STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE, LAFAYETTE, , 47909

(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: October 27 and 28, 2025 Facility number: 014148 Residential Census: 115 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 5, 2025.	R 0000	Requesting desk compliance for tags	
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the	R 0121	~~1 1.~~CNA 2 & 3 time completed on TB skin test administration and results. ~~2 2.~~Employee records audited, any records found with times not documented on 2-Step TB test will be completed.	11/20/2025

	date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and		~~3 3.~~New employee TB test will be added to monthly calendar to ensure all TB test are administered, dated, and timed correctly. ~~4 4.~~Inservice completed to staff nurses who are TB certified to administer TB skin test. Completed on October 30, 2025. ~~5 5.~~DON and/or designee will audit TB compliance weekly to ensure compliance. Audits will be reviewed at monthly QA committee meetings x 6 months and make recommendations as needed. ~~6 6.~~Compliance Date November 20, 2025	

	interview, the facility failed to ensure tuberculin skin test documentation included the time administered and read to ensure accurate testing was completed for 2 of 5 employees reviewed for employee records. (CNA 2 and CNA 3) Findings include: During a record review, on 10/28/25 at 9:15 a.m., the employee records indicated the following: 1. CNA 2's tuberculin skin test documentation did not contain a time administered or read for the 1st or 2nd step test. 2. CNA 3's tuberculin skin test documentation did not contain a time administered or read for the 1st or 2nd step test. During an interview, on 10/28/25 at 9:47 a.m., the Executive Director (ED) indicated they did not have the tuberculin skin tests documentation completed.			

	A current facility policy, titled "Tuberculosis Skin Testing, and Follow-up for Employees and Residents", dated 9/2021 and provided by the Director of Nursing (DON) on 10/28/25 at 9:47 a.m., indicated "...Administrative phase ...Document: Name of recipient, date, time, arm, lot number, solution as listed on bottle, signature of nurse...." Based on record review and interview, the facility failed to ensure tuberculin skin test documentation included the time administered and read to ensure accurate testing was completed for 2 of 5 employees reviewed for employee records. (CNA 2 and CNA 3) Findings include: During a record review, on 10/28/25 at 9:15 a.m., the employee records indicated the following: 1. CNA 2's tuberculin skin test documentation did not contain a time administered or read for the 1st or 2nd step test. 2. CNA 3's tuberculin skin test documentation did not contain a time administered or read for the 1st or 2nd step test. During an interview, on 10/28/25 at 9:47 a.m., the Executive Director (ED) indicated they did not have the tuberculin skin			

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R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure ceilings were free from peeling paint, water stains, and exposed drywall tape for 1 of 1 dining room reviewed for environment. Findings include: During an observation, on 10/27/25 at 10:36 a.m., the ceiling in the dining room had an area approximately 6 feet by 2.5 feet with a brown water stain	R 0154	1 1.Area to ceiling in MDR repair was completed on 11.7.2025 2 2.There were no other areas of concern throughout the community that would have a critical-high level work order status. 3 3.The Maintenance Director will complete an in service on the Work Order Policy given by the Executive Director. 4 4.The Executive Director/Designee will audit compliance with Work Orders and physical plant appearance weekly times 4 weeks and monthly times 6 months. Variances will be completed at the time of	11/07/2025

	and a line going down the middle. On both sides of the line were peeled dried paint and at the end of the line there was 3 inches of exposed blue drywall tape. During an interview, on 10/28/25 at 10:23 a.m., Resident 79 indicated she did not like the way the ceiling looked in the dining room. A facility email, dated 7/24/25 at 12:39 p.m., indicated the Maintenance Director had informed the facility preventative maintenance company, on 7/20/25, they had a leak in the main dining room coming through the ceiling and getting worse as the days went by. The roof care company came out to investigate and found the rooftop air conditioner drain was clogged and the unit had a good amount of water in it. The leak was not roof related and the issue was a clogged condensation line in the heating, ventilation, and air conditioning (HVAC) unit. During an interview, on 10/28/25 at 9:26 a.m., the Maintenance Director indicated in July they had a lot of rain and after the rain the roof started to leak. He called a roofing company, and the leak was not in the ceiling. The leak was caused by a clogged line in the HVAC unit. The maintenance director called		observation and will be sent to the QAPI committee for recommendations. 5 5.Compliance Date November 7, 2025	

the company which did the preventative maintenance and got nowhere. The Maintenance Director was now responsible for repairing the ceiling and was waiting for the ceiling to dry. He indicated it did not take 3 months for the ceiling to dry; he just did not have time to fix the ceiling.

During an interview, on 10/28/25 at 10:08 a.m., the Executive Director (ED) indicated the facility did not have an environmental policy.

A current facility policy, titled "Work Orders," dated as revised on 9/20/21 and received from the ED on 10/28/25 at 10:09 a.m., indicated "...Work orders are to be completed for all work/repairs required in the community...Moderate - work orders that need attention and resolution as soon as possible, but come after Critical and High levels. Examples...drywall cracking...."

Based on observation, interview and record review, the facility failed to ensure ceilings were free from peeling paint, water stains, and exposed drywall tape for 1 of 1 dining room reviewed for environment.

Findings include:

During an observation, on 10/27/25 at 10:36 a.m., the ceiling in the dining room had an

area approximately 6 feet by 2.5 feet with a brown water stain and a line going down the middle. On both sides of the line were peeled dried paint and at the end of the line there was 3 inches of exposed blue drywall tape.

During an interview, on 10/28/25 at 10:23 a.m., Resident 79 indicated she did not like the way the ceiling looked in the dining room.

A facility email, dated 7/24/25 at 12:39 p.m., indicated the Maintenance Director had informed the facility preventative maintenance company, on 7/20/25, they had a leak in the main dining room coming through the ceiling and getting worse as the days went by. The roof care company came out to investigate and found the rooftop air conditioner drain was clogged and the unit had a good amount of water in it. The leak was not roof related and the issue was a clogged condensation line in the heating, ventilation, and air conditioning (HVAC) unit.

During an interview, on 10/28/25 at 9:26 a.m., the Maintenance Director indicated in July they had a lot of rain and after the rain the roof started to leak. He called a roofing company, and the leak was not in the ceiling. The leak was caused by a

	clogged line in the HVAC unit. The maintenance director called the company which did the preventative maintenance and got nowhere. The Maintenance Director was now responsible for repairing the ceiling and was waiting for the ceiling to dry. He indicated it did not take 3 months for the ceiling to dry; he just did not have time to fix the ceiling. During an interview, on 10/28/25 at 10:08 a.m., the Executive Director (ED) indicated the facility did not have an environmental policy. A current facility policy, titled "Work Orders," dated as revised on 9/20/21 and received from the ED on 10/28/25 at 10:09 a.m., indicated "...Work orders are to be completed for all work/repairs required in the community...Moderate - work orders that need attention and resolution as soon as possible, but come after Critical and High levels. Examples...drywall cracking...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling	R 0273	1 1.On 10/30/25 all items in the main kitchen reach refrigerator, dry storage, walk in freezer and refrigerator were sealed and dated. 2 2.The Dietary Department	11/20/2025

	standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food items were securely covered and dated and cardboard boxes were not stored on the floor. This deficient practice had the potential to affect 115 of 115 residents who received food from the kitchen. Findings include: During the kitchen observation, on 10/27/25 at 10:32 a.m., with the Culinary Director, the following were observed: 1. The food preparation table had two cups with liquid and a half container of donut holes. 2. A metal cart next to the food preparation table had a coffee cup with brown liquid. 3. On the floor in the kitchen, there were three empty cardboard boxes. 4. In the dry storage room, there was a half bag of chocolate chips and half a bag of macaroni with no open dates. 5. On the floor, in the walk-in freezer, there was a large cardboard box on the floor. 6. In the walk-in freezer, there was an opened bag of hash browns and an opened bag of		staff were educated on proper food storage, proper dating of food, Culinary Director completed 10.30.2025. 3 3.The Executive Director/designee will complete weekly audits of the main kitchen areas related to this deficiency for the next 4 weeks, then monthly for 4 months. All deficiencies, if found, will be immediately corrected and continued education will continue. Audits and compliance will be reviewed during the monthly QAPI meetings for the next 6 months. 4 4.Compliance Date November 20, 2025	

French fries with no open dates.

7. The reach in refrigerator on the second shelf was a half jar of grape jelly with no open date.

8. The reach in refrigerator on the third shelf there was a dark blue metal water bottle.

During an interview, on 10/27/25 at 10:33 a.m., the Culinary Director indicated the two cups with liquid, the cup with coffee and container of donut holes belonged to staff and should not be in the kitchen.

During an interview, on 10/27/25 at 10:37 a.m., the Culinary Director indicated the frozen food should have been securely covered, all food should be dated, cardboard boxes should not be stored on the floor and employee food, and drinks should not be stored in the refrigerator.

During an interview, on 10/27/25 at 10:40 a.m., Cook 2 indicated he was putting supplies up and did not pick up the cardboard boxes. The boxes should not be stored on the floor.

During an interview, on 10/27/25 at 10:41 a.m., Dietary Aide 3 indicated employee drinks should not be in the kitchen when food was being prepared.

During an interview, on 10/27 25 at 10:42 a.m. Cook 2 indicated

there should not be cardboard boxes on the floor and the opened bag of hash browns and fries should not have been left open, and the bags should have dates.

A current facility policy, titled "Ready-to-Eat Hazardous Food, Date Marking Policy and Procedure", not dated and received from the Executive Director (ED) on 10/27/25 at 11:19 a.m., indicated "...Ready-to-eat potential hazardous foods prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in the kitchen and, if the food is held for more than 24 hours, to indicated the date or day by which the food shall be consumed on the premises or discarded...."

A current facility policy, titled "Dry Food Storage Policy and Procedure", not dated and received from the ED on 10/27/25 at 11:20 a.m., indicated "...Containers of food shall be sorted...six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area...The delivery date shall be written or identified on each product...."

A current facility policy, titled "Dietary General Practices

Policy and Procedure", not dated and received from the ED on 10/27/25 at 11:21 a.m., indicated "...Employees may consume food and drink only in the employee break room...."

A current facility policy, titled "Leftover Food Policy", not dated and received from the ED on 10/27/25 at 11:22 a.m., indicated "...Store all ready-to-eat food that are prepared in-house for a minimum of 3 days and a maximum of 7 days at 41 degrees or lower...Label food items with initial, time of preparation, name of the product, product name and discard date...Place leftover foods in containers with tight-fitting lids. If food is stored in a zip-top plastic bag, push the air out of the bag before sealing...."

Based on observation, interview and record review, the facility failed to ensure food items were securely covered and dated and cardboard boxes were not stored on the floor. This deficient practice had the potential to affect 115 of 115 residents who received food from the kitchen.

Findings include:

During the kitchen observation, on 10/27/25 at 10:32 a.m., with the Culinary Director, the

following were observed:

1. The food preparation table had two cups with liquid and a half container of donut holes.

2. A metal cart next to the food preparation table had a coffee cup with brown liquid.

3. On the floor in the kitchen, there were three empty cardboard boxes.

4. In the dry storage room, there was a half bag of chocolate chips and half a bag of macaroni with no open dates.

5. On the floor, in the walk-in freezer, there was a large cardboard box on the floor.

6. In the walk-in freezer, there was an opened bag of hash browns and an opened bag of French fries with no open dates.

7. The reach in refrigerator on the second shelf was a half jar of grape jelly with no open date.

8. The reach in refrigerator on the third shelf there was a dark blue metal water bottle.

During an interview, on 10/27/25 at 10:33 a.m., the Culinary Director indicated the two cups with liquid, the cup with coffee and container of donut holes belonged to staff and should not be in the kitchen.

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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 SIGNATURELori L Lindsey-Clarkston	TITLEExecutive Director	(X6) DATE11/19/2025