STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND BROOK MEMORY CARE OF FISHERS	9796 EAST 131ST STREET, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00371685. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00371685: Substantiated. State residential findings related to the allegations are cited at R0247 and R0407. Survey dates: February 2, 7, 8, 2022 Facility number: 35 Residential Census: 014253 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 14, 2022.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 2/25/22	
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7)	R 0247	**What corrective action(s) will be accomplished for those**	02/25/2022

	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview the facility failed to ensure staff notified the physician of missed medication for 1 of 7 residents reviewed for medication administration. (Resident H) Findings include: The clinical record for Resident H was reviewed on 2/7/2022 at 3:49 p.m. Diagnoses included, but were not limited to, paroxysmal supraventricular tachycardia, hypertension, bilateral pseudophakia, bradycardia and sinus node dysfunction with pacemaker placement. Review of the physician orders indicated the resident had an order for Seroquel XR (antipsychotic) 50 mg to be given at bedtime, dated 6/9/2021, and an order for Zoloft (antidepressant) 25 mg to be given at bedtime, dated 6/10/2021. Review of the Medication Administration Record for January 2022 indicated on 1/1/2022, the resident did not receive his bedtime medications		**residents found to have been affected by the deficient practice**: Errors in medication administration will be noted in the residents' electronic medical record. The residents' physician or current Medical Provider will be notified of any error in medication administration when there are any actual or potential detrimental effects to resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice. Current staff responsible for administering medications were educated on reporting all medication errors to the Director of Health services or Executive Director immediately upon learning of the medication error. A resident assessment will be completed by a Licensed Nurse. The residents' Medical Provider as well as Responsible Party will be notified of any errors in medication administration within a timely manner.	

	due to sedation. During an interview on 2/8/2022 at 10:00 a.m., the Director of Nursing and the Administrator indicated LPN 1 should have notified the physician that the resident was sedated and received instruction on withholding the medication. During interview on 2/8/2022 at 3:00 p.m., LPN 1 indicated on 1/1/2022, the resident had returned to the facility from a family outing and was tired/sedated. LPN 1 did not administer the resident's night time medications, Seroquel XR and Zoloft per the physician order and did not notify the physician the mediation had been withheld. Review of a current undated policy titled "Medical Care" indicated the following: "... 5. When there is a health problem, the resident's responsible party and physician will be notified. ..." This policy was provided by the DON on 2/8/2022 at 10:18 a.m. This State tag relates to Complaint IN00371685. Based on record review and interview the facility failed to ensure staff notified the physician of missed medication for 1 of 7 residents reviewed for		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: The Director of Healthcare or Executive Director will routinely monitor for medication errors by running a daily report of any missed medications. Education will be provided to new staff that will be responsible for medication administration. Disciplinary action and re-education will be completed to staff that knowingly make a medication error and fail to report to the Director of Healthcare or Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place**: Medication error QA tool to be completed weekly and reviewed monthly in Quality Assurance Meeting to ensure compliance. The Director of Health Services or Designee will routinely monitor until compliance is maintained. The Director of Health services or designee will be responsible for the completion	

	medication administration. (Resident H) Findings include: The clinical record for Resident H was reviewed on 2/7/2022 at 3:49 p.m. Diagnoses included, but were not limited to, paroxysmal supraventricular tachycardia, hypertension, bilateral pseudophakia, bradycardia and sinus node dysfunction with pacemaker placement. Review of the physician orders indicated the resident had an order for Seroquel XR (antipsychotic) 50 mg to be given at bedtime, dated 6/9/2021, and an order for Zoloft (antidepressant) 25 mg to be given at bedtime, dated 6/10/2021. Review of the Medication Administration Record for January 2022 indicated on 1/1/2022, the resident did not receive his bedtime medications due to sedation. During an interview on 2/8/2022 at 10:00 a.m., the Director of Nursing and the Administrator indicated LPN 1 should have notified the physician that the resident was sedated and received instruction on withholding the medication. During interview on 2/8/2022 at 3:00 p.m., LPN 1 indicated on		of the Medication Error QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 2/25/22	

	1/1/2022, the resident had returned to the facility from a family outing and was tired/sedated. LPN 1 did not administer the resident's night time medications, Seroquel XR and Zoloft per the physician order and did not notify the physician the mediation had been withheld. Review of a current undated policy titled "Medical Care" indicated the following: "... 5. When there is a health problem, the resident's responsible party and physician will be notified. ..." This policy was provided by the DON on 2/8/2022 at 10:18 a.m. This State tag relates to Complaint IN00371685.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to	R 0407	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Staff education was provided to current staff with recent COVID-19 infection control Mandates ISDH & CDC Guidance as well as current Company Policy for infection control practices. **How other residents having**	02/25/2022

residents, including, but not limited to, infection transmission and immunizations.

(4) Reporting communicable disease to public health authorities.

Based on record review the facility failed to develop and implement policy and procedure to ensure all staff received current education related to COVID-19 Infection Control mandates. This deficient practice had the potential to effect 35 of 35 residents living in the facility.

Findings include:

On 2/7/2022 at 11:30 a.m., the latest COVID-19 Infection Control staff education, dated 2/2/2022, was reviewed. The education documentation indicated 10 out of 30 staff received education on personal protective equipment, sanitation, screening, trash removal, vaccination status and COVID signs and symptoms.

During an interview on 2/7/2022 at 10:08 a.m., Home Health Aide 2 indicated they had been out of the facility during the time of the education dated 2/2/2022. The staff member indicated they had not received the education prior to or after returning to the facility.

During an interview on 2/7/2022 at 10:56 a.m., the Director of

the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:
All residents had the potential to be affected by this alleged deficient practice. Company RN Consultant provided education and training to the Executive Director and Director of Healthcare of current company COVID policies in accordance with state and federal guidance. Current staff will be educated on the COVID-19 Prevention/Infection Control Policies by the Director of Healthcare or designee by 2/25/22. Education will include Personal Protective Equipment Requirements per Zone, Donning and Doffing of PPE, COVID-19 Prevention and Infection Control. Signage posted throughout various areas of the community reflecting specific facility policies or practices as well as CDC and/or ISDH guidance.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Ongoing Infection Control

Nursing (DON) indicated the facility expected all staff members to be educated on the most current COVID-19 mandates. The DON indicated the staff education dated 2/2/2022, had 10 staff signatures for attendance and was unable to provide documentation for the other 20 staff members. The policy for staff education was requested but not provided by the end of the survey.

This State tag relates to Complaint IN00371685.

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Findings include:

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During an interview on 2/7/2022

education and In-services will be made available to all staff via company communication tool, competency checks, or in-person trainings. The Director of Healthcare and Executive Director or Designee will ensure that all current and future staff will receive routine Infection Control trainings and education as soon as possible or prior to start of their next scheduled shift.
A record of training will be kept in a designated place in the Community. Director of Healthcare, Executive Director or Designee will provide ongoing training, oversight, resources or competencies on an as needed bases or anytime a deficient infection control practice is identified.

How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place:
The Director of Health Services/Designee will monitor daily or more often as necessary until compliance is maintained. The Director of Health services/designee will be responsible for the completion

	at 10:08 a.m., Home Health Aide 2 indicated they had been out of the facility during the time of the education dated 2/2/2022. The staff member indicated they had not received the education prior to or after returning to the facility. During an interview on 2/7/2022 at 10:56 a.m., the Director of Nursing (DON) indicated the facility expected all staff members to be educated on the most current COVID-19 mandates. The DON indicated the staff education dated 2/2/2022, had 10 staff signatures for attendance and was unable to provide documentation for the other 20 staff members. The policy for staff education was requested but not provided by the end of the survey. This State tag relates to Complaint IN00371685.		of Staff COVID education QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 02/25/22	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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