dated 4/28/25). 2. The clinical record for Resident E was reviewed on 5/18/26 at 3:02 p.m. Diagnosis included type 2 diabetes mellitus. Current orders included Basaglar (antidiabetic injection)100 unit/ml Kwikpen,		All licensed nurses and medication aides were re-educated on Medication administration standards, proper storage and labeling documentation requirements by the Director of Nursing on June 1, 2026. 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: Monitor insulin pens for proper labeling Weekly x 4 weeks, then monthly x 6 months. Audits will be reviewed monthly at the QAPI meeting. By what date the systemic changes will be completed 06/02/2026	

inject 40 units subcutaneous at bedtime, (dated 1/27/26) and Novolog 100 unit/ml flex pen, inject subcutaneously 12 units three times daily with meals - 8:00 a.m., 12:00 p.m., and 4:00 p.m., (dated 1/27/26).

During an observation of the medication cart, on 5/18/26 at 12:00 p.m., both insulin pens lacked the resident's name, dated the pen was put into use and the end use date.

3. The clinical record for Resident F was reviewed on 5/19/26 at 9:05 a.m. Diagnosis included type 2 diabetes mellitus. Current orders included Lantus Solostar (long acting insulin) 100 units/ml, inject 10 units subcutaneously at bedtime, (dated 10/27/25).

During an observation of the medication cart, on 5/18/26 at 12:00 p.m., the insulin pen lacked the resident's name, dated the pen was put into use and the end use date.

During an interview on 5/18/26 at 12:30 p.m., the Regional Clinical Consultant indicated the insulin pens were not labeled appropriately.

A current undated policy, titled "Insulin Pen Labeling Protocol for Assisted Living Facilities" was provided by the Regional Clinical Consultant on 5/18/26 at

2:08 p.m. The policy indicated the following:

"...Proper labeling of insulin pens is essential to ensure resident safety, prevent medication errors, and comply with infection control standards. Insulin pens are single-resident use only and must never be shared between residents. ....

Required Label Information

Each insulin pen must be labeled immediately upon opening with the following:

1. Resident's full name

2. Date opened (first use)

3. Beyond-use/discard date

4. Initials of staff member labeling the pen (optional, based on facility policy)

Label Placement

Place the label on the body of the pen.

Do not cover:

Medication name

Strength/concentration

Expiration date

Dose window

	Injection button ...." This citation relates to Intake 469051.			

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 SIGNATUREDarlene Adair	TITLEExecutive Director	(X6) DATE06/05/2026