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	02/04/2025

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00451951 and IN00451219. Complaint IN00451951 - State deficiencies related to the allegations are cited at R0296. Complaint IN00451219- State deficiencies related to the allegations are cited at R0029 and R0295. Survey date: February 4, 2025 Facility number: 015004 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 14, 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 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation, interview, and record review, the facility failed to ensure residents had the right to a homelike environment when public posting were made to dictate what could or could not be worn within the facility. This deficient practice had the potential to effect 6 of 79 residents who resided in the facility. Findings include: On 2/4/25 at 2:00 p.m. a publicly posted announcement was observed in the main lobby elevator which was used by residents. The announcement indicated, "Attention Residents -	R 0029	**R 0029** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; Residents were informed during the February Resident Council meeting that they are able to wear whatever they desire, as this is their home. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the	03/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi Myers	Executive Director	02/25/2025

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	Dress Code: When you are in public areas of the community (dining room, lobby, etc.) you are to be dressed appropriately to be around visitors, tours and resident families. Pajamas, robes and housecoats are NOT acceptable ..." During an interview on 2/4/25 at 2:40 p.m., Resident L indicated, she had noticed the sign in the elevator and it bothered her the way it was worded, "yes, it bothered me greatly." She indicated, since this was supposed to be considered her home, she did not want to be told what she could or could not wear. Resident L indicated if the concern was related to some people in particular, then perhaps it should have been addressed privately. During an interview on 2/4/25 at 2:47 p.m., Resident M indicated she had seen the sign in the elevator, she knew it was not directed towards her but indicated it did bother her to be told what she could or could not wear, "this is our home, that's ridiculous." During an interview on 2/4/25 at 2:50 p.m., Resident N indicated she had seen the announcement in the elevator and indicated she would continue to wear whatever she wanted since this was supposed to be her home. She thought the note was directed toward some other people, but it still was not right to post it for everyone, it should have been handled privately with those individuals. During an interview on 2/4/25 at 3:00 p.m., Resident P indicated she read the sign and it bothered her to be told she could or could not wear certain items. Sometimes she did not feel like getting fully dressed to go down for meals and as long as she was not exposing herself, it shouldn't		corrective action that will be taken; All residents that the potential to be affected by the alleged deficient practice. A) The front office will no longer generate or post messages for the resident council. The resident council will now generate their own messages that result from resident council meetings and share with peers in the resident authored newsletter; B) Staff will be trained during the 2/26/2025 All Staff Meeting on the Resident Right of residents being able to wear whatever they desire. Any further instance of residents exhibiting nudity in public areas will be addressed privately. 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) The front office will no longer type postings for the resident council; B) Staff will be trained during the 2/26/2025 All Staff Meeting on the Resident Right of each resident being able wear whatever they desire; and C) Instances of resident exhibiting nudity in public areas will be addressed on an individual basis. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) Resident council messages will be incorporated into the resident authored newsletter. These messages will not be typed	

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	matter what she wore. During an interview on 2/4/25 at 3:10 p.m., Resident Q indicated she saw the announcement and knew it was about her. She had been harassed by two other residents about a "Tartan," housedress she wore to the dining room. Resident Q held up an oversized, floor length, pink and floral housedress. It had a modest neckline and midarm sleeves. Resident Q indicated she was embarrassed by the announcement since everyone knew it was related to her, and she no longer wanted to go to the dining room if she felt like she was going to be teased. Resident Q indicated she had been told the facility should be considered her home, and she wanted to wear what was comfortable. She indicated she was always covered and it apart from going out naked, she should be able to wear what she wanted. During an interview on 2/5/24 at 3:15 p.m., Resident R indicated she and her friend, who lived across the hall, were on the elevator together when they saw the announcement. Resident R indicated she told her friend, she thought that sounded rude, and they should be able to wear a housecoat at least if they wanted. During an interview on 2/5/25 at 3:20 p.m., the Director of Nursing (DON) indicated the Administrator (ADM) posted the sign after a couple residents had come to the dining room in housecoats and slippers, or other types of pajamas. The DON indicated she believed apart from coming out of their private apartments naked/exposing themselves, residents had the right to wear what they chose as the facility was considered their home. The DON indicated it was up to the ADM as the DON's position was to oversee clinical concerns and the ADM oversaw		or posted by the front office; B) Staff will receive training on Resident Rights upon hire and on an annual basis. The date the systemic changes will be completed by; March 15th, 2025.	

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	resident/community concerns. On 2/5/25 at 3:20 p.m., the DON provided a copy of current facility policy titled, "Resident's Personal Rights Policy and Procedure," revised 12/2024. The policy indicated, " ...each resident will have the right to ... control his or her time, space, and lifestyle ... be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality ... make and act upon decisions ...." This citation relates to Complaint IN00451219.			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on observation, record review, and interview, the facility failed to properly store a resident's medications safely for 1 of 3 residents reviewed. Findings include: On 2/4/25 at 10:32 a.m., during an interview, Resident B indicated he did not self-administer his own medications. Somebody brought his medication in for him to take. A bottle of allergy pills, nasal spray, Tylenol, and nicotine pills were sitting out in the open on tables. Inside a tote were 2 bottles of fluticasone (nasal spray for allergies), 2 bottles of acetaminophen, diclofenac gel (for pain), Lidoderm patches (for pain), 2 bottles of zicam (for allergies), and eye relief drops. On 2/4/25 at 11:00 a.m., a record review was completed for Resident B. He had the following diagnoses which included but were not limited to heart disease, chronic pain syndrome,	R 0295	**R 0295** The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; A) Medications located in resident B's apartment were immediately removed and locked in the nursing med cart; B) A care plan meeting was held with the residents NP, Hospice RN, Home Care and DON, during which the Hospice RN overseeing the resident's care agreed to coordinate resident medications/refills via the VA; and C) Nursing staff will complete regular room audits of resident B's apartment for any unattended medications. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and the	03/15/2025

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	hypertensions, and major depressive disorder. He had a service plan which indicated he would be supported to take all medications safely as ordered. His record lacked an assessment for him to self-administer his own medications. During an interview with the Director of Nursing (DON) on 2/4/25 at 11:32 a.m., she indicated the facility administers Resident B's medications. She was unaware of the medications in the resident's apartment. On 2/4/25 at 1:25 p.m., a policy titled, "Medication Management, Administration, and Storage" dated 1/2025 was provided by the DON. It indicated, " ...The DON or licensed nurse designee will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the residents. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate ...." This citation relates to Complaint IN00451219.		corrective action that will be taken; All residents have the potential to be affected by the alleged deficient practice. A) Hospice RN to coordinate resident med refills with the VA; B) DON or designee to complete regular room audits of resident B's apartment for any unattended medication; and C) Licensed staff passing medication to resident B to be trained on the facility policy for medication administration. 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) Hospice RN to coordinate med refills with the VA; B) DON or designee to complete regular room audits of resident B's apartment; C) Licensed staff administering medications to resident B will be in-serviced on the policy for medication administration. The corrective action will be monitored to ensure the alleged deficient practice will not recur and the quality assurance program put into place; A) Room audits of residents apartment will be signed off by DON or designee; and B) DON and ED to discuss during monthly QAPI meeting. The date the systemic changes will be completed by; March 15th, 2025.	

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R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on observation, interview, and record review, the facility failed to maintain clear written policies and procedures on medication assistance and provide ongoing training to ensure competence of medication staff. This deficient practice affected 2 of 3 residents reviewed for pharmaceutical services. Findings include: During an interview on 2/4/25 at 11:19 a.m., Resident J indicated about a month ago the facility was administering her medications. She indicated the nurses would regularly be up to an hour or two late, bringing her medications. Resident J indicated the Director of Nursing (DON) was not very trustworthy. Resident J indicated she and one of her daughters had left one day and would be gone most of the day. They told an unknown nurse that she would miss one of her medications. Resident J indicated, the unknown nurse then gave her a bag of all of her current medications, and had her daughter sign the bag out. When they arrived back at the facility Resident J's daughter gave the bag back to an unknown nurse but they did not have her daughter sign the medications back in. Later that day they were informed that another resident who was leaving for the weekend ended up with Resident J's bag of medications. She indicated the resident who had her medications had been gone for the weekend, but they had extras of some of her medications. Other medications they did not have on hand so she didn't get those. During an interview on 2/4/25 at 2:37 p.m., Resident K indicated he was going to his cousins	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) Medications for resident J and resident K were returned to nursing and neither resident experienced a negative outcome. 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; All residents that the potential to be affected by the alleged deficient practice. A) LOA medication envelopes were purchase from Medline for use with residents going LOA; B) Medication envelopes will be clearly marked with residents name, date and time the medication is to be taken; C) Once bundled by date, the meds will be locked on the med cart until handed to the resident or family; D) The licensed staff member on the med cart, will verify the medication belongs to that 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) Medication envelopes were purchased from Medline for use with residents	03/15/2025

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	for a family reunion. He told the DON he was leaving for one night but ended up staying two nights. The DON brought his medications to him in the dining room. The medications were in a big bag, but he didn't look in it at that time. Resident K indicated, he left the facility and later that evening when he went to set up his night time medications he could not understand what medications he had. He noticed a different name on the bottles but thought it was maybe a doctor's name. He indicated he had taken one of his medications and one of Resident J's medications. Resident K indicated, he realized that all of the medications in the bag were Resident J's except for one medication. He indicated, because he could not take his medications, he had a lot of side effects. He indicated he endured a lot of restless leg and body symptoms and as the days went on, he fell deep into depression. Resident K indicated he ended up having a breakdown and he couldn't sleep either night because the medication he took to help him sleep would not work. He indicated he was missing his medication for restless leg syndrome, an antidepressant and antianxiety medication, among others. On the first night he indicated he was ok, but the next morning he got a call from an unknown nurse from the facility. He indicated the unknown nurse said he had taken the wrong medications. She asked him if he had taken any of the medications and asked if he would bring the bag back to her. He told the unknown nurse that he was too far away, and he would bring them back when he returned to the facility. Resident K indicated, when he returned to the facility, he ran into Resident J's daughter who indicated the nursing staff had told her that he was the resident who took her mom's medications. Resident K was upset that the facility was blaming him for the mix up. He indicated he went into the building and went straight to the front desk. He		going LOA; B) Prior to going LOA, medication will be pulled and placed in the LOA envelopes. The envelopes will be clearly marked with resident's name, date and time the medication is to be taken; C) Once bundled by date, the meds will be locked on the med cart until handled to the resident or family; D) The licensed staff member on the med cart, will double check and verify the medication belongs to that resident. 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 instruct licensed staff on the use of the medication envelopes and the instructions for use; B) Licensed staff will be trained on medication administration during the February 26th All Staff Meeting. The date the systemic changes will be completed by; March 15th, 2025.	

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	indicated that he was crying and asked to talk to the Administrator right away. The administrator wasn't there that day, but he talked to a staff member who works in the office, and he gave the bag of medications to that staff member. He indicated the DON came down a few days later. He could not remember the whole conversation but remembered that he brought up her giving the medications to him and she agreed that she did hand the bag to him. During an interview on 2/4/25 at 12:15 p.m., the DON indicated Resident J was going on a Leave of Absence (LOA) and her daughter was in a rush asking an unknown nurse for her mom's medications so they gave her a bag with all of them in it. When the resident and her daughter got back to the facility the DON indicated Resident J and her daughter left the bag of medications on top of a medication cart as Qualified Medication Aide (QMA) 4 was preparing Resident K's medication bag. The DON indicated, Resident K was to pick up his medication bag off of the medication cart but he picked up the wrong bag. She indicated, they had enough overflow medications to cover all Resident J's medications aside from two vitamins. She indicated, Resident K had all his medications. Neither resident had any negative outcomes from this incident. The DON indicated, after the mix up occurred, she provided a one-on-one in-service for QMA 4 and conducted an all-staff in-service regarding medication preparation for LOA residents. During an interview on 2/4/25 at 12:38 p.m., the DON indicated she could not find the original in-service she provided for QMA 4. She indicated she was there the day the incident occurred and reported it to the administrator, but when they			

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	spoke with corporate, they indicated it did not need to be reported to the state because there were no negative outcomes for either resident involved. During an interview on 2/4/25 at 12:50 p.m., Licensed Practical Nurse (LPN) 3 indicated it depended on how long the resident would be gone how they prepared the medications for LOA. If the resident was going to be gone for a few days, the nurse would put all the cards or bottles of medications for that resident in a facility bag, print the residents orders off and then put them in the bag. She indicated a family member must pick the medications up. During an interview on 2/4/25 at 2:00 p.m., QMA 4 indicated to send medications with a resident going LOA nurses checked with the resident how many days they would be gone. They would then pack all their medications if the resident planned to be gone multiple days and half of their medications if they were back the same day. For narcotics they only put the exact amount the resident would miss in the bag. QMA 4 indicated on the day of the incident Resident J had been out but was not gone for as long as they had thought she would be gone. When Resident J came back, she dropped her medication bag off at the medication cart as QMA 4 was preparing Resident K's medication bag. QMA 4 indicated she left Resident K's medication bag on top of the medication cart for Resident K to pick up. QMA 4 indicated when Resident K came to pick up his medication bag, he picked up the wrong one. She indicated she did not remember an in-service about this incident. During an interview on 2/4/25 at 2:30 p.m., the DON indicated the current procedure to send			

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	medications LOA with a resident was to put the medications into a facility bag, staple a label to the bag and staple the bag shut. The bags were to be prepared right before the resident leaves and handed directly to the resident. The DON indicated the medication bag should never be out of the licensed nurses' sight after it is made. On 2/4/25 at 11:00 a.m., Resident J and Resident K's records were reviewed. Upon review of both records, there was no documentation about the mix up of medications and there was no documentation of any medications being released to the residents or being returned to the facility. On 2/4/25 at 2:45 p.m., the DON provided a copy of a current facility policy titled, "Medication Management, Administration, & Storage (Indiana and Ohio Only)" dated 01/2024. The policy indicated, " ...The purpose of this policy is to ensure that resident's safety is maintained when managing preparing administering and storing all medications while complying with state and federal guidelines ... "The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response and right documentation ...." During an interview on 2/4/25 at 3:08 p.m. the DON indicated they did not have a policy or procedure related specifically to LOA medication handling or reporting medication errors they only follow state policy and guidance. This citation relates to Complaint IN00451951.			