STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASSWATER CREEK OF PLAINFIELD	10480 GLASSWATER LANE, INDIANAPOLIS, , 46231

(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: February 3 and 4, 2026. Facility number: 014410 Residential Census: 131 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 17, 2026.	R 0000		
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.	R 0154		02/26/2026

Based on observations and interviews the facility failed to ensure dry goods were stored and labeled properly and expired food was discarded. This deficient practice had the potential to affect 131 of 131 residents receiving food from the kitchen.

Findings include:

On 2/3/26 at 10:00 a.m. the kitchen was observed with the assistant Culinary Director (CD). In dry storage there was a bag of uncooked rice that had the corner cut open sitting on the shelf exposing the rice to air. The bag of rice had a date on it which the assistant CD indicated was the date it was received. She indicated there should have been an open date on the bag, which she wrote on the bag at that time. She rolled the top of the bag down and indicated they had been rolling it that way to keep the inside from being exposed, but it must have unrolled. There were also boxes of biscuit mix, pancake mix and cornbread mix that had been opened but only had the date they were received on them. The assistant CD indicated there should have been an open date written on those boxes. She did not know when they were opened so she threw the

	boxes away. When observing the walk-in refrigerator three containers of leftover food were found with expiration dates of 2/2/26. The assistant CD indicated those containers should have been thrown away already. On 2/4/26 at 2:45 p.m. the Executive Director (ED) indicated the facility followed the state rules and guidelines for labeling and dating foods. Based on observations and interviews the facility failed to ensure dry goods were stored and labeled properly and expired food was discarded. This deficient practice had the potential to affect 131 of 131 residents receiving food from the kitchen. Findings include: On 2/3/26 at 10:00 a.m. the kitchen was observed with the assistant Culinary Director (CD). In dry storage there was a bag of uncooked rice that had the corner cut open sitting on the shelf exposing the rice to air. The bag of rice had a date on it which the assistant CD indicated was the date it was received. She indicated there should have been an open date on the bag, which she wrote on the bag at that time. She rolled the top of the bag down and			

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R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.	R 0300		02/26/2026

Based on observations and interviews the facility failed to ensure prescription and over the counter medications were labeled appropriately 5 of 5 residents' medications observed without labels.

Findings include:

On 2/4/26 at 12:00 p.m. the 200/400 hall medication cart was reviewed with QMA 2, and the findings were as follows:

1. Resident 11 had over the counter Calcium tablets with no label on the bottle.

2. Resident 11 had over the counter Vitamin D tablets with no label on the bottle.

3. Resident 12 had prescription Linzess (a prescription medication used to treat chronic constipation and abdominal pain) that had no prescription label.

4. Resident 13 had prescription Rexulti (an antipsychotic medication used to treat major depressive disorder, schizophrenia, and agitation associated with dementia due to Alzheimer's disease) with no prescription label.

5. Resident 14 had over the counter Vitamin D tablets with no label on the bottle.

On 2/4/26 at 12:30 p.m. the Director of Nursing (DON) indicated the prescription bottles that did not have labels should have been in the boxes they came in which should have had the pharmacy printed label on them.

On 2/4/26 at 1:30 p.m. a copy of a current facility policy titled, "Medication Administration, Management and Storage," dated 1/2024 was provided. That policy did not speak to the expectations for labeling medications.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE