STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASSWATER CREEK OF WHITESTOWN	5829 NEW HOPE BOULEVARD, WHITESTOWN, , 46075

(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 Intakes IN00464416, IN00464882, and IN00465181. Intake IN00464416 - No deficiencies related to the allegations are cited. Intake IN00464882 - State deficiencies related to the allegations are cited at R0241. Intake IN00465181 - State deficiencies related to the allegations are cited at R0241. Survey date: October 6 and 7, 2025 Facility number: 015004 Residential Census: 108 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 15, 2025.	R 0000	**R 0000** This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request consideration for paper compliance.	

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility staff failed to administer medication prescribed by a physician for 18 days following receipt of the medication, and staff failed to observe resident administration of prescribed medications for 1 of 3 residents reviewed for pharmaceutical services (Resident C). Findings include: The clinical record review for Resident C was completed on 10/6/25 at 12:10 p.m. Diagnoses included lung cancer, dementia, and essential tremors (a neurological condition that causes involuntary shakiness in various parts of the body). During an interview on 10/6/25 at 3:15 p.m., Resident C's	R 0241	**R 0241** The corrective action that will be accomplished for those residents found to have been affected by the deficient practice; A) Resident C’s medications were added to the EMAR on 9/30, physician notified of the medication error and new orders faxed to pharmacy; B) QMA’s #4 and #5 were educated on the proper procedure for receipt of medication from a family, notification of the licensed nurse and the facility policy for medication administration. The facility will identify other residents having the potential to be affected by the same deficient practice and corrective action will be taken; All residents who have medications administered by nursing staff and those with medications delivered to the community by a family member have the potential to be affected by the alleged deficient practice. The	11/16/2025

daughter indicated she had taken Resident C to an appointment with her neurologist regarding her mother's essential tremors. The neurologist asked her to call him if her tremors had not improved. She did call him on 9/12/25 and the physician prescribed her a medication. She picked up the medication and took it to the facility. She gave the medication and explained what needed to be done and repeated the instructions provided by the neurologist. The two staff members seemed to understand. Two weeks later, she picked up her mother to go to the store and her shaking was very bad. When they returned to the facility she asked LPN 3 about the new medication and asked if it needed refilled already. LPN 3 informed her that the medication had not been administered and she had not known anything about the new medication. LPN 3 indicated she would look into it and call her later in the afternoon. LPN 3 had called and said she found the medication and would be starting it that evening. This was on 9/30/25, eighteen days after the medication was to be started. She indicated also that the staff were not observing her mother taking her medications. She arrived to the facility on 9/1/25 at 1:30 p.m. and found her mother's 8:00 a.m. medications

measures that will be put into place and systemic changes that will be made to ensure that the deficient practice does not recur; A) All QMA's on staff will be trained by the Director of Nursing by November 16, 2025 on the facility policy of notifying the licensed nurse when a new medication has been delivered by a residents family member so that the order can be processed with pharmacy and medication added to the EMAR; B) The new orders will be passed on to the on-coming shift during report and added to the 24 report sheet; and C) All staff administering medications will receive education on medication administration and the facility policy for receipt of medication.

How the corrective actions will be monitored to ensure the deficient practice will not recur and the quality assurance program that will be put into place;
A) The Director of Nursing or designee will conduct med cart audit weekly x 4 weeks and then monthly x 5 months to ensure all medications have orders in EMAR; B)The monthly QA committee will review audits x 6

	in a medication cup on her table. During an interview on 10/7/25 at 11:15 a.m., LPN 3 indicated she had worked on 9/30/25 and Resident C's daughter had asked the resident about the new medication for her mother's essential tremors. The resident's orders lacked the new medication as being prescribed. She found the medication bottle, with the label indicating the order, in the medication cart. Whoever the daughter had given the medication to, had not followed up with the nurse on duty to have the order put into the system. LPN 3 assured the order was entered into the system and administered the medication that evening. During an interview on 10/7/25 at 11:38 a.m., QMA 4 indicated she had worked on 9/12/25 and was present in the building at 1:00 p.m. She was in the nurse's station using the computer to complete charting. She recalled Resident C's daughter speaking with QMA 5 but was unaware what it was in regard to at that time. She and QMA 5 switched cart assignments the following Monday and she observed the new medication in the cart, but the order was not in the system so she had not administered that medication. She had not informed the nurse on duty		months and make recommendations as needed. The date of the systemic changes will be completed by: November 16, 2025.	

regarding the medication in the cart. She felt eventually it would be sent back to pharmacy or entered as a new order. QMA 4 indicated she had left medications on a residents table for administration for the resident's who request them to be left there. In the old electronic medication administration system, there was information on who requested them to be left on the table and which residents needed to be observed taking their medications. Resident C was one of the residents who's medications could be left at bedside.

During an interview on 10/7/25 at 1:57 p.m., QMA 5 indicated had not spoken to Resident C's daughter and knew nothing about a new medication being delivered on 9/12/25. She was in the building on 9/12/25 at 1:00 p.m. If she had been provided a new medication for a resident, she would place the medication in the medication cart and inform the nurse on duty regarding a new medication order. She indicated she mostly observed residents taking their medications. She declined to elaborate on the medication administration.

During an interview on 10/7/25 at 10:05 a.m., the Administrator indicated the staff should observe all residents that they

administer medications to, no matter who the resident was; if the staff administer the medications, they should observe the resident consume the medications.

A current facility policy, revised 1/2024, titled, "Medication Management, Administration, & Storage," provided by the Administrator on 10/6/25 at 11:39 a.m., included the following: "...Policy: A. Assessment:...2. If a resident is assessed as Needing Assistance with Medication Administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident."

A current facility policy, dated 9/19, untitled, provided by the Administrator on 10/7/25 at 3:19 p.m., and indicated this was the current policy for new medication orders, included the following: "...Licensed nursing staff, where permitted by applicable law and community policy as it pertains to the entering, transcription, editing, updating of 'prescribing practitioner' order(s), will communicate these updates, changes in set-up, and timing to the pharmacy using the 'pharmacy order/cycle change request' fax...."

This citation relates to Intakes

IN00464882 and IN00465181.

Based on interview and record review, the facility staff failed to administer medication prescribed by a physician for 18 days following receipt of the medication, and staff failed to observe resident administration of prescribed medications for 1 of 3 residents reviewed for pharmaceutical services (Resident C).

Findings include:

The clinical record review for Resident C was completed on 10/6/25 at 12:10 p.m. Diagnoses included lung cancer, dementia, and essential tremors (a neurological condition that causes involuntary shakiness in various parts of the body).

During an interview on 10/6/25 at 3:15 p.m., Resident C's daughter indicated she had taken Resident C to an appointment with her neurologist regarding her mother's essential tremors. The neurologist asked her to call him if her tremors had not improved. She did call him on 9/12/25 and the physician prescribed her a medication. She picked up the medication and took it to the facility. She gave the medication and explained what needed to be done and repeated the instructions provided by the

neurologist. The two staff members seemed to understand. Two weeks later, she picked up her mother to go to the store and her shaking was very bad. When they returned to the facility she asked LPN 3 about the new medication and asked if it needed refilled already. LPN 3 informed her that the medication had not been administered and she had not known anything about the new medication. LPN 3 indicated she would look into it and call her later in the afternoon. LPN 3 had called and said she found the medication and would be starting it that evening. This was on 9/30/25, eighteen days after the medication was to be started. She indicated also that the staff were not observing her mother taking her medications. She arrived to the facility on 9/1/25 at 1:30 p.m. and found her mother's 8:00 a.m. medications in a medication cup on her table.

During an interview on 10/7/25 at 11:15 a.m., LPN 3 indicated she had worked on 9/30/25 and Resident C's daughter had asked the resident about the new medication for her mother's essential tremors. The resident's orders lacked the new medication as being prescribed. She found the medication bottle, with the label indicating the order, in the medication cart.

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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 SIGNATUREHeidi Myers	TITLEExecutive Director	(X6) DATE10/23/2025