STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00438318. Complaint IN00438318- State deficiencies related to the allegations are cited at R0053. Unrelated deficiencies are cited. Survey dates: July 26, 29 and 30, 2024. Facility number: 014148 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 9, 2024.	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse from a staff member for 1 of 3 residents reviewed for verbal abuse. (Resident H) Finding includes: An Indiana Department of Health intake form indicated Resident H reported to the Executive Director (ED) she had been verbally abused by staff member 8. Resident H indicated staff member 8 threatened her and she was afraid of the staff member. The resident indicated she did not tell anyone for a while and then decided she could	R 0053	1 1. Staff member 8 was found to have verbally abused resident H, staff member 8 was terminated from employment after investigation completed. 2 2. No other residents were found to have been affected by staff member 8's actions. 3 3.Ombudsmen address resident council on reporting abuse immediately when it occurs or is witnessed. Executive Director and/or designee to Abuse Inservice to all staff by August 30,	08/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori L Lindsey-Clarkston	Executive Director	08/22/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	not go on with her fear and anxiety. Staff member 8 was suspended and had not returned to the facility. A video tape, dated 7/5/24 at 5:52 a.m. to 5:57 a.m., was viewed on 7/30/24 at 11:05 a.m., with the Executive Director (ED). A verbal alteration did occur between the resident and the staff member at the designated time the resident indicated the incident had occurred. The clinical record for Resident H was reviewed on 7/29/24 at 12:50 p.m. Diagnoses included, but were not limited to, anxiety, hypertension, and myalgia. The resident had no cognitive impairments. A facility document, dated 7/25/24 at 3:43 p.m., documented by the ED as an interview with staff member 8 indicated the staff member said she did not abuse Resident H. She had been a staff member for 6 years and nothing like this had ever happened to her. Staff member 8 then offered the statement she had been accused by a coworker of argumentative behaviors which was not true. A facility document, dated 7/24/24, indicated staff member 11 had witnessed staff member 8 with an attitude problem, she had started picking on everything, and she verbally harassed her. A facility document, dated 7/25/24, indicated staff member 10 had witnessed staff member 8 on many occasions being mean to staff member 11 and staff member 8 did not know how to speak to others when she was mad. A facility document, dated 7/29/24, indicated staff member 9 had witnessed staff member 8 on many occasions yelling and cussing at staff members.		2024. Re-Occurring education to staff with competency on types of abuse and reporting abuse every six months/as needed by DON or designee for one year then yearly thereafter. Ombudsman or other outside source to present to resident council on abuse and reporting abuse every six months/as needed for one year then yearly thereafter. 4 4. QA committee to audit reportable occurrences for abuse monthly x 6 months. QA committee to make recommendations if needed.	

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	She indicated staff member 8 was very verbally aggressive. During an interview, on 7/29/24 at 3:10 p.m., Resident H indicated the staff member threatened her. It was elder abuse, and she was verbally threatened by the staff member. The staff member was no longer in the building, and she did not want to be around her anymore. She was afraid of the staff member. The resident had been in the human resources field of work prior to her move to the facility and she knew she had been abused. During an interview, on 7/29/24 at 4:15 p.m., staff member 8 indicated she had never verbally abused any resident in the facility. She never had any issues with the resident. She was surprised with the accusation. During an interview, on 7/30/24 at 10:20 a.m., the ED indicated the resident, and the staff member were seen on video tape having an altercation at the time the resident reported the incident had occurred. A current facility policy, titled "Abuse, Neglect, and Financial Exploitation Prevention," dated 01/2022 and received from the ED on 7/29/24 at 3:00 p.m., indicated "...Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times, Staff behavior that is abusive, neglectful or exploits residents will not be tolerated by the management of the community...." A current facility policy, titled "Resident's Personal Rights Policy and Procedure," dated 01/2022 and received from the ED on 7/29/24 at			

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	3:00 p.m., indicated "...Each resident shall have the right to...Be free from mental, emotional, social and physical abuse and neglect and exploitations...." This citation relates to Complaint IN00438318.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure residents were provided their prescribed medications as ordered for 1 of 3 residents reviewed for medication administration. (Resident D) Finding includes: The clinical record for Resident D was reviewed on 7/30/24 at 1:22 p.m. The diagnoses included, but were not limited to, dementia, hypertension, low back pain, and chronic kidney disease. The Medication Administration Record (MAR) for Resident D indicated the following: a. to give Olopatadine 1% eyedrops (an eyedrop for itchy eyes) (1 drop) into the right eye twice daily. The medication was not documented as given on 6/7, 6/8, 6/10, 6/11, 6/12, 6/13, 6/15, 6/16, 6/18, 6/19, 6/21, 6/24, 6/25, 6/26, 6/27,6/28, 6/29, 6/30 7/1, 7/2, 7/4, 7/5, 7/6, 7/7, and 7/9 at 4:00 p.m., and on 6/11, 6/12, 6/15, 6/18, 6/21, 6/24, 6/25, 6/27, 6/28, 6/29, 6/30, 7/3, 7/4, 7/5, 7/6, 7/7 and 7/9 at 8:00 p.m.	R 0297	1 1. Audit of resident D MAR was completed on 8.9.2024 with no other issues noted. 2 2. No other residents were affected by this deficient practice. 3 3. Inservice to all nurses and QMA by DON/designee on medication administration policy will be completed by 8.30.2024 DON/designee will audit 10% of MAR monthly x6 months. ADON/designee to run weekly MAR unattended medication report x4 weeks, then biweekly for 2 months, then every 12-15th of every month monthly thereafter 4 4. QA committee will review audits monthly x 6 months. QA committee will make recommendations as needed.	08/30/2024

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	b. to give Refresh P.M. (an eye ointment) to the right eye twice daily. The medication was not documented as given on 6/21, 6/22 and 6/23 at 8:00 a.m., and on 6/20 and 6/21 at 4:00 p.m. c. to give Estradiol (an estrogen medication) 0.5 mg (milligrams) (1 tablet) by mouth once a day. The medication was not documented as given on 7/4, 7/5 and 7/6. d. to give donepezil (a medication used to treat dementia) 10 mg (1 tablet) by mouth once a day. The medication was not documented as given on 7/3, 7/4, 7/5, 7/6, 7/7 and 7/8. During a telephone interview, on 7/29/24 at 2:30 p.m., the Director of Nursing (DON) indicated she was not aware of Resident D's missed medications. During an interview, on 7/26/24 at 4:32 p.m., a pharmacy staff member indicated the eyedrop Olopatadine was filled on 4/30/24, 7/8/24 and 7/29/24. During an interview, on 7/29/24 at 2:45 p.m., staff member 5 indicated if a medication was not available for administration, the nurse was to be notified to reorder the medication. The medications were not administered because they were not available for the resident according to the MAR. A family member for Resident D could have obtained the medication for the resident since the resident did receive some medications in June. During an interview, on 7/29/24 at 2:50 p.m., staff member 12 indicated if a medication was not available for administration the nurse was to be			

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	notified to reorder the medication. The medications were not given to the resident due to the unavailability of the medication. During an interview, on 7/29/24 at 2:55 p.m., staff member 3 indicated if a medication was not available for administration the nurse was to be notified to reorder the medication. The MAR for Resident D indicated she did not receive her medications. During an interview, on 7/30/24 at 2:11 p.m., the Executive Director (ED) indicated she was not aware the medications for Resident D had not been given. She was not aware the medications were not available for the resident. The OTC medication may have been refilled by a family member while she was visiting, since the MAR indicated the resident did receive some medications in June. The medications should have been ordered and given to the resident. A current facility policy, "Medication Management, Administration, & Storage," dated as effective 1/2024 and received from the Executive Director on 7/29/24 at 3:00 p.m., indicated "...Medication Administration: Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA...."			
R 0351 Bldg. 00	410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such			

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	records only as permitted by law. Based on interview and record review, the facility failed to ensure staff kept confidential information of a residents record from unauthorized use by other residents and visitors for 1 of 1 resident reviewed for confidentiality. (Resident B) Finding includes: An Indiana Department of Health intake form indicated a family member of Resident D was in possession of Resident B's medication documentation from the resident's chart. Resident D's family member was asked to return the documents, and she refused. The local police were called to obtain the documents. A police report, dated 7/26/24, indicated the incident occurred on 7/24/24. An allegation of potential theft of confidential information by a family member of Resident D was reported to the police. The police report indicated the Executive Director (ED) had explained a family member had taken confidential documents from the premises. The documents for Resident B were reportedly left out by an employee and subsequently picked up by Resident D's family member. The ED indicated the documents were for Resident B and not Resident D. The family member was unhappy with the facility and intended to use the documents to file a complaint with the state regarding a HIPPA violation. The family member refused to return the documents to the facility after multiple requests by staff members. The police spoke with Resident C who initially found the documents. He indicated he had told a nurse about the documents but then forgot where he had placed them. The police spoke with the family member of Resident D. The family member indicated she had turned in a copy of the documents to the State Department of	R 0351	1 1. Resident B had no adverse effects related to alleged deficient practice. Audit of 10% of resident charts completed 8.9.2024 2 2. No other residents were affected by this alleged deficient practice. 3 3. Education to all staff on HIPPA completed on 7.25.2024. Inservice to all nurses by DON/designee on HIPPA policy and PHI will be completed by 8.30.2024. Each nurse is provided with a transport clipboard that closes and protects resident personal documents while taking them from one place to another. Each clipboard is marked with Glasswater Creek name and nurse name. Completed 7.31.2024 4 4. DON and/or designee will audit use of Clipboards weekly x 4 weeks, monthly x 5 months. QA committee will review audits and make recommendations as needed.	08/30/2024

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	Health to show the HIPPA violation of the facility. She then gave the documents to the facility after filing her report. During an interview, on 7/26/24 at 1:30 p.m., the ED indicated on 7/24/24 at 2:30 p.m., a staff member on the evening shift took a fax from the machine on the first floor. The staff member was distracted, and she left the fax outside of Resident C's door on a table. Resident D's daughter obtained the documentation from Resident C and refused to give the paperwork back to the facility. The facility called the police and filed a report against the person of interest since they refused to give the medical information back to the facility. The police came on 7/26/24 to investigate the incident. During an interview, on 7/26/24 at 3:14 p.m., Resident C indicated he found the documents outside his room on a table. He notified a nurse and then took the documents to the second floor but did not remember where he left them. Resident C was observed to be in Resident D's room multiple times throughout the survey. During an interview, on 7/26/24 at 4:10 p.m., Resident D's family member indicated the documents were left in Resident D's room. She did not know by whom, but she knew a HIPPA violation had occurred because the documents were for another resident. She was going to use them to report the facility. She did give the facility back the documents when she was aware the police had been called and a report was filed against her. During an interview, on 7/26/24 at 1:43 p.m., staff member 2 indicated she was not aware she had left			

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	medical documents outside a resident's room. She had been working with the pharmacy on Resident B's medications so she must have been the one who retrieved the fax. She was aware another resident had the paperwork and a HIPPA violation had occurred. During an interview, on 7/26/24 at 1:57 p.m., staff member 3 indicated she was aware medical documents had been left outside a resident's room. The nursing staff should not leave a resident's confidential information exposed to anyone other than nursing staff. A HIPPA violation occurred when the staff member left the documents outside another resident's room. A current facility policy, titled "Resident's Personal Rights Policy and Procedure," dated 01/2022 and received from the ED on 7/29/24 at 3:00 p.m., indicated "...Each resident shall have the right to...Have his or her records kept confidential and released only with his or her consent or in accordance with applicable law...."			