STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/04/2026

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 a State Residential Licensure Survey. Survey dates: May 1 and 4, 2026 Facility number: 015004 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 14, 2026.	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 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and	R 0117	**R 0117** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) All resident have the potential to be affected by the alleged deficient practice; B) Staff members who had completed the CPR/First aid	06/04/2026

	training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interviews and record review, the facility failed to ensure there was at least one staff member in the building every shift who was certified in Cardiopulmonary Resuscitation (CPR) and first aid. This deficient practice had the potential to affect 89 of 89 residents who resided in the facility. Findings include: On 5/1/26 at 1:40 p.m. the Executive Director (ED) provided a copy of the clinical nursing staff schedules from		class, provided copies of their completed first aid certification; and B) Copies of the printed certifications was placed in the CPR/First aid binder to reflect that all shifts have coverage. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; A) All residents that the potential to be affected by the alleged deficient practice; and B) Each shift will have at least one CPR/first aid certified staff member scheduled. What measures will be put into place and the systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) All nursing staff will be required to have CPR/First aid certification in place; and B) New hires who do not have certification in place will be certified as a part of their onboarding. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) The ED or designee will audit the CPR/First aid binder quarterly to identify staff members needing recertification; B) Quarterly training will be provided for those who need recertification;	

	4/15/26 to 4/28/26. The findings were as follows: 1. On 4/16/26, on night shift there was not a staff member present who had an active certification for first aid. 2. On 4/18/26, on evening shift and night shift there was not a staff member present who had an active certification for first aid. 3. On 4/19/26, on evening shift and night shift there was not a staff member present who had an active certification for first aid. 4. On 4/20/26, on evening shift and night shift there was not a staff member present who had an active certification for first aid. 5. On 4/21/26, on day shift, evening shift and night shift there was not a staff member present who had an active certification for first aid. 6. On 4/23/26, on evening shift and night shift there was not a staff member present who had an active certification for first aid. 7. On 4/25/26, on day shift there was not a staff member present who had an active certification for first aid.		and C) The monthly QA committee will review and make recommendations as needed. The date the systemic changes will be completed by; June 4th, 2026.	

	8. On 4/26/26, on day shift there was not a staff member present who had an active certification for first aid. 9. On 4/27/26, on evening shift there was not a staff member present who had an active certification for first aid. On 5/4/26 at 12:50 p.m. the ED indicated she spoke with the company who did the first aid and CPR certification for all clinical staff members and the company indicated the staff members were responsible for printing their own certifications and giving them to the facility. The ED indicated she did not know that the company wouldn't send the updated cards, so she planned to call the staff members and have them print their new cards. The ED indicated that by the end of the business day on 5/5/26 she would send the new CPR and first aid cards for review. The ED also indicated she would provide a copy of the policy for CPR and first aid coverage as well in the event she was unable to provide the requested information. At the end of the business day on 5/5/26 the requested information nor the policy for CPR and first aid coverage were provided.			

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.	R 0217	**R 0217** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #4 received a new assessment for functional LOC and the DON met with the resident to explain the reason for the service plan; B) A service plan meeting was scheduled with resident and/or POA to review and sign. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; A) All residents have the potential to be affected by the alleged deficient practice; B) DON or designee will audit all resident service plans to ensure there is a current signed service plan in place which addresses the individual desires, needs and preferences of the resident. What measures will be put into place and the systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) DON or designee will complete a quarterly audit of service plans to ensure that a signed updated service plan is in place; and B) An audit sheet will be utilized to track service plans due for an	06/04/2026

	(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a resident's service plan was agreed upon and signed by the resident or resident's representative for 1 of 7 residents reviewed for service plans (Resident 4). Findings include: During an interview, on 5/1/26 at 11:55 a.m., Resident 4 indicated she did not know what a service plan was, and she did not remember being involved in the development of her service plan. Resident 4's record was reviewed on 5/4/26 at 10:00 a.m. Census information indicated the resident was admitted to the facility on 11/19/23. A current service plan was electronically signed by a staff member on 11/19/25. A hand written note next to the staff member's electronic signature indicated, "Would like daughter to review." The handwritten note was not dated.		update. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) DON or designee will completed a quarterly audit to ensure service plans are completed timely; B) Updated service plans will be reviewed with and signed by the resident or POA; and C) The monthly QA committee will review and make recommendations as needed. The date that the systemic changes will be completed by; June 4th, 2026.	

	The resident's record lacked documentation the resident's daughter reviewed, agreed upon, or signed the service plan. During an interview on 5/4/26 at 1:22 p.m., the Director of Nursing (DON) indicated she was unable to find documentation the resident's daughter reviewed or signed the service plan. The DON indicated the service plans were completed every six months, and Resident 4 was almost due for another one to be completed. The service plan should have been signed by the resident or her daughter. On 5/4/26 at 1:48 p.m., the Administrator provided a document titled, "Service Plans," last reviewed in June 2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Each resident will have a written plan of care that is developed based on...semiannual assessments, and with any changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident. Procedure...D. Following completion of an evaluation, a licensed nurse in the Community shall identify and document the services to be			

	provided by the Community, as follows...4. The agreed upon service plan shall be signed and dated by the resident...."			
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, record review, and interview, the facility failed to ensure beard restraints were worn in the kitchen for 3 of 3 kitchen observations. Findings include: During an initial kitchen observation, on 5/1/26 at 10:39 a.m., the Culinary Director assisted with a tour of the kitchen. The Culinary Director had an uncovered goatee with no beard restraint in place. At the same time, Cook 4 was observed washing dishes. Cook 4 had beard and mustache growth but was not wearing a beard restraint. During a kitchen observation, on 5/1/26 at 12:23 p.m., Cook 5 was in the food prep area. Cook 5 had a beard and mustache	R 0273	**R 0273** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; No residents were found to have been affected by the alleged deficient practice; A) Kitchen staff were immediately trained on the correct use of hair/beard nets. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; A) All residents that the potential to be affected by the alleged deficient practice; and B) Hair nets/beard nets were made readily available and kitchen staff trained on the facility policy and correct use of hair nets/beard nets. What measures will be put into place and the systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) Culinary director will re-educate kitchen staff on the appropriate use/placement of hair/beard nets; and B) All new kitchen	06/04/2026

	with a beard restraint in place covering only part of the beard. Cook 5's mustache and sideburns were uncovered. Cook 4 was observed in the food prep area with beard and mustache growth and no beard restraint in place. Dietary Aide 6 was in the food prep area standing near a tray of uncovered fruit cups. Dietary Aide 6 had a hair restraint in place, but braided hair was sticking out the bottom of it and was uncovered. Dietary Aide 6 had beard and mustache growth and no beard restraint in place. During a kitchen observation, on 5/4/26 at 9:52 a.m., the Culinary Director was observed with a goatee. The Culinary Director wore a beard restraint, but the mustache was uncovered. Cook 4 was washing dishes. Cook 4 had beard and mustache growth and no beard restraint in place. At the same time, the Culinary Director indicated beard restraints should have been worn at all times in the kitchen. On 5/4/26 at 12:14 p.m., the Administrator provided a document titled, "Culinary Dress Code & Requirements," last reviewed in May 2026, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy...F. Long hair must be restrained or tied back. All		staff will be trained on the appropriate use of hair/beard nets during onboarding. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) Culinary director will monitor 5 x weekly for three weeks, then one-time weekly x three weeks, then monthly x 3 months to ensure compliance with the facility policy; and B) The monthly QA committee will review and make recommendations as needed. The date the systemic changes will be completed by; June 4th, 2026.	

	employees must wear hairnets in the kitchen. G. Beard nets must be worn if facial hair is longer than 1/8th of an inch long...."			
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 record review and interview, the facility failed to ensure staff obtained a resident's blood pressure prior to administering medications according to the physician's ordered parameters for 1 of 3 residents reviewed (Resident 2). Findings include: On 5/1/26 at 1:03 p.m., a record review was completed for Resident 2. She had the following diagnoses which included, but were not limited to, hypertension. As of 5/1/26 current medication orders included the following: Amlodipine (used for hypertension)10 milligram (mg) daily; hold if blood pressure was	R 0296	**R 0296** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) The MAR was corrected for resident #2 to reflect that staff obtain the resident's blood pressure prior to administering medications, according to the physician's ordered parameters. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; A) All residents have the potential to be affected by the alleged deficient practice; and B) Resident #2's MAR was corrected to include obtaining the resident's blood pressure prior to administering medication, per the parameters ordered by the physician. What measures will be put into place and the systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) DON or designee will review all	06/04/2026

	less than 120. Furosemide (used as a diuretic) 20 mg daily; hold if blood pressure was less than 120. Lisinopril (used for hypertension) 20 mg daily; hold if blood pressure was less than 120. On 5/4/26 at 1:18 p.m., the Administrator sent a copy of Resident 2's medication administration record (MAR) for April 2026. The resident's blood pressure was not documented as being obtained prior to administering the medications for the whole month of April. Resident 2's medical record lacked documentation of blood pressure being taken prior to administering hypertension medications to ensure the blood pressure was in parameters. On 5/4/26 at 11:30 a.m., the Director of Nursing (DON) indicated she corrected the MAR. On 5/4/26 at 1:49 p.m., the Administrator sent a copy of a policy titled, "Medication Management, Administration, and Storage (Indiana and Ohio Only)" dated 1/2024. The policy indicated, " ...The purpose of this policy is to ensure that resident safety is maintained when managing, preparing,		residents who have physician's ordered parameters in place for blood pressure to ensure the MAR includes obtaining blood pressures prior to medication administration; and B) Licensed staff will be trained on the facility policy for medication management, administration and storage during the next all staff meeting. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) DON or designee, will complete a monthly review of the MAR for all residents with physician's ordered parameters quarterly to ensure that blood pressures are being taken prior to medication administration. The date the systemic changes will be completed by; June 4th, 2026.	

	administering, and storing all medications while complying with state and federal guidelines ....".			
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. Based on observation and interview, the facility failed to label over the counter medications for 1 of 2 medication carts observed. Findings include: 1. Resident 9 had a bottle of Caltrate 600+D (a supplement) and a bottle of diphenhydramine HCL (an antihistamine 25 milligram (mg) in the medication cart with no label on the bottles. 2. Resident 10 had Mucinex (an expectorant) in the medication cart with no label on the package. On 5/1/26 at 12:30 p.m., Licensed Practical Nurse (LPN)	R 0300	**R 0300** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Labels were immediately placed on the medications for residents #9 and #10 and a medication cart audit completed to ensure that all medications were labeled. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the corrective action that will be taken; A) All residents that the potential to be affected by the alleged deficient practice; B) Nursing staff immediately placed labels on the two medications lacking a label. What measures will be put into place and the systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) An order was immediately placed for additional labels; B) Upon receipt of medications, staff will ensure that each medication is labeled according to facility policy; and C) Licensed staff will	06/04/2026

	7 indicated they had ordered labels for the medications. On 5/4/26 at 1:30 p.m., the Director of Nursing (DON) indicated they had labeled all medications lacking a label. A policy was provided but it did not discuss medication storage. There were no other policies provided by the end of survey.		be trained on the facility policy for medication management, administration and storage during the next all staff meeting. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) Night shift nursing staff will complete a weekly medication cart audit to ensure that all medications are labeled; B) These audit forms will be provided to the DON for review; and C) The monthly QA committee will review and make recommendations as needed. The date the systemic changes will be completed by; June 4th, 2026.	

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) DATE05/27/2026