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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00404536, IN00404943, IN00405633 and IN00401860. Complaint IN00404536 - State deficiencies related to the allegations are cited at R117. Complaint IN00401860 - State deficiencies related to the allegations are cited at R117, R120, and R121. Complaint IN00405633 - State deficiencies related to the allegations are cited at R117. Complaint IN00404943 - No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12 and 13, 2023. Facility number: 014148 Residential Census: 133 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 21, 2023.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lori L Lindsey-Clarkston | Executive Director | 05/09/2023

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.

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 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 record review and interview, the facility failed to ensure the staff on duty met the requirements of first aid training for 4 of 21 shifts reviewed for first aid. Finding includes: The employee work schedule, dated 4/3/2023 through and including 4/9/2023, indicated the facility had 4 out of 21 shifts without a first aid certified staff member in the facility. During an interview, on 4/10/2023 at 4:10 p.m., the Executive Director (ED) indicated first aid trained certified staff members were not on duty at the facility for the 4 shifts on the staffing schedule reviewed for 4/3/2023 through 4/9/2023. A current facility policy, titled "CPR & First Aid Certifications," dated as effective 9/2021 and received from the ED on 4/12/2023 at 11:30 a.m.,	R 0117	1. 1. Personnel records were audited and staff in need of First Aid Certification were identified. 2. 2. All necessary staff will receive First Aid Certification on 5/12/23. 3. 3. DON and/or designee will obtain First Aid Certification cards at time of hire or will get signed up for class to obtain required certification. 4. 4. DON/designee will audit schedule weekly for 4 weeks, then monthly for 5 months. The QA committee will review audits monthly x 6 months and make recommendations as needed.	05/13/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated "...It is the responsibility of the Director of Nursing or designee to ensure at least one on duty employee has a current CPR & First Aid Certification at all times...." This State tag related to complaints IN00401860, IN00404536 and IN00405633.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following:			

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure staff received dementia training for 1 of 10 staff members reviewed for staff dementia training. (Staff Member 2) Finding includes: The staff record for Staff Member 2 was reviewed, on 4/12/2023 at 2:00 p.m., the employee dementia training for Staff Member 2 was not completed. During an interview, on 4/13/2023 at 2:30 p.m., the Executive Director indicated Staff Member 2 did not have a dementia training record in the file. The current facility policy, titled "Staff Training Policy and Procedure," dated as effective on 6/6/2021 and received from the Executive Director on 4/12/2023 at 11:30 a.m., indicated "...Within 30 days of employment, all staff members will complete orientation and training to the community and their assigned department and area of responsibility...Training topics will include, but not be limited to...Techniques for working with persons with disabilities and the elderly population...." This State tag related to complaint IN00401860.	R 0120	~~1.~~ ~~1.~~ Staff #2 will complete Dementia training by May 11, 2023. 2. 2. The facility audited personnel records for dementia training completion Dementia training will be completed by all staff May 11, 2023. 3. 3. The Business Office Director will run a report monthly to ensure all new employees have completed dementia training. 4. 4. The administrator and/or designee will audit reports monthly and staff will be removed from the schedule if new employee required training is not complete. Audits will be reviewed at monthly QA meetings and make recommendations. 5.	05/12/2023
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident			

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to perform employee health screenings for	R 0121	~~1.~~ ~~1.~~ Employees 2, 3, 4, 5, 6 and 7 will have complete 2-step	05/31/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Tuberculosis (TB) using the two-step skin test for 3 of 5 employees and a yearly TB screening for 3 of 5 staff reviewed for TB screening. (Dietary Aide 2, CNA 3, LPN 4, QMA 5, QMA 6 and Housekeeper 7) Findings include: 1. During a review of Dietary Aide 2's record, on 4/12/2023 at 2:00 p.m., the record indicated a hire date of 9/13/2022, a first step skin test was completed. No second step skin test was completed. 2. During a review of CNA 3's record, on 4/12/2023 at 2:05 p.m., the record indicated a hire date of 1/26/2022, there was no TB 1st step or 2nd step health screening record completed. 3. During a review of LPN 4's record, on 4/12/2022 at 2:10 p.m., the record indicated a hire date of 5/19/2019, there was no TB yearly health screening record completed. 4. During a review of QMA 5's record, on 4/12/2022 at 2:15 p.m., the record indicated a hire date of 8/23/2018, there was no TB yearly health screening record completed. 5. During a review of QMA 6's record, on 4/12/2022 at 2:20 p.m., the record indicated a hire date of 9/19/2022, there was no TB 1st step or 2nd step health screening record completed. 6. During a review of Housekeeper 7's record, on 4/12/2022 at 2:25 p.m., the record indicated a hire date of 8/20/2018, there was no TB yearly health screening record completed. During an interview, on 4/13/2023 at 2:30 p.m., the		TB tests completed by May 31, 2023 ~~2. 2.~~ Employee records audited; any records found with incomplete 2-Step TB test will be completed. ~~3. 3.~~ New employee TB tests will be added to the monthly calendar to ensure all TB tests are administered correctly. ~~4. 4.~~ DON and/or designee will audit TB compliance weekly to ensure compliance. Audits will be reviewed at monthly QA committee meetings x 6 months and make recommendations as needed.	

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director indicated the employees were missing a health screening for TB. The current facility policy, titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated as effective 9/2021 and received from the Executive Director on 4/13/2023 at 12:05 p.m., indicated "...A health screen is required for each employee prior to resident contact...The facility must assure that at the time of employment, or within one month prior to employment, and at least yearly thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work...." This State tag related to complaint IN00401860.			
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian for 1 of 17 resident pets records reviewed. (Resident 21) Findings include: The record review of resident pet vaccinations, on 4/10/2023 at 4:51 p.m., indicated the pet for Resident 21 had no current vaccination record. During an interview, on 4/11/2023 at 5:15 p.m., the Executive Director indicated the current pet vaccination record for Resident 21 could not be	R 0151	1. 1. Cat for resident twenty-one has an updated vaccination record as of 4.17.23. 2. 2. Resident records audit completed; any missing animal documentation will be obtained. 3. 3. Administrator/Designee will inservice Move- In Coordinator on the emotional support and service animal policy. 4. 4. Move-in coordinator/designee will audit resident animal binder for vaccinations records weekly for 4 weeks, then monthly x 5 months.	05/13/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	located. The current facility policy, titled "Pet Policy," dated effective 1/2022 and received from the Executive Director on 4/12/2023 at 11:10 a.m., indicated "...Pets need to be certified by a veterinarian to be in good health an up to date with required immunizations...."		QA committee will review audit x 6 months and make recommendations. 5.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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, interview and record review, the facility failed to ensure food was labeled and dated in the open kitchen and dry storage area for 1 of 1 kitchen reviewed. This deficiency had the potential to affect 133 of 133 residents who received food from the kitchen. Findings include: During the tour of the kitchen, on 4/11/2023 at 3:30 p.m., the following observations were made: 1.) The dry storage area was observed to have opened and not dated items: Two packages of potato chips were opened and not dated or sealed. Two packages of pasta were opened and not dated or sealed. 2.) The open kitchen area was observed to have open and not sealed items and a scoop was found in the oatmeal storage bin: Three loaves of bread were open and not dated. Two packages of hamburger buns were opened	R 0273	1. 1. No residents were affected by non-labeled/dated food items. Unlabeled food was discarded. 2. 2. All dry food and refrigerator audited; non-labeled/dated food items discarded. 3. 3. Inservice to dietary department staff on labeling and dating food items, not leaving scoop in food container completed on 4.27.2023 4. 4. Culinary Director/designee will audit food areas for labeling and dating daily for 4 weeks, weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 6 months. The culinary director and administrator will review the audit weekly and report findings at monthly quality assurance meeting x 6 months.	05/13/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and not dated. Two packages of hot dog buns were opened and not dated. During a second tour of the kitchen, on 4/13/2023 at 2:00 p.m., the following observation was made: The dry storage area had three packages of flour opened and not dated or sealed. During an interview, on 4/11/2023 at 3:55 p.m., the Acting Dietary Manager indicated all items should be sealed, labeled, and dated when opened. The oatmeal storage bin should not have contained the scoop. During an interview, on 4/13/2023 at 3:55 p.m., the Executive Director indicated there was no policy or procedure for the dating of opened items stored in the kitchen or the proper utilization of the scoop utensil in the food storage bins.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on interview and record review, the facility failed to ensure the reconciliation of controlled drugs were completed for 1 of 1 medication room reviewed for controlled drugs. Finding includes: During a record review of the controlled drug	R 0304	1. 1. No residents were affected by the deficient practice. 2. 2. Residents have potential to be affected by the deficient practice. 3. 3. Inservice to nursing staff on the proper use of narcotic count sheet completed on 4.12.23	05/13/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	records, on 4/12/2023 at 12:21 p.m., with LPN 8, the Controlled Medication Shift to Shift Change Log (narcotic count record- reconciliation) was incomplete. The narcotic reconciliation sign in and sign out documentation record, for April 2023, was missing the month and year. The narcotic count reconciliation sign in and sign out documentation record, for April 2023, was missing 41 of 66 entries. The narcotic count reconciliation sign in and sign out documentation record, for April 2023, had only one signature listed to identify the initials of the staff signing in and out. The narcotic count reconciliation sign in and sign out documentation record, for March 2023, was missing 106 of 186 entries. The narcotic count reconciliation sign in and sign out documentation record, for March 2023, had only 3 signatures listed to identify the initials of the staff signing in and out. During an interview, on 4/12/2023 at 12:40 p.m., LPN 8 indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to the supervisor. During an interview, on 4/12/2023 at 12:43 p.m., LPN 4 indicated the staff were to sign in and out		and 4.13.23. 4. 4. DON/Designee will audit narcotic count sheet weekly for 4 weeks, monthly for 4 months. The QA committee will review audit monthly x 6 months and make recommendations as needed. 5.	

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to the supervisor. During an interview, on 4/13/2023 at 1:40 p.m., the Director of Nursing (DON) indicated the staff were to sign in and out each shift when they did a narcotic count to verify the correct narcotic count for that shift. The reconciliation records for controlled drugs were signed when you count the controlled drugs before each shift and after the shift was over. The count must be conducted with another nurse or QMA and must be accurate or it was reported to her. The current policy, titled "Medication Management, Administration & Storage," dated as effective 3/23/2022 and received from the Executive Director on 4/14/2023 at 4:18 p.m., indicated "...Storage of Medications...All controlled substances shall be kept in a designated, secured location under double lock...Controlled Substances - Hand Off Procedure 1. At shift change, the oncoming license nurse or QMA responsible for the medication administration will verify the resident medication, dosage and count of all controlled substances by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log...."			

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to screen residents for yearly Tuberculosis (TB) for 6 of 7 resident reviewed for Tuberculin screening. (Residents 2, 4, 5, 6, 12, and 14) Findings include: 1. A Mantoux (Tuberculin skin test) Test record for Resident 2 indicated the yearly TB skin test or screening was not administered in 2022. 2. A Mantoux (Tuberculin skin test) Test record for Resident 4 indicated the yearly TB skin test or screening was not administered in 2022. 3. A Mantoux (Tuberculin skin test) Test record	R 0410	1. 1. Residents 2, 6, 12, and 14 had TB Health screen completed on 5.4.2023, residents # 4 and #5 are no longer in the building. ~~2. 2.~~ The Director of Nursing/Designee will audit all Resident charts, any missing documentation will be completed. ~~3. 3.~~ Annually, in August all residents will have TB screen completed. Nursing staff in-serviced by Director of Nursing and/or designee. ~~4. 4.~~ Director of Nursing and/or designee will audit new resident record monthly and audit yearly in	05/13/2023

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	04/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for Resident 5 indicated the yearly TB skin test or screening was not administered in 2022. 4. A Mantoux (Tuberculin skin test) Test record for Resident 6 indicated the yearly TB skin test or screening was not administered in 2022. 5. A Mantoux (Tuberculin skin test) Test record for Resident 12 indicated the yearly TB skin test or screening was not administered in 2022. 6. A Mantoux (Tuberculin skin test) Test record for Resident 14 indicated the yearly TB skin test or screening was not administered in 2022. During an interview, on 4/13/2023 at 2:30 p.m., the Executive Director indicated the residents were missing a yearly health screening for TB. The current facility policy, "Tuberculosis Skin Testing and Follow-Up for Employees and Residents," dated as effective 9/2021 and received from the Executive Director on 4/13/2023 at 12:05 p.m., indicated "...A health screen is required for each resident...Tuberculosis screening shall be completed within 3 months prior to admission or upon admission and read at forty-eight to seventy- two hours and annually thereafter...."		August. Audits will be reviewed by the QA committee monthly x 6 months and make recommendations as needed. ~~5~~	