

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 08/11/2026	
NAME OF PROVIDER OR SUPPLIER GLASSWATER CREEK OF LAFAYETTE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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. This visit included the Investigation of Intakes 470911, 469972, 471145, 470225 and 470308. Intake 470911-No deficiencies related to the allegations are cited. Intake 469972-State deficiencies related to the allegations are cited at R407. Intake 471145-State deficiencies related to the allegations are cited at R45. Intake 470225-State deficiencies related to the allegations are cited R349. Intake 470308-No deficiencies related to the allegations are cited. Survey dates: August 10 and 11, 2026	R 0000	GLASSWATER CREEK OF LAFAYETTE PLAN OF CORRECTION Indiana Department of Health Survey Completed August 11, 2026 The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the following statement of deficiencies, or of any violation of regulation.				

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	Facility number: 014148 Residential Census: 119 These State Residential Findings were cited in accordance with 410 IAC 16.2-5. Quality review was completed August 24, 2026.			
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency	R 0045	R045 - Residents' Rights / Involuntary Discharge Correction for the Cited Resident Resident C was permitted to return to the facility following identification of the deficient practice. The facility reviewed the resident's discharge process and confirmed required involuntary discharge notices, appeal rights documentation, and supporting records had not been completed in accordance with Indiana requirements. The interdisciplinary team reviewed the discharge process to ensure future compliance. Identification of Other Residents Potentially Affected The Executive Director reviewed involuntary transfers and discharges completed during the six months preceding the survey to identify residents potentially affected by the	08/26/2026

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responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs;	deficient practice. Any concerns identified were addressed immediately. Systemic Changes The facility implemented an involuntary discharge checklist requiring verification of: • Written discharge notice • Appeal Rights documentation • Ombudsman notification when applicable • Notification of responsible parties • Physician notification when applicable • Retention of documentation in the resident record See Exhibit "A" The Executive Director must review and approve all involuntary discharges prior to implementation. Education The Executive Director, Director of Nursing, and management staff were educated regarding Indiana involuntary transfer and discharge regulations and resident rights requirements. Monitoring The Executive Director, or
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or

(E) a resident has not resided in the facility for thirty (30) days.

(9) For health facilities, the written notice specified in subdivision (7) must include the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident is transferred or discharged.

(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .

(E) The name of the director and

designee will audit 100% of involuntary transfers and discharges prior to implementation for three months. Audit findings will be reviewed through QAPI and corrective action taken as necessary.

Responsible Person

Executive Director

Date of Completion

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	the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to ensure proper discharge notices were provided for an involuntary discharge for 1 of 3 residents reviewed for discharge. (Resident C) Findings include: During an interview, on 8/10/26 at 11:29 a.m., the Ombudsman indicated Resident C was transferred to another facility without proper notice and the facility did not complete the proper notices for an involuntary discharge.			
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	During an interview, on 8/10/26 at 2:14 p.m., Resident C indicated he was not aware he was being moved to another facility and did not receive notice or paperwork related to the move. A document, titled "Notice of Transfer or Discharge", dated 6/30/26, was received from the facility Resident C was transferred to. The document was not filled out. It only contained Resident C's name and the name of the discharging facility. The clinical record for Resident C was reviewed on 8/10/26 at 10:30 a.m. The diagnoses included, but were not limited to, Hepatitis C, hypertension, vascular dementia, chronic obstructive pulmonary disease, depression, and psychotic disorder with delusions. There was no documentation provided from the facility or documented in the clinical record related to the reason for discharge, a 30-day notice was provided, and a copy was in the clinical record. During an interview, on 8/10/26 12:48 p.m., the Director of Nursing (DON) indicated Resident C had received several warnings for not following the smoking policy. She indicated she had			
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	communicated with the new facility about the resident's transfer, and the resident had been accepted. She was not sure if the resident had received a 30-day notice. During an interview, on 8/11/26 at 3:11 p.m., the Interim Executive Director indicated she was contacted by the Ombudsman about the improper discharge on 7/30/26. She indicated the facility did not complete the appropriate documentation for an involuntary discharge. The resident was allowed to return to the facility. A current facility policy, titled "Discharge Policy", dated last revised on 4/2023 and received from the Interim Executive Director on 3/11/26 at 2:53 p.m., indicated "...before an interfacility transfer or discharge occurs, the community must, on a form prescribed by the department, do the following: notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language that the resident understands. The community must place a copy of the notice in the residents clinical record and transmit a copy to the following: the resident, family member, residents legal representative, the local long term care ombudsman...the			
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	residents physician when the transfer or discharge is necessary due to the level of care changes and/or behaviors...record the reasons in the residents clinical record...include in the notice: the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, the name of the director...a hearing request form prescribed by the department, the name, address and phone number of the long term care ombudsman...A notice of transfer or discharge must be made by the community at least thirty (30) days before the resident is transferred or discharged...." This citation relates to Intake 471145.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe	R 0092	R092 - Fire and Disaster Preparedness Correction for the Deficient Practice The facility reviewed fire and disaster drill documentation and determined documentation supporting invitations to the local fire department was not maintained as required. Documentation systems were implemented immediately.	08/26/2026

areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to ensure documentation was provided to show the local fire department had been invited to participate in a fire/disaster drill at least every six (6) months.

Findings include:

The fire drill documentation was reviewed on 8/11/26. The facility was unable to provide documentation to show the local fire department had been invited to attend or had attended a fire and disaster drill between 7/2025 to 7/2026.

During an interview, on 8/11/26 at 9:09 a.m., the Interim Executive Director indicated the

Identification of Other Areas Potentially Affected

The facility reviewed all fire and disaster drill records from the previous twelve months to identify additional documentation concerns.

Systemic Changes

A fire and disaster drill tracking log was implemented that includes:

- Date of drill
- Shift of drill
- Fire department invitation date
- Fire department attendance documentation
- Retention of supporting records

See Exhibit "B"

Education

The Executive Director, Maintenance Director, and department managers were educated regarding state requirements for fire and disaster drills.

Monitoring

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	facility followed the state regulations. During an interview, on 8/11/26 at 1:03 p.m., the Director of Nursing indicated the facility did not have a policy which addressed fire department invitation for fire/disaster drills.		The Executive Director will review drill documentation monthly for six months through QAPI. Responsible Person Executive Director Date of Completion September 30, 2026	
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure employee files contained documentation of pre-employment references for 2 of 5 employees reviewed for references. (QMA 7 and LPN 9). Findings include: The employee records were reviewed on 6/5/26 at 11:30 a.m. QMA 7 was hired on 5/6/26 and	R 0116	R116 - Personnel Reference Checks Correction for the Cited Employees The personnel files of QMA 7 and LPN 9 were reviewed. The facility completed a review of reference verification documentation and updated personnel records as appropriate. Identification of Other Employees Potentially Affected Employee personnel files for employees hired within the previous twelve months are currently being audited using state form 53877 to verify required reference documentation was maintained. Systemic Changes The facility implemented a	08/26/2026

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	did not have complete references on file. LPN 9 was hired on 5/27/26 and did not have complete references on file. During an interview, on 8/11/26 at 12:03 p.m., the Director of Nursing (DON) indicated the facility could not locate documentation of completed reference checks for the employees and if it was not provided it was not completed. During an interview, on 8/11/26 at 2:11 p.m., the DON indicated the facility did not have a policy related to reference checks.		pre-employment hiring checklist requiring documented reference verification prior to completion of the hiring process See Exhibit "C" Education Management personnel responsible for hiring were educated regarding reference verification requirements and personnel file maintenance. Monitoring The Executive Director or designee will audit 100% of newly hired employee files for three months. Responsible Person Executive Director Date of Completion September 30, 2026	
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	R 0121	R121 - Employee Tuberculosis Screening Correction for the Cited Employees The employee health records for QMA 7 and LPN 9 were reviewed. Tuberculosis screening documentation was reviewed, and employee health records were updated as	08/26/2026

millimeters of induration with the 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.

appropriate.

Identification of Other Employees Potentially Affected

A facility-wide audit of employee health files was completed to verify compliance with tuberculosis screening requirements.

Systemic Changes

The facility implemented a tuberculosis screening tracking log incorporated into the onboarding process.

Education

Personnel responsible for onboarding and employee health records received education regarding Indiana tuberculosis screening requirements.

Monitoring

The Director of Nursing or designee will audit 100% of newly hired employee records for three months.

See Exhibit "D"

Responsible Person

Director of Nursing

Date of Completion

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Based on interview and record review, the facility failed to ensure a two-step tuberculosis test was completed upon employment for 2 of 5 employees reviewed for tuberculosis testing. (LPN 9 and QMA 7)

Findings include:

The employee records were reviewed on 8/11/26 at 11:30 a.m.

LPN 9 was hired on 5/27/26 and a two-step tuberculosis test was not documented and included in the record.

QMA 7 was hired on 5/6/26 and a two-step tuberculosis test was not documented and included in the record.

During an interview, on 8/12/26 at 12:10 p.m., the Director of Nursing (DON) indicated the facility could not locate documentation of the two-step tuberculosis tests for the employees.

The facility could not provide any further documented tuberculosis testing.

A current facility policy, titled "Tuberculosis Skin Testing and Follow Up (Residents & Employees)," revised on 5/2025 and received from the Interim

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	Executive Director on 8/11/26 at 2:53 p.m., indicated "...Residents and employees of health care communities have been identified as high-risk group for re-activation of latent TB infection...A two-step...tuberculosis skin test will be administered...New employees within 90 days prior to the date of hire or commenced no more than seven days after the date of hire...The facility will maintain a health record of each employee that includes reports of all employment related health screenings...."			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of	R 0123	R123 - Personnel Records Correction for the Cited Employees The personnel files of QMA 7 and LPN 9 were reviewed. Orientation documentation, job descriptions, and onboarding records were reviewed, and personnel files were updated as appropriate. Identification of Other Employees Potentially Affected A facility-wide personnel file audit was conducted to verify required orientation, and onboarding documentation was maintained utilizing state form	08/26/2026

completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure employee job descriptions, general orientations, and job specific orientations were completed and documented in the employee record for 2 of 5 employees reviewed for employee records. (LPN 9 and QMA) 7) Findings include: The employee records were reviewed on 8/11/26 at 11:30 a.m. LPN 9 was hired on 5/27/26, a signed job description, a general orientation or a job specific orientation checklist were not completed and included in the employee file. QMA 7 was hired on 5/6/26, a	53877. Systemic Changes A standardized onboarding packet and checklist were implemented to ensure required documentation is completed and retained in employee files. See Exhibit E-1, E-2 Education Department managers received education regarding personnel file requirements and documentation standards. Monitoring The Executive Director or designee will audit 100% of new employee files weekly for four weeks and monthly for two additional months. See Exhibit "E" Responsible Person Executive Director Date of Completion September 30, 2026	
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	signed job description, a general orientation or a job specific orientation checklist were not completed and included in the employee file. During an interview, on 8/12/26 at 12:03 p.m., the Director of Nursing (DON) indicated the facility could not locate documentation of the orientation checklists or signed job descriptions for the employees. A current facility policy, titled "Nursing Staff Development/Orientation & Inservice Education", revised on 4/2024 and received from the Interim Executive Director 8/11/26 at 2:53 p.m., indicated "...Staff development begins with thoroughly planned orientation of each employee and continues with a coordinated program of instruction for individual departments and the community as a whole...Review a job specific orientation sheet as well as general orientation checklist...."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to	R 0296	R296 - Pharmaceutical Services Correction for the Cited Resident Resident J's discharge instructions, physician orders,	08/26/2026

ensure competence of medication staff. Based on interview and record review, the facility failed to ensure a physician's order was transcribed and a resident received medication as ordered for 1 of 7 residents reviewed for medications. (Resident J) Findings include: During an interview, on 8/11/26 at 1:00 p.m., Resident J's representative indicated Resident J was not receiving one of the medications which had been ordered by the nephrologist. The clinical record for Resident J was reviewed on 8/11/26 at 2:00 p.m. The diagnoses included, but were not limited to, hyperlipidemia, depression, mild cognitive impairment, hypertension, hyponatremia, and gastroesophageal reflux disease.	and medication administration records were reviewed. The attending physician was notified regarding the omitted medication identified during survey and appropriate follow-up actions were completed according to physician direction. Identification of Other Residents Potentially Affected The Director of Nursing reviewed residents who returned from a hospital stay during the previous thirty days to verify discharge medications were reconciled with active physician orders and medication administration records. Systemic Changes The facility implemented a medication reconciliation process requiring: • Review of discharge instructions • Verification of physician orders • Verification of pharmacy processing • Documentation of reconciliation completion Education Licensed nurses, medication management staff, and management personnel	
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The hospital discharge notes and instructions, dated 7/18/26, indicated Resident J's list of discharge medications included, but were not limited to, allopurinol (a medication used to lower high uric acid levels in the body) 100 milligrams (mg), one (1) tablet daily for 90 days. It was last administered at the hospital on 7/18/26 at 9:10 a.m.

The current physician's orders for Resident J did not include an order for the allopurinol.

The medication administration record, for July and August 2026, did not indicate Resident J received the allopurinol.

During an interview, on 8/11/26 at 3:00 p.m., the Interim Executive Director indicated there was not a physician's order for Resident J's allopurinol and she had not been receiving the medication.

A current facility policy, titled "Medication Management, Administration, & Storage (Indiana and Ohio only)", dated last revised 5/2026 and received from the Interim Executive Director on 8/11/26 at 2:53 p.m., indicated "...the purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering and storing all medications while complying with state and federal

received education regarding medication reconciliation requirements.

Monitoring

The Director of Nursing or designee will audit:

- 100% of hospital returns for four weeks
- Five hospital-return records monthly for two additional months

See Exhibit "F"

Results will be reviewed through QAPI.

Responsible Person

Director of Nursing

Date of Completion

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	guidelines...." There was no policy provided on the process of reconciling medications.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure interventions initiated following an incident were documented for 1 of 7 residents reviewed for documentation. (Resident D) Findings include: The clinical record for Resident D was reviewed on 8/10/26 at 12:22 p.m. The diagnoses included, but were not limited to, vascular dementia, bipolar disorder, suicidal ideations, schizophrenia, and anxiety	R 0349	R349 - Clinical Records Correction for the Cited Resident Resident D's clinical record was reviewed. The facility confirmed documentation supporting the monitoring intervention initiated following the incident was not retained in the clinical record as required. Nursing staff received education regarding documentation and record retention requirements. Identification of Other Residents Potentially Affected Residents currently receiving monitoring interventions, behavioral observations, or safety monitoring were reviewed to verify supporting documentation was maintained in the clinical record. Systemic Changes The facility implemented a process requiring monitoring records and intervention documentation to be scanned into the electronic health record within 24 hours of completion.	08/26/2026

disorder.

A progress note documented by the Director of Nursing (DON), dated 5/29/26 at 2:48 p.m., indicated there was an incident with Resident D. The resident returned to his room and "We will check on him every 15 minutes x 4 hours, then every 30 minutes until 2:00 pm on Saturday, May 30th."

The clinical record review did not contain documentation to indicate Resident D was checked frequently following the incident.

During an interview, on 8/10/26 at 2:12 p.m., the DON indicated the incident occurred on a Friday, and the resident was checked on every 15 minutes throughout the weekend, then hourly starting Monday for 3 days. This was documented on a frequent check paper, but she did not keep the paper, and it was not scanned into his clinical record.

During an interview, on 8/10/26 at 2:48 p.m., Licensed Practical Nurse (LPN) 3 indicated she was the nurse caring for Resident D at the time of the incident, on 5/29/26, and she was never made aware that frequent checks were to be initiated for Resident D following the incident.

Education

Licensed nurses were educated regarding documentation standards and clinical record requirements.

Monitoring

The Director of Nursing or designee will audit five resident clinical records weekly for four weeks and monthly for two additional months.

See Exhibit "G"

Responsible Person

Director of Nursing

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	During an interview, on 8/11/26 at 2:31 p.m., the DON indicated there was no other documentation found for the frequent checks. During an interview, on 8/11/26 at 2:38 p.m., the Interim Executive Director indicated frequent check sheets should be scanned into a resident's clinical record once the checks were completed. The facility did not have a policy regarding documentation of frequent checks or nursing interventions. This citation relates to Intake 470225.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.	R 0407	R407 - Infection Control Correction for the Deficient Practice The infection control program was reviewed following identification of the deficient practice. Residents impacted by bed bug treatment were reviewed. Infection surveillance activities, antibiotic tracking activities, and pest management documentation were reviewed and updated. Staff education regarding bed bug management procedures and personal protective equipment requirements was completed. Identification of Other	08/26/2026

Based on interview and record review, the facility failed to ensure education was provided to the employees, and the policy and procedure was followed after a bug infestation was identified and failed to ensure a program which included protocols and a system to monitor antibiotic use was implemented. This deficient practice had the potential to affect 119 of 119 residents who reside in the facility.

Findings include:

1. During an interview, on 8/10/26 at 9:46 a.m., the Maintenance Director indicated the facility found the first bed bug in February of 2026, and a pest control company was called out to the facility. The pest control company confirmed bed bugs were in eight (8) apartments. The Maintenance Director indicated he did not document any education was provided to the employees on the policy and procedure of caring for the residents with confirmed bed bugs. He did provide education in July after the staff had become really upset about having to care for residents with bed bugs. The Maintenance Director indicated the facility told the staff if they did not want to wear Personal Protective Equipment (PPE) in a

Residents Potentially Affected

Because the deficient practice had the potential to affect all residents of the facility, infection surveillance records, antibiotic utilization records, and pest management practices were reviewed facility wide.

Systemic Changes

The facility implemented:

- Infection surveillance logs
- Antibiotic stewardship tracking logs
- Bed bug management tracking logs
- Monthly infection prevention reviews
- Staff education tracking records

Education

All staff received education regarding:

- Bed Bug Policy and Protocol
- PPE requirements
- Infection prevention practices
- Infection surveillance responsibilities
- Antibiotic stewardship expectations

confirmed bed bug room, then the staff did not have to.

The Maintenance Director was unable to provide any documentation employees were recently educated to follow the bed bug policy and procedure.

During an interview, on 8/10/26 at 11:00 a.m., LPN 3 indicated she normally worked on the second floor where the bed bugs were found. On several occasions, she asked the Director of Nursing (DON) and former Executive Director (ED) for information on the bed bug situation and requested a policy and procedure to determine what the staff should be following to keep the staff and residents safe. The former ED informed LPN 3 the facility did not provide policy and procedures to staff. LPN 3 was concerned about the staff and residents' safety. The bed bugs were found in March and LPN 3 had asked several times for the facility to provide education on handling the bed bugs. The facility finally provided education in July. The facility had at least 8 rooms with bed bugs.

During an interview, on 8/10/26 at 1:42 p.m., QMA 11 indicated a CNA found a bed bug in a resident's bed while providing care. The DON and the former ED told them to catch the bug

Monitoring

The Director of Nursing will review infection surveillance data, antibiotic utilization data, pest management activity, and staff education compliance monthly for six months.

See Exhibit "H"

Findings will be reviewed through QAPI.

Responsible Persons

Director of Nursing
Executive Director

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and put it in a baggie. The staff asked to be educated on bed bugs and wanted to know what to do if a resident had bed bugs. The facility's first bed bug was found in March, and the facility did not provide any education until July. The former Executive Director informed the staff they did not have to wear Personal Protective Equipment (PPE) if they did not want to.

During an interview, on 8/10/26 at 1:43 p.m., CNA 10 indicated she was made aware of the bed bugs on the second floor at the end of February or the first part of March. The employees were not educated on how to take care of a resident with bed bugs until they had education in July. The former ED told the staff when they took care of a resident with bed bugs, they did not have to wear PPE.

During an interview, on 8/10/26 at 2:22 p.m., the Maintenance Director indicated the facility did not complete education with the staff on the bed bugs until July when the employees had become upset. He did not have any documentation or an attendance sheet for employees. He should have had employees sign an attendance sheet.

A current facility policy, titled "Bed Bug Policy and Protocol,"

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revised 8/2023 and provided by Interim Executive Director on 8/11/216 at 2:53 p.m., indicated "...The purpose of this policy is to set a standard to aid in the prevention and remedy of bed bug infestations in the community...Have staff members don appropriate and available PPE (head to toe suits, booties, hair cover, gloves) ...Ensure all staff members are trained on the prevalence and identification of bed bugs. Early detection is crucial to limit spread. If signs are present staff members are to alert their supervisor immediately...."

2. A review of the "Infection Control" binder indicated no infections or antibiotics had been tracked, monitored, or documented since December of 2025.

During an interview, on 8/11/26 at 1:00 p.m., the Director of Nursing (DON) indicated the infection control binder was not up to date. She indicated she did not have time to complete it.

A current facility policy, titled "Infection Prevention & Control", dated last revised 1/2025 and received from the Interim Executive Director on 8/11/26 at 3:00 p.m., indicated "...it is the policy of this community to prevent and/or minimize the

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	spread of infectious diseases through infection control practices based on a variety of resources including but not limited to, guidelines from the Centers for Disease Control and Prevention (CDC)...." This citation relates to Intake 469972.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.	R 0410	R410 - Resident Tuberculosis Screening Correction for the Cited Residents Resident D and Resident E records were reviewed for tuberculosis screening compliance. Tuberculosis screening records and supporting documentation were reviewed and follow-up actions were completed as appropriate. Identification of Other Residents Potentially Affected A facility-wide audit of resident tuberculosis screening documentation was conducted to identify other residents potentially affected by the deficient practice. Systemic Changes The facility implemented a tuberculosis screening tracking log and admission checklist to ensure required testing and	08/26/2026

Based on interview and record review, the facility failed to ensure two-step tuberculosis tests were completed and documented for 2 of 2 residents reviewed for tuberculosis testing. (Resident E and D)

Findings include:

1. The clinical record for Resident E was reviewed on 8/11/26 at 10:50 a.m. The diagnoses included, but were not limited to, gout, chronic heart failure, and hypertension.

The resident was admitted to the facility on 10/21/25.

The initial admission 2-step tuberculosis test was not documented in the clinical record.

2. The clinical record for Resident D was reviewed on 8/10/26 at 12:22 p.m. The diagnoses included, but were not limited to, vascular dementia, bipolar disorder, suicidal ideations, schizophrenia, and anxiety disorder.

A transition of care, discharge summary, dated 2/27/26, indicated the first step tuberculosis test was administered to Resident D on 1/7/26 at 3:50 p.m.

documentation are completed timely.

Education

Licensed nurses, admissions personnel, and management staff received education regarding tuberculosis screening requirements and documentation standards.

Monitoring

The Director of Nursing or designee will audit:

- 100% of the admissions for four weeks
- Five resident records monthly for two additional months

See Exhibit "I"

Audit results will be reviewed through QAPI.

Responsible Person

Director of Nursing

Date of Completion

September 30, 2026

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There was no documentation, a second step tuberculosis test was administered and documented in the clinical record.

During an interview, on 8/11/26 at 1:04 p.m., the Director of Nursing (DON) indicated she could not locate documentation to show Resident D received a second step tuberculosis test and it should have been completed when he was admitted to the facility.

During the exit conference, on 8/11/26 at 4:00 p.m., the Director of Nursing indicated the facility did not have any further information to provide.

A current facility policy, titled "Tuberculosis Skin Testing and Follow Up (Residents & Employees)," last revised 5/2025 and received from the Interim Executive Director on 8/11/26 at 2:53 p.m., indicated "...A two-step Mantoux...tuberculosis skin test will be administered to...New residents within 90 days prior to the date of admission or commenced no more than seven days after the date of admission...."

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	TITLEExecutive Director	(X6) DATE09/04/2026
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FORM APPROVED

OMB NO. 0938-0391

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURELori Weaver		
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