STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF WHITESTOWN	5829 NEW HOPE BOULEVARD WHITESTOWN, IN 46075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00432864 and IN00438840. Complaint IN00432864 - No deficiencies related to the allegations are cited. Complaint IN00438840 - State deficiencies related to the allegations are cited at R0216, R0217, and R0297. Survey dates: July 25 and 26, 2024 Facility number: 015004 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 7, 2024.	R 0000	**R 0000** This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request consideration for paper compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observations, record reviews, and interviews, the facility failed to complete medication self-administration assessments for residents who kept their medications in their apartments for 2 of 2 residents observed (Residents B and C). Findings include: 1. On 7/25/24 at 11:00 a.m., Resident B was observed in his apartment coming out of his bathroom. On his nightstand was a clear cup. It contained two pills. One was orange in color and	R 0216	**R 216** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) The new QMA for resident B was re-educated not to leave medications at bedside; B) A self-medication assessment was completed for Resident C which reflected that she was able to administer her own medications; C) Resident C's physician	09/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi M Myers	Executive Director	08/22/2024

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	the other was light pink. He also had fluticasone (nasal spray) and allergy relief pills on his dresser. Resident B had a level of care (LOC), dated 5/2/24, which indicated he did not administer his own medications. On 7/25/24 at 12:30 p.m., a record review was conducted for Resident B. He had the following diagnoses which included but were not limited to liver transplant, gout, insomnia, chronic kidney disease and edema. He had a medication self-administration assessment completed on 11/9/23 which indicated he did not administer his own medications. On 7/25/24 at 2:00 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) and Executive Director (ED). They indicated the Qualified Medication Assistant (QMA) was new and left his medications at the bedside. She had been counseled about leaving his medications at bedside since he did not self-administer his own medications. 2. On 7/25/24 at 11:25 a.m., Resident C was observed sitting in a recliner in her apartment. In a container on her dresser there were multiple medications. They included, vitamins, Systane eye drops (for dry eyes), acetaminophen, xyzal (an allergy medications), senekot (for constipation), colace (for constipation), CoQ10 (a supplement), atorvastatin (for high cholesterol), latanoprost eye drops (for glaucoma), timolol eye drops (for glaucoma), fluticasone, Tylenol PM, allergy relief pills and in her refrigerator, there was Mounjaro (used to treat diabetes mellitus). On 7/25/24 at 1:10 p.m., a record review was conducted for Resident C. She had the following		provided an order stating that she could administer her own medications; D) Resident C's medications (Mounjaro and Ozempic) were clarified and Ozempic discontinued due to non-use; and E) Resident C's service plan updated to reflect changes. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All Assisted Living residents who do not self-administer their own medications have the potential to be affected by the alleged deficient practice. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; A) All new staff who administer medications will receive training during orientation on the medication administration/not leaving meds at bedside; and B) Monthly room sweeps checking for unsecured meds will continue for all self-medicating residents. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; A) DON will complete a monthly review of all self-medication orders to ensure that a self-medication evaluation has been completed and	

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	diagnoses which included but were not limited to diabetes mellitus, glaucoma, headache, major depressive disorder, and insomnia. Resident C had a level of care assessment dated 7/13/24. It indicated round the clock caregiver administration and/or observation of medications was required for judgement of necessity, dosage and/or effect of medications. On 7/26/24 at 10:30 a.m. an interview was conducted with Licensed Practical Nurse (LPN) 3 and ADON. They indicated Resident C needed some clarification on Resident C's medications and that they had a call out to her doctor. She had Ozempic (a diabetic medication) and Mounjaro which are the same medication which needed clarified. On 7/26/24 at 1:45 p.m., Resident was concerned about staff taking her medications out of her apartment. She indicated she wanted to administer all her medications. LPN 3 indicated they would make that happen. Resident was happy and went back to her apartment. A policy titled, "Medication Assistance," was provided by the ED on 7/26/24 at 10:14 a.m. It indicated, " ...To provide safe assistance with medication administration to residents. To provide guidance to the staff for medication services. To provide consistency in the style of medication delivery system thus reducing confusion and errors ..." A policy titled, "Medication Orders," was provided by the ED on 7/26/24 at 10:14 a.m. It indicated, "...Must keep medication(s) inaccessible to other individuals in a locked compartment within their apartment or keep		physicians' orders are in place; B) Nursing staff will complete a monthly sweep of Assisted Living resident apartments to ensure that medications are secured in a locked cabinet. The date the systemic changes will be completed by; September 15th,2024.	

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	apartment door closed and locked at all times..." This citation relates to Complaint IN00438840.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record reviews and interviews, the facility failed to update the level of care with resident changes for 2 of 3 residents (Residents B and D). Findings include: 1. On 7/25/24 at 12:30 p.m., a record review was conducted for Resident B. He had the following diagnoses which included but were not limited to liver transplant, gout, insomnia, chronic kidney disease and edema. Resident B's record indicated the resident had a liver transplant with the need of close monitoring of labs and medication levels of prograf (a transplant medication used to prevent rejection). Resident B's service plan lacked documentation of the required monitoring of medication levels or labs. 2. On 7/25/24 at 10:44 a.m., Resident D was observed sitting in her recliner. She complained that she had a fall from the toilet after waiting some time for assistance. She indicated her legs hurt and she took medications for the pain. Staff provided a bedside commode for her to use when in bed and she needed to use the bathroom. The bedside commode was checked and was full of yellow urine. She indicated she had to tell staff to empty it. There were soiled briefs in the trash can next to the commode.	R 0217	**R 217** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) The comprehensive service plan for resident B was updated to include documentation on required monitoring of medication levels and labs; and B) Resident D's service plan was updated to include the intervention to place a bedside commode and trash can next to her bed for use while in bed. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All Assisted Living residents have the potential to be affected by the alleged deficient practice. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; A) The facility policy and ISDH regulations for comprehensive service plans were reviewed by the licensed nursing team; B) AL resident service plans were reviewed to ensure that each	09/15/2024

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	On 7/25/24 at 1:35 p.m., a record review was conducted for Resident D. She had the following diagnoses which included but were not limited to chronic pain, essential hypertension, pain in right shoulder, and shortness of breath. Resident D's record indicated she had falls related to weakness. Resident D's service plan lacked documentation of the intervention to place a bedside commode and trash can next to her bed for her to use when in bed. On 7/26/24 at 10:50 a.m., The Executive Director (ED) indicated she and the Assistant Director of Nursing (ADON) were reviewing and updating every residents' service plan. A policy titled, "Assistance/Service Plan," was provided by the Executive Director (ED) on 7/26/24 at 10:15 a.m. It indicated, " ...Any personal care services needed will be indicated on the assistance/service plan ..." This citation relates to Complaint IN00438840.		resident had comprehensive documentation was in place; and C) DON or designee will be responsible to review all service plans to ensure that any personal care services needed will be indicated on the service plan. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; A) The facility policy and ISDH regulations for comprehensive service plans were reviewed by the licensed nursing team; B) A tracking tool will be utilized by the DON or designee, who will audit service plans monthly to ensure that updates are completed timely, C) Visits with residents/family will be scheduled to review updated service plans. The date the systemic changes will be completed by; September 15th, 2024.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance Based on observation, record review and interview, the facility and pharmacy failed to provide an accurate order for a resident's medication for 1 of 3 residents reviewed for medications (Resident D). Findings include: On 7/25/24 at 1:35 p.m., a record review was conducted for Resident D. She had the following	R 0297	**R 297** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) The neurontin order for Resident D was clarified to include the 100 mg afternoon dose; and B) A meeting was held with the representative for the house pharmacy to discuss	09/15/2024

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	diagnoses which included but were not limited to chronic pain, essential hypertension, pain in right shoulder, and shortness of breath. On 7/25/24 at 2:22 p.m., Licensed Practical Nurse (LPN) 3 provide a paper with a new order for Resident D's neurontin (medication for nerve pain and/or seizures). The order was received from Resident D's hospice provider on 7/24/24 at 8:47 p.m. The order was to change neurontin to 100 milligrams (mg) in the morning, 100 mg in the afternoon and 200 mg at bedtime. The paper order was faxed to the facility's pharmacy. LPN 3 indicated nurses do not place orders into the electronic medical record. The pharmacy was responsible for this. The pharmacy transcribed the order wrong and omitted the afternoon dose. The pharmacy transcribed the order as 100 mg in the morning and 200 mg at bedtime. They missed the afternoon dose. On 7/25/24 at 12:44 p.m., Resident D's niece phoned and indicated there was a delay in resident's neurontin being administered because there was a medication error. She indicated the medication was increased. A policy titled, "Medication Policy," was provided by the Executive Director (ED) on 7/26/24 at 10:14 a.m. It indicated, " ...Prescription Requirements: in order for our pharmacy to fill orders, doctor's prescriptions must include the following: resident's name, name of medication, strength of medication, dosage, instructions for use, date of order, quantity, physician's signature, address and licenses numbers ..." This citation relates to Complaint IN00438840.		transcription concerns. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; All residents who utilize the house pharmaceutical services for medications have the potential to be affected by the alleged deficient practice. What measures will be put into place and the systemic changes the facility will make to ensure that the deficient practice does not recur; A) The facility nursing team met with the pharmacy representative to share concerns regarding pharmacy transcriptions issues; B) The licensed nursing team will review new orders twice daily @ 7am and 10pm to confirm transcription into the EMAR is correct; and C) Any issues will be logged and reported to the pharmacy immediately for corrections. The corrective action will be monitored to ensure the deficient practice will not recur and the quality assurance program put into place; A) The licensed nursing team will review new orders twice daily during day shift and evening shift to ensure proper transcription in the EMAR; and B) Any issues will be logged and reported to the pharmacy immediately for corrections. The date the systemic changes	

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			will be completed by: September 15th, 2024.	