STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/04/2024

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. This visit included the Investigation of Complaint IN00420125 and IN00427335. Complaint IN00420125 - No deficiencies related to the allegations are cited. Complaint IN00427335 - No deficiencies related to the allegations are cited. Survey dates: February 29, March 1 and 4, 2024. Facility number: 014410 Residential Census: 134 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2024.	R 0000	No Response was Required	
R 0301	Pharmaceutical Services -	R 0301	A. No residents experienced	04/30/2024

	Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to ensure medications were labeled with expiration dates and failed to ensure expired medications were removed from 1 of 1 medication storage rooms during 1 of 1 medication storage observations. Findings include: On 2/29/24 at 10:50 a.m., during a medication storage observation, the following was		adverse effects from the alleged deficient practice. B. All residents whose insulin pens required labels, by the facility, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriately labeling all insulin pens. Employees will receive additional education on its use and the policy on labeling. C. All clinical staff will be re-educated and in-serviced on the insulin pen label policy and the use of the facility supplied label printer located in the insulin station by 4/1/2024. The Director of Nursing, or designee will educate all newly hired clinical staff on these procedures relating to labeling requirements for insulin pens during employee job-specific orientation moving forward. D. The Director of Nursing or designee will audit the label process and compliance two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper labeling is being used for all insulin pens. Results to be reviewed at monthly QI meetings and make further recommendations based off audit results E. Education and in-service will be	

	observed: a. 3 opened/undated Lantus SoloStar injection pens (used to treat diabetes); one opened/undated Humalog KwikPen (used to treat diabetes). b. 1 expired Humalog KwikPen (used to treat diabetes). During an interview on 2/29/24 at 12:05 p.m., the Executive Director (ED) indicated all opened insulin should be labeled with the opened and expiration dates. During an interview on 3/4/24 at 11:11 a.m., the Director of Nursing (DON) indicated all opened insulin pens should include the following: the name of the resident, the date the medication was opened, the date the medication expired, and the prescriber. On 2/29/24 at 2:12 p.m., the ED provided a copy of current facility policy titled, "Medication Management, Administration, & Storage," dated 1/2024. The policy indicated, "...resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines...." Based on observation, interview and record review, the facility		provided to all clinical staff regarding Medication Management, Administration, & Storage between now and to conclude on 4/30/2024.	

failed to ensure medications were labeled with expiration dates and failed to ensure expired medications were removed from 1 of 1 medication storage rooms during 1 of 1 medication storage observations.

Findings include:

On 2/29/24 at 10:50 a.m., during a medication storage observation, the following was observed:

a. 3 opened/undated Lantus SoloStar injection pens (used to treat diabetes); one opened/undated Humalog KwikPen (used to treat diabetes).

b. 1 expired Humalog KwikPen (used to treat diabetes).

During an interview on 2/29/24 at 12:05 p.m., the Executive Director (ED) indicated all opened insulin should be labeled with the opened and expiration dates.

During an interview on 3/4/24 at 11:11 a.m., the Director of Nursing (DON) indicated all opened insulin pens should include the following: the name of the resident, the date the medication was opened, the date the medication expired, and the prescriber.

On 2/29/24 at 2:12 p.m., the ED

	provided a copy of current facility policy titled, "Medication Management, Administration, & Storage," dated 1/2024. The policy indicated, "...resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines...."			
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	A. No residents experienced adverse effects from the alleged deficient practice. B. All residents requiring the use of glucometers, by the facility, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all medical staff on procedures of appropriately disinfecting glucometers. Employees found to be out of compliance with disinfecting glucometers will receive additional documented education and possible corrective action. C. All clinical staff will be re-educated and in-serviced on disinfecting glucometers no later than April 30, 2024 on use of Super Sani-Cloth & Sani-Cloth HB Germicidal disposable wipes. Allow glucometer to dry thoroughly between uses. Any clinical staff member out of compliance with facility's policies and protocols relating to disinfecting glucometers will receive progressive corrective	04/30/2024

Based on observation, interview, and record review, the facility failed to ensure resident's glucometers were sanitized after use for 2 of 2 residents reviewed for insulin services.

Findings include:

On 2/29/24 at 11:20 a.m., Qualified Medication Aide (QMA) 3 was observed as obtained a blood glucose level from Resident 17. QMA 3 failed to follow facility policy and cleaned the glucometer with 70% Isopropyl alcohol (IPA) pad for 20 seconds, instead of using germicidal disposable wipes for 2-minutes.

On 2/29/24 at 11:30 a.m., QMA 3 was observed as she obtained a blood glucose level from Resident 16. QMA 3 cleaned the glucometer with 70% IPA pad for 15 seconds, instead of using germicidal disposable wipes for 2-minutes.

During an interview on 2/29/24 at 11:40 a.m., QMA 3 indicated each resident had their own glucometer. After usage, the glucometer was wiped with a 70% (IPA) pad, and the glucometer was returned to the resident's storage bin.

During an interview on 2/29/24 at 12:05 p.m., the Executive Director (ED) indicated germicidal wipes, such as

action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to disinfecting glucometers during employee job-specific orientation moving forward.

D. The Director of Nursing or designee will audit the cleaning of glucometers two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, then two (2) times a month for one (1) month and then as needed to ensure that proper disinfecting technique is being executed. Results to be reviewed at monthly QAPI meetings and make further recommendations based off audit results

E. Education and in-service will be provided to all clinical staff between now and concluding on April 30, 2024

Sani-Cloths, should be used to disinfect glucometers after usage. The ED indicated the time requirement for disinfecting depended on the brand of germicidal wipes.

On 3/4/24 at 10:30 a.m., the ED provided a copy of current, but undated, facility guidelines titled, "Disinfecting Glucometers." The guidelines indicated, " ...Apply an EPA-Registered disinfectant per product direction. Allow glucometer to dry thoroughly between uses ..."

Based on observation, interview, and record review, the facility failed to ensure resident's glucometers were sanitized after use for 2 of 2 residents reviewed for insulin services.

Findings include:

On 2/29/24 at 11:20 a.m., Qualified Medication Aide (QMA) 3 was observed as obtained a blood glucose level from Resident 17. QMA 3 failed to follow facility policy and cleaned the glucometer with 70% Isopropyl alcohol (IPA) pad for 20 seconds, instead of using germicidal disposable wipes for 2-minutes.

On 2/29/24 at 11:30 a.m., QMA 3 was observed as she obtained a blood glucose level from Resident 16. QMA 3 cleaned the glucometer with 70% IPA

pad for 15 seconds, instead of using germicidal disposable wipes for 2-minutes.

During an interview on 2/29/24 at 11:40 a.m., QMA 3 indicated each resident had their own glucometer. After usage, the glucometer was wiped with a 70% (IPA) pad, and the glucometer was returned to the resident's storage bin.

During an interview on 2/29/24 at 12:05 p.m., the Executive Director (ED) indicated germicidal wipes, such as Sani-Cloths, should be used to disinfect glucometers after usage. The ED indicated the time requirement for disinfecting depended on the brand of germicidal wipes.

On 3/4/24 at 10:30 a.m., the ED provided a copy of current, but undated, facility guidelines titled, "Disinfecting Glucometers." The guidelines indicated, " ...Apply an EPA-Registered disinfectant per product direction. Allow glucometer to dry thoroughly between uses ..."

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