STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/23/2022

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 the Investigation of Complaints IN00374334, IN00375469 and IN00383332. Complaint IN00374334 - Substantiated. State findings related to the allegations are cited at R0052. Complaint IN00375469 - Substantiated. State findings related to the allegations are cited at R0274. Complaint IN00383332 - Substantiated. State findings related to the allegations are cited at R0274. Survey dates: June 21, 22 and 23, 2022 Facility number: 014148 Residential Census: 124 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review was completed July 6, 2022.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure the EMS (Emergency Medical Services) were only used when needed in an emergency situation and not as supplemental staffing to pick residents up off the floor, who had fallen and needed assessed and the facility failed to ensure appropriately trained nursing staff members were present on all shifts to ensure residents' were given a post-fall assessment for injuries, prior to being picked up off the floor for 3 of 3 residents reviewed for neglect (Residents C, D and E). Findings include: A Confidential interview was	R 0052	R052 What corrective action will be accomplished for those residents found to be affected by this deficient practice? -No resident was found to be affected by the practice. How the facility will identify other residents having the potential to be affected by the same deficient and what corrective actions will be taken? -A review of the practice and all residents was conducted and no resident had an adverse affect to the practice. What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur? -Conference with ADM, AIT,	07/22/2022

	conducted during the course of the survey. Confidential Interviewee 1 indicated all the firemen at a particular fire department were Emergency Medical Technicians (EMTs), which meant they were not licensed to physically assess a resident. Only the paramedics could physically assess a resident laying on the ground for injuries. The EMTs would ask the resident if they hurt or in pain anywhere and as long as the resident indicated they were not hurt or in pain, then the EMTs would assist the resident off the floor. The facility staff called 911 to get EMS to come provide a lift assist because they did not have a licensed staff member to do an assessment of the resident, prior to picking them up off the floor. Some of the residents were smaller sized women who only required one person physical assist to lift them off the floor, but the facility staff on the midnight shift refused to lift the residents off the floor or the staff indicated there was no nurse available in the facility to complete the post-fall assessment for injuries prior to lifting the resident off the floor. Confidential Interviewee 1 indicated on 2/12/22 at 11:32 p.m., Resident C was found sitting on the floor while the staff watched until the Station arrived to assist her off the floor and back into bed. The staff member		DON and Regional Nurse was conducted to review for corrective action. Review of the company policy and education of staff to ensure compliant practice was initiated beginning 6/23/22. Inservice training for all nursing staff includes Fall Policy procedure and Proper Lifting techniques. Emphasis in the training included prompt and appropriate care of resident during a fall event, evaluation and assessment of resident condition and determination when outside emergency services are needed. Inservice training will continue until every nursing staff member has completed this training, and additional in service training will be available as needed. How the corrective action will be monitored to ensure the deficient practice does not recur, ie what quality assurance program will be put into place? -The ADM, AIT And DON will review fall events daily for 4 weeks for compliance, then weekly for four weeks, bi weekly	

	who stayed with the resident indicated she was getting dressed when she mis-stepped and fell onto her buttocks. Confidential Interviewee 1 indicated on 2/16/22, Resident D was found lying on the floor of her apartment waiting for them to lift her off the floor. Confidential Interviewee 1 indicated on 3/21/22 at 12:02 a.m., Resident E was found on the floor when the Station arrived at her apartment. The staff members on duty were in her room not providing any assistance for the resident. The staff present indicated they had been told they were not to lift anyone because they did not have trained medical staff working at night. He indicated the facility continued to use the Fire Department and the Ambulance Service to "supplement their staffing." The staff at this facility did not care they were using emergency services to lift residents off the floor, they did not seem concerned with leaving an elderly person lying on the floor until the fire department arrived to pick the resident off the floor. The fire department staff was informed by the facility staff they did not have trained medical personnel at night. A Confidential interview was conducted during the course of the survey. Confidential Interviewee 2 indicated the		for four weeks and then monthly thereafter. By what date the systemic changes will be complete? Effective date 7/20/2022	

	other morning (the Confidential Interviewee 2 was unable to remember the exact date of the incident) between 1:00 a.m. and 2:00 a.m., his station had to go to this facility to pick an elderly person up off the floor, when there were two able bodied women present working, who could have picked the resident up off the floor. The staff members indicated their facility protocols would not allow them to lift residents up off the floor because no nurse was available to assess the resident prior to lifting them off the floor. Confidential Interviewee 2 indicated elderly residents should not have to lay on the facility floor, after they fall, waiting for EMS to arrive to assist them off the floor, when there were able bodied staff members available to immediately assist them off the floor. The residents were not physically assessed prior to being assisted off the floor. They were not allowed to assess the residents due to they were not trained to physically assess residents, only Paramedics could. If the facilities needed the residents physically assessed for injuries, then an ambulance needed to be dispatched to the facility, so a Paramedic would be sent out. Confidential Interviewee 2 indicated prior to assisting the resident off the floor, the resident was verbally asked if			

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	seizure and did nothing to intervene prior to the EMS arriving. If his station was called out on a non-emergent call for a lift assist only, then if they get an emergent call, they must continue to the non-emergent call. The station cannot re-route to the emergent call. Another station, which may be 15-20 minutes away from his original station area must respond to the emergent call, which slows down the response time for them to respond to the emergency calls. A Confidential interview was conducted during the course of the survey. Confidential interviewee 6 indicated if a nurse was available on duty when a resident fell, she called for the nurse to come and assess the resident prior to assisting the resident off the floor. A nurse was not available in the facility from 9 p.m. to 7 a.m., so according to the facility protocol the CNAs and QMAs were to call 911 when a resident fell on the floor. The staff member, whomever called 911, gave the emergency dispatcher the information they requested. A Confidential interview was conducted during the course of the survey. Confidential interviewee 7 indicated when she was hired as a new employee, she was told the protocol when a resident fell on			

	the floor and a nurse was not available in the facility was to call 911. The CNAs document the resident's fall information in the employee book and on the report board. The person, whomever calls 911, tells the emergency dispatcher where they were calling from, who the resident was and what room number the resident was residing in. When the EMS staff get to the facility, they ask if the resident was hurt. If the resident was hurt, the EMS staff take the resident with them and if not, they assist the resident back into the bed or his or her chair. The Fire Department usually came out to the facility to assist the residents who have fallen off the floor. An email document received from (Name of City Fire Department Station) Captain 1, dated 6/21/22 at 4:09 p.m., indicated he had reviewed the station's fire run reports back until 1/1/21 to the present date of 6/21/22. He indicated the station had responded to this facility 25 times, with 23 of the 25 occurring since this time last year. The 25 runs were all coded as lifting assistance, which was classified as non-emergent runs. An email document received from (Name of Fire Department Station) Captain 1, dated 6/21/22 at 4:25 p.m., included			

	an email sent to him from (Name of Fire Department Station) Lieutenant 5, dated 11/6/21 at 4:31 a.m., which indicated his Station was sent to this facility for a lift assist call (a non-emergent call), where they found an elderly female sitting on the floor with two staff members with her. The resident did not have any injuries, she just required help to get up off the floor. As soon as the firemen arrived at the resident's room, one of the staff members left the area and he asked the other staff member if the staff had ever attempted to use a sheet under the residents' arms to assist them off the floor. The staff member responded to him, they were not allowed to lift any resident without a nurse available at the facility because it was against the facility protocol. The staff called the Fire Department to pick residents off the floor, so they did not get into trouble. During an interview, on 6/22/22 at 12:10 p.m., the Executive Director (ED) indicated the staff only needed to call EMS (911) if a resident who fell needed to go to the hospital or if they physically were unable to pick a resident up due to the size of the resident. She believed there was a misunderstanding with the way the staff understood how the fall procedure was supposed to be followed. The			

	previous Director of Nursing (DON) opened the building as the DON and there had never been a nurse scheduled to work the night shift. The facility chose not to hire nurses to work the night shift. The staff were expected to call the DON for any falls when a nurse was not available. The night shift documented the fall events, then the dayshift nurse who came in on the shift after the night shift documented the residents' fall in their records and on incident reports. The ED indicated she was not aware the fire department had EMT's who responded to calls, who could not physically assess a resident. If a resident needed to be physically assessed after a fall for injuries an ambulance had to be called out to the facility, so a Paramedic assessed the resident for injuries. A current policy, titled "Resident's Personal Rights Policy and Procedure," dated with the last revised date of 01/22, provided by the ED on 6/22/22 at 4:03 p.m., indicated "The Statement of Resident's Personal Rights is included in the Resident's Admission Agreement. All of the resident's rights are applicable at the time of executing the Resident's Admission Agreement. A copy of the Resident's Admission Agreement that includes Resident's Personal Rights is			

	given to the resident upon execution of the document...Each resident shall have the right to: 1. Be free from mental, emotional, emotional, social and physical abuse and neglect and exploitations...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality...." A current policy, titled "Fall Prevention and Management Policy," dated 11/2021, provided by the ED on 6/22/22 at 4:03 p.m., indicated "...Procedure...C. Upon a resident fall event, an immediate assessment (if by a licensed clinician) and/or evaluation (if by a non-licensed, trained staff member) of the resident will be completed to determine any possible injury. The licensed nurse at the Community shall be promptly notified and consulted as appropriate. Any injuries noted shall be communicated to the Community licensed nurse for consideration of further direction...." This State finding relates to Complaint IN00374334. Based on interview and record review, the facility failed to ensure the EMS (Emergency Medical Services) were only used when needed in an emergency situation and not as supplemental staffing to pick			

	residents up off the floor, who had fallen and needed assessed and the facility failed to ensure appropriately trained nursing staff members were present on all shifts to ensure residents' were given a post-fall assessment for injuries, prior to being picked up off the floor for 3 of 3 residents reviewed for neglect (Residents C, D and E). Findings include: A Confidential interview was conducted during the course of the survey. Confidential Interviewee 1 indicated all the firemen at a particular fire department were Emergency Medical Technicians (EMTs), which meant they were not licensed to physically assess a resident. Only the paramedics could physically assess a resident laying on the ground for injuries. The EMTs would ask the resident if they hurt or in pain anywhere and as long as the resident indicated they were not hurt or in pain, then the EMTs would assist the resident off the floor. The facility staff called 911 to get EMS to come provide a lift assist because they did not have a licensed staff member to do an assessment of the resident, prior to picking them up off the floor. Some of the residents were smaller sized women who only required one person physical assist to lift them off the			

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did not get into trouble.

During an interview, on 6/22/22 at 12:10 p.m., the Executive Director (ED) indicated the staff only needed to call EMS (911) if a resident who fell needed to go to the hospital or if they physically were unable to pick a resident up due to the size of the resident. She believed there was a misunderstanding with the way the staff understood how the fall procedure was supposed to be followed. The previous Director of Nursing (DON) opened the building as the DON and there had never been a nurse scheduled to work the night shift. The facility chose not to hire nurses to work the night shift. The staff were expected to call the DON for any falls when a nurse was not available. The night shift documented the fall events, then the dayshift nurse who came in on the shift after the night shift documented the residents' fall in their records and on incident reports. The ED indicated she was not aware the fire department had EMT's who responded to calls, who could not physically assess a resident. If a resident needed to be physically assessed after a fall for injuries an ambulance had to be called out to the facility, so a Paramedic assessed the resident for injuries.

A current policy, titled

	"Resident's Personal Rights Policy and Procedure," dated with the last revised date of 01/22, provided by the ED on 6/22/22 at 4:03 p.m., indicated "The Statement of Resident's Personal Rights is included in the Resident's Admission Agreement. All of the resident's rights are applicable at the time of executing the Resident's Admission Agreement. A copy of the Resident's Admission Agreement that includes Resident's Personal Rights is given to the resident upon execution of the document...Each resident shall have the right to: 1. Be free from mental, emotional, emotional, social and physical abuse and neglect and exploitations...14. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality...." A current policy, titled "Fall Prevention and Management Policy," dated 11/2021, provided by the ED on 6/22/22 at 4:03 p.m., indicated "...Procedure...C. Upon a resident fall event, an immediate assessment (if by a licensed clinician) and/or evaluation (if by a non-licensed, trained staff member) of the resident will be completed to determine any possible injury. The licensed nurse at the Community shall be promptly notified and consulted as appropriate. Any injuries			

	noted shall be communicated to the Community licensed nurse for consideration of further direction...." This State finding relates to Complaint IN00374334.			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university	R 0274	R274 What corrective action will be accomplished for those residents found to be affected by this deficient practice? No resident was found to be affected by this practice. How the facility will identify other residents having the potential to be affected by the same deficient and what corrective actions will be taken? No resident was found to be affected by this practice. What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur?	07/20/2022

	with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on interview and record review, the facility failed to ensure the food service department was directed by a supervisor who was competent in food service management and knowledgeable in sanitation standards, food handling, food preparation and meal service and the facility failed to ensure a Dietician provided consultant services to the facility at peak periods of operation on a regular scheduled basis. This deficiency had the potential to affect 124 of 124 residents who reside in the facility. Finding includes: During an interview, on 6/22/22 at 12:10 p.m., the Executive Director (ED) indicated there		A supervisor for the food service department was appointed on 7/19/22. The facility has in place a designee in the event of an absence in supervisor who has the credentials to remain in compliance. The dietician will be available to provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. How the corrective action will be monitored to ensure the efficient practice does not recur, ie what quality assurance program will be put into place? The Administrator will ensure that the food service department remains in compliance by having a supervisor of food service, and/or have a designee and dietician services available. By what date the systemic changes will be complete? 7/20/22.	

was no Dietary supervisor at the time. The last Dietary supervisor walked out in April. The Lead Cook on the evening shift was being reviewed for the Dietary supervisor position, but was on a leave of absence at this time. The Activity Director had 30 years' experience in culinary work and she was working in the kitchen when she could. The Registered Dietician visited the facility every other month.

The Registered Dietician (RD) Reports were reviewed on 6/22/22 at 4:15 p.m., the RD visited the facility on the following dates and times:

1/25/22 from 8:30 a.m. to 1:15 p.m.

3/17/22 from 10:00 a.m. to 1:00 p.m.

5/18/22 from 7:15 a.m. to 11:45 a.m.

A facility policy related to food service management was not provided at the time of exit.

This State finding relates to Complaint IN00383332 and IN00375469.

Based on interview and record review, the facility failed to ensure the food service department was directed by a supervisor who was competent in food service management and knowledgeable in sanitation

standards, food handling, food preparation and meal service and the facility failed to ensure a Dietician provided consultant services to the facility at peak periods of operation on a regular scheduled basis. This deficiency had the potential to affect 124 of 124 residents who reside in the facility.

Finding includes:

During an interview, on 6/22/22 at 12:10 p.m., the Executive Director (ED) indicated there was no Dietary supervisor at the time. The last Dietary supervisor walked out in April. The Lead Cook on the evening shift was being reviewed for the Dietary supervisor position, but was on a leave of absence at this time. The Activity Director had 30 years' experience in culinary work and she was working in the kitchen when she could. The Registered Dietician visited the facility every other month.

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1/25/22 from 8:30 a.m. to 1:15 p.m.

3/17/22 from 10:00 a.m. to 1:00 p.m.

	5/18/22 from 7:15 a.m. to 11:45 a.m. A facility policy related to food service management was not provided at the time of exit. This State finding relates to Complaint IN00383332 and IN00375469.			

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 SIGNATURE	TITLE	(X6) DATE