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	03/18/2025

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

(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. Survey dates: March 17 and 18, 2025 Facility number: 015004 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 25, 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 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure semi-annual functional level of care (LOC) assessments were completed for a resident (Resident 17) to correlate with her abilities and preferences of care for 1 of 5 residents reviewed for semi-annual assessments. Findings include: During an interview on 3/17/25 at 10:20 a.m., Resident 17 indicated she had not had a level of care assessment in a long time. She asked staff about the assessment because she wanted to be able to administer her own medications again, but no one had come to evaluate her for medication and/or her functional level of care. On 3/17/25 at 11:15 a.m., Resident 17's medical record was reviewed. She had admitted to the facility on 11/6/23 and had a diagnosis which	R 0214	**R 214** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #17 received a new assessment which reflected functional LOC and the ability to self-administer own medications; 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 that have the potential to be affected by the alleged deficient practice; B)	04/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi Myers	Executive Director	04/04/2025

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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	included, but was not limited to, recurrent and moderate major depressive disorder. She had a LOC assessment, dated 6/11/24, which meant her next LOC was due in December of 2024 but was not found in her medical record. During an interview on 3/17/25 at 11:32 a.m., the Director of Nursing (DON) indicated the facility was in the middle of a transition from one form of electronic medical charting software to another software system. In that transition, the DON had not been granted access to the appropriate LOC assessment materials and several residents LOC were missed which included an up to date LOC for Resident 17. On 3/18/25 at 10:38 a.m., the DON provided a copy of current facility policy titled, "Service Plans, revised 6/2022. The policy indicated, "The purpose of this policy is to outline necessary components of the resident evaluation and assessment process to ensure that the individual needs, desires and preferences of the resident are obtained and noted in the Service Plan as needed and appropriate within the frequency and assessment schedule specified ... Each resident will have written plan of care that is developed based on initial and semi-annual assessments and with any changes in resident needs ... the scope and content of the evaluation includes: 1. The resident's physical, cognitive, and mental status. 2. the residents independence and the activities of daily living. 3. the residents weight taken on admission and semiannually thereafter. 4. if applicable, the residents ability to self-administer medications. 5. the evaluation shall be documented in writing and kept in the community ...."		Resident service plans will be audited by the DON or designee to ensure there is a current LOC assessment 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 an updated plan is in place; B) An audit sheet will be utilized to track service plans needing updated; and C) Licensed nurses will be educated on the facility policy for service plans. 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; and C) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date of the systemic changes will be completed by; April 18th, 2025.	

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a semi-annual functional level of care (LOC) assessment was completed for a resident (Resident 17) to address her desire and functional ability to administer her own medication for 1 of 3 residents reviewed for self-administration of medication. Findings include: During an interview on 3/17/25 at 10:20 a.m., Resident 17 indicated she had not had a level of care assessment in a long time. She asked staff about the assessment because she wanted to be able to administer her own medications again, but no one had come to evaluate her for medication and/or her functional level of care. During an interview on 3/18/25 at 10:00 a.m., the Director of Nursing (DON) indicated, she was aware Resident 17 wanted to resume administration of her own medication, but she was no longer capable of being able to do so. After the resident's return from a rehabilitation stay, she no longer had the dexterity or strength to open her bottles and also had a diagnosis of dementia and could be forgetful. The DON and Resident 17's daughter had spoken and agreed it was best for the facility to continue to manage and administer her medication. The DON indicated, the nursing staff had not completed a LOC assessment or self-administration of medication assessment even though they knew the resident desired to manage her own medications. On 3/17/25 at 11:15 a.m., Resident 17's medical record was reviewed. She had admitted to the	R 0216	**R 216** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #17 received a new assessment for functional LOC and the ability to self-administer own medications; 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) Resident service plans will be audited by the DON or designee to ensure there is a current LOC assessment 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 an updated plan is in place; and B) An audit sheet will be utilized to track service plans	04/18/2025

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	facility on 11/6/23 and had a diagnosis which included but was not limited to, recurrent and moderate major depressive disorder and unspecified dementia. She had a LOC assessment, dated 6/11/24, which meant her next LOC was due in December of 2024 but was not found in her medical record. Resident 17 had a self-administration assessment dated 11/6/23 which indicated she was capable of independently managing her own medication. Resident 17's record lacked documentation of any LOC and/or self-medication administration assessment to address the change in her functional ability to no longer be able to manage her medications. Resident 17's most recent Service Plan was dated 1/19/25 and indicated she was " ...oriented and able to recall or retain information (i.e. recent events, directions, time, place of situation) ... and able to make safe judgments and functions appropriately in social situation ...." On 3/18/25 at 10:45 a.m., the DON provided a copy of current facility policy titled, "Medication Management, Administration, & Storage," revised 1/2024. The policy indicated, " ... the Director of Nursing or licensed nurse designee will assess the resident's ability to self-administer daily medication using the self-medication assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set up and storage protocol will be implemented based on the assessment outcome. The medication assessments will be reviewed biannually as part of the review process and periodically with any significant change in		needing updated; and C) Licensed nurses will be educated on the facility policy for service plans. 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 quarterly audit to ensure service plans are completed timely; B) Updated service plans will be reviewed with and signed by the resident; and C) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date the systemic changes will be completed by April 18th, 2025.	

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	condition or as level of service indicate...." On 3/18/25 at 10:38 a.m., the DON provided a copy of current facility policy titled, "Service Plans," revised 6/2022. The policy indicated, "The purpose of this policy is to outline necessary components of the resident evaluation and assessment process to ensure that the individual needs, desires and preferences of the resident are obtained and noted in the Service Plan as needed and appropriate within the frequency and assessment schedule specified ... Each resident will have written plan of care that is developed based on initial and semi-annual assessments and with any changes in resident needs ... the scope and content of the evaluation includes: 1. The resident's physical, cognitive, and mental status. 2. the residents independence and the activities of daily living. 3. the residents weight taken on admission and semiannually thereafter. 4. if applicable, the residents ability to self-administer medications. 5. the evaluation shall be documented in writing and kept in the community ...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to complete service plans and have the residents sign the service plans for 2 of 3 residents reviewed (Resident 2 and 3). Findings include: 1. On 3/17/25 at 10:20 a.m., a record review was completed for Resident 2. He had diagnosis which included but were not limited to dementia, hyperlipidemia, insomnia, and diabetes.	R 0217	**R 217** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #2 was admitted to the hospital on 8/17/24 and has since passed away and Resident #3 was discharged on 2/10/25. How the facility will identify other residents having the potential to be affected by the same alleged	04/18/2025

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	His medical record lacked a service plan to include his signature. 2. On 3/17/25 at 11:00 a.m., a record review was completed for Resident 3. He had the following diagnosis which included but were not limited to hip pain, hypertension, chronic kidney disease, and diabetes. His medical record lacked a service plan to include his signature. On 3/18/25 at 10:38 a.m., during an interview with the director of nursing (DON), she indicated the facility was moving from one medical record program to another making it difficult to find items requested. A policy titled, "Service Plans" was provided by the DON on 3/18/25 at 10:38 a.m. It indicated, " ...An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident's condition, or mor often at the resident's and/or Community's request. A licensed nurse shall evaluate the nursing needs of the resident...."		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) Resident service plans are being audited by the DON or designee, to ensure that all service plans have been reviewed and signed by resident/POA. 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 each has been reviewed/signed by resident or POA; B) An audit sheet will be utilized to review services plans for signature of resident/POA; and C) Licensed nurses will be educated on the facility policy for service plans and signature of resident/ POA. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) Updated resident service plans will be reviewed with the resident/POA and signed at that time; B) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date the systemic changes will be completed by; April 18th, 2025.	

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R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure all medications and treatments were stored and labeled properly for the facility in 1 of 1 medication carts reviewed. This deficient practice had the potential to affect 38 of 38 residents whose medications were stored in medication cart 1. Findings include: On 3/17/25 at 1:00 p.m., medication cart 1 was observed with Licensed Practical Nurse (LPN) 1. The medications reviewed were as follows: a. Fluticasone (a type of nasal spray), no open date. b. Brimonidine 0.2% (a type of eye drop), no open date. c. Ofloxacin (a type of antibiotic ear drop), no open date. In an interview on 3/17/25 at 1:05 p.m., LPN 1 indicated after a nurse opened a new ear drop, eye drop or nasal spray they should write the date on the bottle and then follow manufactures expiration date for disposal. In an interview on 3/18/25 at 10:27 a.m., the Director of Nursing (DON) indicated the expectation was the nurse who opened the bottle should write the date and time it was opened on the bottle. they should go off manufacture expiration date unless otherwise specified. On 3/18/25 at 10:45 a.m., the DON provided a copy of a current facility policy titled, "Medication Management, Administration, & storage" dated	R 0301	**R 301** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) An audit of the med cart was completed and medications verified to have open dates. 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) Licensed staff will complete weekly medication cart audits to ensure all medications have open dates. 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) A weekly medication cart audit will be completed by nursing staff to ensure all medications have open dates; B) Licensed staff will be educated on the facility policy for medication management, administration and storage at the next All Staff meeting; and C) An audit sheet will be utilized for weekly med cart audits. The corrective action will be monitored to ensure the alleged deficient practice will not recur and	04/18/2025

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	1/2024. 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 ...."		the quality assurance program put into place; A) DON or designee, will spot check the medication carts to ensure that all medications are labeled and have open dates; and B) Weekly audit sheets will be turned in the DON for review. Monthly QA committee will review audits x 6 months and make recommendations as needed. The date of the systemic changes will be completed by; April 18th, 2025.	
R 0378 Bldg. 00	410 IAC 16.2-5-11.1(b)(1)(A-H)(2-3) Mental Health Screening- Deficiency Based on interview and record review, the facility failed to ensure a resident (Resident 17) who was a recipient of Medicaid funding, and had a diagnosis of a major mental illness, (MMI) received mental health screening for her illness to determine if special services and/or accommodations were needed for 1 of 1 resident reviewed for MMI. Findings include: During an interview on 3/17/25 at 10:20 a.m., Resident 17 indicated she did have depression, and it would get "pretty bad" sometimes. She worried a lot about the loss of her independence and would get very sad at times. She took medication for depression but did not see a psychiatrist or counselor that she knew of. On 3/17/25 at 11:15 a.m., Resident 17's medical record was reviewed. She had admitted to the facility on 11/6/23 and had a diagnosis which	R 0378	**R 378** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #17 received an updated mental health screen required for residents receiving Medicaid funding. 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 have major mental illness have the potential to be affected by the alleged deficient practice; B) DON completed an audit of residents with major mental illness to ensure those residents receiving Medicaid funding had a mental health	04/18/2025

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	included, but was not limited to, recurrent and moderate major depressive disorder. The record lacked documentation of any mental health screening related to her diagnosis of major depressive disorder. During an interview on 3/17/25 at 11:32 a.m., the Director of Nursing (DON) indicated Resident 17 did have a diagnosis of a MMI which was major depressive disorder. The DON was unaware if any mental health screening had been completed in compliance with requirements related to her Medicaid funding. On 3/18/25 at 10:00 a.m., the DON indicated there was no policy related to Mental Health Screening requirements for residents who received Medicaid funding as a payor source, but the facility should follow the Residential Regulations.		screen in place. 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 resident with major mental illness and receive Medicaid funding to ensure that an updated mental health screen has been completed ; B) License nurses will be educated that all residents receiving Medicaid funding and have a MMI must have a mental health screen in place; and C) An audit sheet will be utilized to track mental health screens needing updated. 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 with utilize the audit sheet on a quarterly basis to verify that the mental health screens have been completed timely; and B) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date the systemic changes will be completed by; April 18th, 2025.	
R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance Based on interview and record review, the facility failed to ensure a resident (Resident 17) who was	R 0382	**R 382** The corrective actions that will be	04/18/2025

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	a recipient of Medicaid funding, and had a diagnosis of a major mental illness, (MMI) had a comprehensive care plan developed to address her MMI, potential needs and services with measurable goals and interventions to monitor her for worsening symptoms for 1 of 1 resident reviewed for MMI. Findings include: During an interview on 3/17/25 at 10:20 a.m., Resident 17 indicated she did have depression, and it would get "pretty bad" sometimes. She worried a lot about the loss of her independence and would get very sad at times. She took medication for depression but did not see a psychiatrist or counselor that she knew of. On 3/17/25 at 11:15 a.m., Resident 17's medical record was reviewed. She had been admitted to the facility on 11/6/23 and had a diagnosis which included, but was not limited to, recurrent and moderate major depressive disorder. The record lacked documentation of any mental health screening related to her diagnosis of major depressive disorder. The record lacked a comprehensive care plan to address her diagnosis, potential needs for services and treatments, goals and interventions to monitor for worsening symptoms. During an interview on 3/17/25 at 11:32 a.m., the Director of Nursing (DON) indicated Resident 17 did have a diagnosis of a MMI which was major depressive disorder. The DON was unaware if any mental health screening had been completed in compliance with requirements related to her Medicaid funding, because there was no		accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #17 received an updated mental health comprehensive care plan required for residents receiving Medicaid funding. 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) DON completed a audit of residents with major mental illness to ensure those residents receiving Medicaid funding had a mental health comprehensive care plan in place. 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 resident with major mental illness and receive Medicaid funding to ensure that an updated mental health comprehensive care plan has been completed ; B) License nurses will be educated that all residents receiving Medicaid funding and have a MMI must have a mental health comprehensive care plan in place; and C) An audit sheet will be utilized to track mental health comprehensive care plan needing	

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	assessment, there was no corresponding care plan. On 3/18/25 at 10:00 a.m., the DON indicated there was no policy related to Mental Health Screening and care planning requirements for residents who received Medicaid funding as a payor source, but the facility should follow the Residential Regulations.		updated. 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 with utilize the audit sheet on a quarterly basis to verify that the mental health comprehensive care plan are been completed timely; and B) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date of the systemic changes will be completed by; April 18th, 2025.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record reviews and interviews, the facility failed to administer first and second step tuberculosis testing (PPD) for 1 of 3 residents reviewed (Resident 3). Findings include: On 3/17/25 at 11:00 a.m., a record review was completed for Resident 3. He had the following diagnosis which included but were not limited to hip pain, hypertension, chronic kidney disease, and diabetes. He admitted to the facility on 5/28/24. His medical record lacked an initial and step PPD. On 3/18/25 at 10:10 a.m., the Director of Nursing (DON) indicated she could not locate the PPDs	R 0410	**R 410** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Resident #3 was discharged on 2/10/25. 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) DON has completed a tuberculosis screen on each resident. What measures will be put into place and the systemic changes	04/18/2025

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	03/18/2025

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

(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
	either. A policy titled, "Tuberculosis Skin Testing and Follow Up (Residents and Employees) dated 2/2010 was provided by the DON on 3/18/25 at 10:38 a.m. It indicated " ...A two-step Mantoux (PPD) tuberculosis skin test will be administered to: new residents within 90 days prior to the date of admission or commenced no more than seven days after the date of admission ...."		the facility will make to ensure that the alleged deficient practice does not recur; A) Upon admission, a first and second step tuberculosis test will be administered and all residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray; B) A TB clinic will be held annually for community residents; and C) DON will educate nurses on TB policy for residents. 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 will audit TB test for new residents monthly x 6 months; and B) Monthly QA committee will review audits x 6 months and make recommendations as needed. The date the systemic changes will be completed by; April 18th, 2025.	