STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/20/2024

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. This visit included the Investigation of Complaints IN00429614 and IN00421330. Complaint IN00429614 - No deficiencies related to the allegations are cited. Complaint IN00421330 - No deficiencies related to the allegations are cited. Survey dates: March 18, 19 and 20, 2024 . Facility number: 014148 Residential Census: 133 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 1, 2024.	R 0000		
R 0121	Personnel - Noncompliance	R 0121	Employees 9, 16, 18, 22, and 23 will have complete	04/20/2024

	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 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		2-step TB tests completed by April 20, 2024 Employee records audited; any records found with incomplete 2-Step TB test will be completed. New employee TB tests will be added to monthly calendar to ensure all TB test are administered correctly. 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.	

	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 interview, the facility failed to screen new hire staff utilizing the 2 step process for TB testing for 5 of 5 staff reviewed for tuberculin tests. (Staff members 23, 9, 16, 18 and 22). Findings include: 1. A Mantoux (Tuberculin skin test) Test record for Staff Member 23 indicated the TB skin test was not administered in 10/2023 when the staff member was hired. 2. A Mantoux Test record for Staff Member 9 indicated the TB skin test was not administered in 10/2023 when the staff member was hired. 3. A Mantoux Test record for Staff Member 16 indicated the TB skin test was not administered in 3/2021 when the staff member was hired. The record for Staff Member 16 indicated the TB skin test was not administered in 2022 and 2023.			

	4. A Mantoux Test record for Staff Member 18 indicated the TB skin test was not administered in 12/2023 when the staff member was hired. 5. A Mantoux Test record for Staff Member 22 indicated the TB skin test was not administered in 11/2018 when the staff member was hired. The record for Staff Member 22 indicated the TB skin test was not administered in 2019, 2020, 2021, 2022 and 2023. During an interview, on 3/20/2024 at 4:40 p.m., the Administrator indicated the staff members TB record could not be located. A current facility policy, titled " Tuberculosis Skin Testing and Follow Up", dated as effective 2/2024 and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated "...A. A two-step mantoux, P.P.D., tuberculosis skin test will be administered to: 1. New Employees and interns within 90 days prior to the date of hire or commenced no more than seven days after the date of hire...." Based on record review and interview, the facility failed to screen new hire staff utilizing the 2 step process for TB testing for 5 of 5 staff reviewed for tuberculin tests. (Staff members			

	23, 9, 16, 18 and 22). Findings include: 1. A Mantoux (Tuberculin skin test) Test record for Staff Member 23 indicated the TB skin test was not administered in 10/2023 when the staff member was hired. 2. A Mantoux Test record for Staff Member 9 indicated the TB skin test was not administered in 10/2023 when the staff member was hired. 3. A Mantoux Test record for Staff Member 16 indicated the TB skin test was not administered in 3/2021 when the staff member was hired. The record for Staff Member 16 indicated the TB skin test was not administered in 2022 and 2023. 4. A Mantoux Test record for Staff Member 18 indicated the TB skin test was not administered in 12/2023 when the staff member was hired. 5. A Mantoux Test record for Staff Member 22 indicated the TB skin test was not administered in 11/2018 when the staff member was hired. The record for Staff Member 22 indicated the TB skin test was not administered in 2019, 2020, 2021, 2022 and 2023. During an interview, on			

	3/20/2024 at 4:40 p.m., the Administrator indicated the staff members TB record could not be located. A current facility policy, titled " Tuberculosis Skin Testing and Follow Up", dated as effective 2/2024 and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated "...A. A two-step mantoux, P.P.D., tuberculosis skin test will be administered to: 1. New Employees and interns within 90 days prior to the date of hire or commenced no more than seven days after the date of hire...."			
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 standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was labeled and dated in the main kitchen area of one of one kitchen and the waste containers were covered and the dishwasher record logs were documented in one of one kitchen. This deficient practice	R 0273	On 3/19/24 all items in the main kitchen were sealed and dated, trash cans found to be without lids were replaced and the dishwasher temp log was implemented. The Dietary Department staff will be provided education on proper food storage, proper dating of food, proper garbage and refuse storage, and dishwasher temp log procedure by the Culinary Director/Designee by April 20, 2024. The Culinary Director/designee	04/20/2024

	had the potential to affect 133 of 133 residents who receive food from the kitchen. Findings include: During the tour of the kitchen, on 3/19/2024 at 2:15 p.m., the following observations were made: 1. The main kitchen area was observed to have the following opened, no sealed and not dated items: a. in the dry storage are a packet of split peas b. in the freezer a log of ground sausage was sealed but not labeled or dated c. in the refrigerator a pitcher of lemonade was sealed but not labeled or dated 2. The main kitchen area had 2 of 4 trash containers with no lids.		will complete weekly audits of the main kitchen areas related to this deficiency for the next 4 weeks, then monthly for 4 months. Any and 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.	

	3. The main kitchen area dishwasher did not have documented log temperatures for April, May June, July and December 2023 . The temperature logs for September 2023 were missing the dates of 15, 29 and 30. The temperature logs for October 2023 were missing the dates of 2, 16, 29, 30 and 31. The temperature logs for January and February 2024 were not documented. During an interview, on 3/20/2024 at 2:55 p.m., with Culinary Director, she indicated all items should be sealed, labeled, and dated when opened, the trash containers should have had lids and the dishwasher should have had documented daily temperatures logged by the staff. A current facility policy titled, "Garbage and Refuse Storage", not dated and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated, "...Garbage and refuse on the premises shall be stored in a manner inaccessible to insects and rodents...Lids shall be in place and remain closed at all times...." A current facility policy titled, "Dry Food Storage," not dated received from the Administrator on 3/20/2024 at 4:35 p.m., indicated, "... The delivery date shall be written or identified on			

each product...."

Based on observation, interview, and record review, the facility failed to ensure food was labeled and dated in the main kitchen area of one of one kitchen and the waste containers were covered and the dishwasher record logs were documented in one of one kitchen. This deficient practice had the potential to affect 133 of 133 residents who receive food from the kitchen.

Findings include:

During the tour of the kitchen, on 3/19/2024 at 2:15 p.m., the following observations were made:

1. The main kitchen area was observed to have the following opened, no sealed and not dated items:

a. in the dry storage are a packet of split peas

b. in the freezer a log of ground sausage was sealed but not labeled or dated

c. in the refrigerator a pitcher of lemonade was sealed but not labeled or dated

2. The main kitchen area had 2 of 4 trash containers with no lids.

3. The main kitchen area

	dishwasher did not have documented log temperatures for April, May June, July and December 2023 . The temperature logs for September 2023 were missing the dates of 15, 29 and 30. The temperature logs for October 2023 were missing the dates of 2, 16, 29, 30 and 31. The temperature logs for January and February 2024 were not documented. During an interview, on 3/20/2024 at 2:55 p.m., with Culinary Director, she indicated all items should be sealed, labeled, and dated when opened, the trash containers should have had lids and the dishwasher should have had documented daily temperatures logged by the staff. A current facility policy titled, "Garbage and Refuse Storage", not dated and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated, "...Garbage and refuse on the premises shall be stored in a manner inaccessible to insects and rodents...Lids shall be in place and remain closed at all times...."			

	A current facility policy titled, "Dry Food Storage," not dated received from the Administrator on 3/20/2024 at 4:35 p.m., indicated, "... The delivery date shall be written or identified on each product...."			
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 ensure competence of medication staff. Based on interview and record review, the facility failed to ensure medications were given as ordered by the resident's physician and supervised by a licensed nurse on the premises or on-call for 1 or 6 residents reviewed for administration of medications (Residents K). Findings include: The record for Resident K as reviewed on 3/19/2023 at 2:46 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, and Parkinson's disease. The Narcotic Administration Record reviewed on 3/19/2024 at 11:54 a.m.,indicated Resident	R 0296	1 Resident K had no long-term effects from missed medications. 2 Residents that are administered medications are at risk for alleged deficient practice. Audit of Medication Administration Records and medications were completed on April 12, 2024, by Director of Nursing and/or designee. Any discrepancies were addressed with physician/provider or pharmacy. 3 Director of Nursing and/or Designee in serviced nurses and QMA's on 5 rights of medication administration on April 4, 2024. Director of Nursing and/or designee will audit medication administration weekly x 1 month, then monthly x 5 months. 4	04/20/2024

	K was to receive a Klonopin 1 mg tablet twice daily by mouth. The medication was not given on 3/18/2024 at 8:00 a.m. and on 3/19/2024 at 8:00 a.m. During an interview, on 3/19/2024 at 11:00 a.m., the Administrator indicated the mediations should have been given. During an interview on 3/19/2024 at 12:10 p.m. Staff Member 6 indicated the mediation should have been given. The Primary Care Physician (PCP) was notified of the medication error/omission on 3/19/2024 at 11:54 a.m. The Primary Care Physician (PCP) call the facility and informed Staff Member 6 on 3/20/2024 at 11:00 a.m.to continue with medication as ordered.		Medication audits will be reviewed monthly by QAPI committee x 6 months. QAPI committee will make recommendations as needed.	

During an interview on 3/20/2024 at 4:10 p.m. Resident K indicated she had been informed of the medication error. She indicated she had been more anxious and had more tremors during the last few days. She indicated she now knew why she had felt diffent. She indicated she was feeling OK at the time of the interview. She indicated she was upset her medications had not been given.

During an interview via a phone call, on 03/20/2024, Staff Member 7 indicated she did not give the medication.

During an interview via a phone call, on 03/20/2024, Staff Member 8 indicated she did not give the medication.

A current facility policy titled, "Medication, Management, Administration, & Storage," dated as effective 1/2024 and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated "... Medication Administration : Medication Administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA."

Based on interview and record review, the facility failed to ensure medications were given as ordered by the resident's

physician and supervised by a licensed nurse on the premises or on-call for 1 or 6 residents reviewed for administration of medications (Residents K).

Findings include:

The record for Resident K as reviewed on 3/19/2023 at 2:46 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, and Parkinson's disease.

The Narcotic Administration Record reviewed on 3/19/2024 at 11:54 a.m.,indicated Resident K was to receive a Klonopin 1 mg tablet twice daily by mouth. The medication was not given on 3/18/2024 at 8:00 a.m. and on 3/19/2024 at 8:00 a.m.

During an interview, on 3/19/2024 at 11:00 a.m., the Administrator indicated the mediations should have been given.

During an interview on 3/19/2024 at 12:10 p.m. Staff Member 6 indicated the mediation should have been given.

The Primary Care Physician (PCP) was notified of the medication error/omission on 3/19/2024 at 11:54 a.m.

The Primary Care Physician (PCP) call the facility and

informed Staff Member 6 on 3/20/2024 at 11:00 a.m.to continue with medication as ordered.

During an interview on 3/20/2024 at 4:10 p.m. Resident K indicated she had been informed of the medication error. She indicated she had been more anxious and had more tremors during the last few days. She indicated she now knew why she had felt diffent. She indicated she was feeling OK at the time of the interview. She indicated she was upset her medications had not been given.

During an interview via a phone call, on 03/20/2024, Staff Member 7 indicated she did not give the medication.

During an interview via a phone call, on 03/20/2024, Staff Member 8 indicated she did not give the medication.

A current facility policy titled, "Medication, Management, Administration, & Storage," dated as effective 1/2024 and received from the Administrator on 3/20/2024 at 4:35 p.m., indicated "... Medication Administration : Medication Administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA."

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