STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

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 Complaint IN00460352. Complaint IN00460352 - State deficiencies related to the allegations are cited at R296. Survey dates: July 14, and 15, 2025 Facility number: 015004 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 22, 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 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	R 0296	**R 0296** The corrective action that will be accomplished for those	08/15/2025

	shall provide for ongoing training to ensure competence of medication staff. Based on interview, and record review, the facility failed to maintain a system for the monitoring of narcotic medication orders, and to provide education and oversight, resulting in QMAs administering 2 doses of hydrocodone (a narcotic pain medication) within 1-2 hours, for 1 of 3 residents reviewed for medication administration (Resident B). Findings include: During an interview on 7/14/25 at 11: 53 a.m., Resident B's family representative indicated she had concerns spanning several months related to the hospice narcotic orders that were in the resident's record were wrong on more than one occasion. The resident representative indicated she had spoken with administrative staff and been assured the nursing staff would double-check the system and ensure the orders were correct. On 6/14/25 the pharmacy entered new hospice orders for hydrocodone into the system incorrectly, which resulted in the resident being administered double doses of hydrocodone for 2 days.		residents found to have been affected by the deficient practice; A) Resident B did not experience any adverse reactions to the medication error; B) A care plan conference was held on 7/18/25 with the DON, hospice nurse and POA to review Resident B’s care. 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 with narcotic orders have the potential to be affected by the alleged deficient practice. The 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 new narcotic orders will be reviewed for accuracy and double checked by the on-coming shift for correct transcription onto the EMAR; B) Licensed nurses will receive training on the review of all new narcotic orders; C) The community will be transitioning to a new pharmacy effective 8/29/2025; D) The community will discontinue the	

	Resident B's clinical record was reviewed on 7/15/25 at 10:30 a.m. Diagnoses on the resident's profile included chronic pain syndrome, polyarthritis, and pain in the right shoulder. Physician's orders, included the following, a. An order dated 5/23/25, hydrocodone/APAP 5-325 mg (milligram) give 1 tablet by mouth every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. and give 1 tablet by mouth every 4 hours as needed. b. An order dated 6/10/25, hydrocodone/APAP 5-325 mg give 1 tablet by mouth three times daily for pain at 6:00 a.m., 12:00 p.m., and 6:00 p.m. and give 1 tablet by mouth every 4 hours as needed for pain. c. An order dated 6/11/25, hydrocodone/APAP 7.5-325 mg give 2 tablets by mouth every evening at 12:00 a.m. and 8:00 p.m. d. An order dated 6/14/25 hydrocodone/APAP 5-325 mg give 1 tablet by mouth twice daily at 12:00 p.m. and 6:00 p.m. and e. An order dated 6/14/25, hydrocodone/APAP 7.5-325 mg give 1 tablet by mouth every morning at 7:00 a.m. and give 2 tablets by mouth every evening		use of all paper MAR'S. 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 DON or designee will review all narcotic orders for accuracy weekly x 8 weeks and the monthly x 4 months; The monthly QA committee will review audits x 6 months and make recommendations as needed. The date of the systemic changes will be completed by: August 15, 2025.	

at 9:00 p.m.

f. An order dated 6/19/25, hydrocodone/APAP 5-325 mg give 1 tablet by mouth every 4 hours as needed for pain.

An electronic medication administration record (eMAR), dated June 2025, included the following,

a. On 7/13/25 Hydrocodone 5-325 mg 1 tablet was administered at 6:00 a.m., 8:00 a.m., 12:00 p.m., 6:00 p.m., and Hydrocodone 7.5-325 mg 2 tablets were administered at 12:00 a.m., 7:00 a.m., 5:00 p.m. and 8:00 p.m.

b. On 7/14/25 Hydrocodone 5-325 mg 1 tablet was administered at 6:00 a.m., 8:00 a.m., 12:00 p.m., and Hydrocodone 7.5-325 mg 2 tablets were administered at 12:00 a.m., 7:00 a.m., 5:00 p.m.

A nursing progress note dated 6/14/25 at 9:28 a.m., indicated the night Qualified Medication Aide (QMA 7) reported there were new orders for hydrocodone on the eMAR per pharmacy, but there was not a hard copy order.

A nursing progress note dated 6/14/25 at 2:39 p.m., indicated QMA 7 had reported to the day nurse that Resident B had new medications on the eMAR and the resident was complaining of

feeling strange after taking her morning medications. Licensed Practical Nurse (LPN 8) observed the orders submitted on 6/10/25 - 6/12/25 overlapped times/strengths within a 24-hour time frame.

A nursing progress note dated 6/19/25 at 2:00 p.m., indicated the Assistant Director of Nursing (ADON) had met with the family representative and hospice personnel related to a medication error. The resident was administered a 6:00 a.m. dose of Hydrocodone and was then given another dose of the pain medication due to the resident having a duplicate order on the eMAR.

During an interview on 7/15/25 at 11:10 a.m., the Director of Nursing (DON) indicated the hospice nurse had written almost daily order changes for Resident B's pain medications. The continuous changes in orders, in addition to issues with pharmacy challenges, was causing difficulties for the nursing staff to keep up with the new orders. The hospice nurse did not specify to discontinue orders when writing new orders for the same medication. Pharmacy was having difficulty in keeping the correct dosages on hand, and this created a situation for a high potential for errors. There had been issues with the pharmacy either not

adding new orders, orders appearing randomly on the eMAR after having been discontinued, or when adding a new order, current orders would disappear from the eMAR. The DON indicated, she and the nurses completed on-going audits to monitor for errors in orders on the eMARs ,but the current concerns with the hydrocodone had not been found.

The DON indicated, she had no documentation of an internal audit of resident medication and eMARs having been completed.

During an interview on 7/15/25 at 12:20 p.m., the DON indicated on 6/14/25 Resident B had gone down to breakfast, then reported to LPN 6 she thought she was "snowed" related to taking medications too close together the day before. LPN 6 had contacted the hospice nurse who in turn called the resident representative who was upset. Resident B and the resident representative refused to have the resident sent to the emergency department (ED) and the resident was monitored in the facility. On 6/19/25, there was a care conference between hospice, the resident representative, and the ADON after the family claimed the resident was overdosed with hydrocodone.

The resident record lacked documentation of the physician being notified of concerns with Resident B's hydrocodone orders, or that the resident had been monitored for signs and symptoms to include vital signs or complaints of lethargy, level of consciousness, or respiratory depression.

An In-Service sign-in log, dated 4/10/25, indicated topic: Facility Policy for Medication Management, Administration, and Storage. Ten (10) staff members documented their signature as having received the education.

On 7/15/25 at 2:10 p.m., the DON provided a Medication Management, Administration, & Storage policy, dated 04/2025, and indicated the policy was the one currently being used by the facility. The policy indicated, "The purpose of this policy is to ensure that resident safety is maintained when managing, preparing, administering, and storing all medications while complying with state and federal guidelines ...Side effects: The resident will be observed for effects of medications. The QMA will immediately report to the licensed nurse any observed reactions and side effects to medications exhibited by the resident ...The resident's primary care provider will be notified immediately if

	undesirable effects occur, and such notification will be documented in the clinical record ..." Based on interview, and record review, the facility failed to maintain a system for the monitoring of narcotic medication orders, and to provide education and oversight, resulting in QMAs administering 2 doses of hydrocodone (a narcotic pain medication) within 1-2 hours, for 1 of 3 residents reviewed for medication administration (Resident B). Findings include:			

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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 SIGNATURE	TITLE	(X6) DATE