STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND BROOK MEMORY CARE OF ZIONSVILLE	11870 SANDY DRIVE, ZIONSVILLE, , 46077

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00461030. Complaint IN00461030 - No deficiencies related to the allegations are cited. Survey dates: July 21 and 22, 2025 Facility number: 014376 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 24, 2025.	R 0000		
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain	R 0148	The medical devices have been installed correctly by our maintenance director.	07/21/2025

	buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure mobility devices were appropriately installed and routinely inspected for safety monitoring to prevent the potential for accidents for 2 of 2 residents reviewed for mobility devices (Residents B and C). Findings include: On 7/21/25 at 11:10 a.m., Resident B was observed. He was seated on the edge of his bed, and the head of the bed was elevated at an		The Director of Health will careplan the residents need for the device in the resident's medical records. The monthly newsletter will be sent out by 8/06/25 and families will be notified that if they bring in any devices to be used by the resident that they must let the Director of Health or the Executive Director know so that we can determine if the device is helpful/necessary and that our maintenance director can inspect and installation is done correctly. The staff have been in-serviced that if any safety devices are noticed in the resident's room to immediately notify the Director of Health and/or the Executive Director. All rooms will be inspected monthly by the Maintenance Director to determine if there are any devices being used by residents that we have not been made aware of.	

	approximately 45 degree angle so that Resident B was upright. There was a white metal mobility bar observed with two legs to the floor and two legs that went under the mattress. There was a large gap between the edge of the mattress and the edge of the rail. When Resident B adjusted his position to sit farther up in bed, he grabbed the mobility bar, which wobbled and slid under the mattress, and the two legs came off the floor. On 7/21/25 at 12:50 p.m., Resident C's room was observed. There was a mobility bar installed under his mattress with two rails and two legs that went to the floor. The mobility bar easily slid towards and away from the mattress. On 7/22/25 at 10:10 a.m., Resident B's mobility device was observed with the Maintenance Director. He indicated he was not aware a mobility bar had been installed to the resident's bed, and it did not appear to be installed correctly as there was a large gap between the mattress and the rail. The Maintenance Director lifted the mattress and confirmed the security straps for the rail were loose and incorrectly tied to the bed frame. On 7/22/25 at 10:15 a.m., Resident C's mobility device			

	was observed with the Maintenance Director. He indicated he was not aware Resident C had a mobility bar installed. He maneuvered the device and indicated it easily slid away from the mattress. He lifted the mattress to reveal that the device had no security straps. During an interview on 7/22/25 at 10:40 a.m., the Maintenance Director indicated there was no facility policy for bed rail or mobility device use because the facility did not allow those items as a company policy. He indicated family members should let him know if they bring something in, but if they forget, the staff should notify him if a new device was installed so that he could ensure it was appropriately installed and safety monitoring could be implemented. On 7/22/25 at 10:50 a.m., Resident B and C's record were reviewed. Both records lacked documentation of any initial and/or ongoing assessments for the use and appropriateness of bed mobility devices. During an interview on 7/22/25 at 11:00 a.m., the Administrator indicated there was no facility policy to address bed rails or mobility devices, but the facility followed the Residential Regulations to keep a resident's			

environment free from the potential from accidents. The Administrator indicated staff would be in-serviced to notify the Administrator and Maintenance Director if a new device was noted to be installed by a family member.

Based on observation and interview, the facility failed to ensure mobility devices were appropriately installed and routinely inspected for safety monitoring to prevent the potential for accidents for 2 of 2 residents reviewed for mobility devices (Residents B and C).

Findings include:

On 7/21/25 at 11:10 a.m., Resident B was observed. He was seated on the edge of his bed, and the head of the bed was elevated at an approximately 45 degree angle so that Resident B was upright. There was a white metal mobility bar observed with two legs to the floor and two legs that went under the mattress. There was a large gap between the edge of the mattress and the edge of the rail. When Resident B adjusted his position to sit farther up in bed, he grabbed the mobility bar, which wobbled and slid under the mattress, and the two legs came off the floor.

On 7/21/25 at 12:50 p.m.,

	Resident C's room was observed. There was a mobility bar installed under his mattress with two rails and two legs that went to the floor. The mobility bar easily slid towards and away from the mattress. On 7/22/25 at 10:10 a.m., Resident B's mobility device was observed with the Maintenance Director. He indicated he was not aware a mobility bar had been installed to the resident's bed, and it did not appear to be installed correctly as there was a large gap between the mattress and the rail. The Maintenance Director lifted the mattress and confirmed the security straps for the rail were loose and incorrectly tied to the bed frame. On 7/22/25 at 10:15 a.m., Resident C's mobility device was observed with the Maintenance Director. He indicated he was not aware Resident C had a mobility bar installed. He maneuvered the device and indicated it easily slid away from the mattress. He lifted the mattress to reveal that the device had no security straps. During an interview on 7/22/25 at 10:40 a.m., the Maintenance Director indicated there was no facility policy for bed rail or mobility device use because the facility did not allow those items			

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R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following:	R 0302	All over the counter medications have labels on them that include the following: Resident name	08/10/2025

	(A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observations and interviews, the facility failed to label over the counter drugs with the resident's physician and failed to date eye drops when opened for 1 of 2 medication rooms reviewed. Findings include: On 7/21/25 at 10:05 a.m., the medication room was reviewed. The facility utilized storage cabinets with bins for each resident on the unit. Inside the bins were over the counter medications, along with prescription medications. a. Resident C had anti-diarrheal 2 mg (milligram) medication in his bin with no physician name on the label. b. Resident 8 had preservation AREDS 2 tablets, Tums, Acetaminophen 325mg, antidiarrheal 2 mg and magnesium in her bin with no physician name on the labels. c. Resident 2 had aspirin 81 mg with no physician name on the		Physician name Expiration date Name of drug Strength of medication All eye drops will have the date opened on the bottle or package. Routine med room audits will be conducted weekly for the next 6 months by our Director of Health to verify the OTC meds are labeled. Clinical in-service will be held on medication storage for all clinical staff by August 10, 2025.	

label. She had a bottle of refresh eye drops and tetrahydrozoline eye drops with no date to indicate when it was opened.

d. Resident 9 had vitamin D3 25 mcg (microgram)/1000 u (units) in her bin with no physician name on the label.

e. Resident 10 had calcium 600 mg, B complex vitamin, and melatonin 5 mg with no physician name on the labels.

f. Resident 11 had vitamin C 500 mg, Viactive, vitamin D and Culturelle with no physician name on the label.

g. Residetn 12 had aspirin 81 mg with no physician name on the label.

h. Resident 13 had a bottle of atropine 1% eye drops with no date to indicate when it was opened.

i. Resident 14 had a bottle of refresh eye drops with no date to indicate when it was opened.

j. Resident 3 had a bottle of latanoprost 0.005% eye drops with no date to indicate when it was opened.

A policy titled, "Medication Storage" was provided by the Director of Health (DOH) on 7/22/25 at 10:20 a.m. There was no mention of labeling over

	the counter medications and dating eye drops. Based on observations and interviews, the facility failed to label over the counter drugs with the resident's physician and failed to date eye drops when opened for 1 of 2 medication rooms reviewed. Findings include: On 7/21/25 at 10:05 a.m., the medication room was reviewed. The facility utilized storage cabinets with bins for each resident on the unit. Inside the bins were over the counter medications, along with prescription medications. a. Resident C had anti-diarrheal 2 mg (milligram) medication in his bin with no physician name on the label. b. Resident 8 had preservation AREDS 2 tablets, Tums, Acetaminophen 325mg, antidiarrheal 2 mg and magnesium in her bin with no physician name on the labels. c. Resident 2 had aspirin 81 mg with no physician name on the label. She had a bottle of refresh eye drops and tetrahydrozoline eye drops with no date to indicate when it was opened. d. Resident 9 had vitamin D3 25 mcg (microgram)/1000 u (units)			

	in her bin with no physician name on the label. e. Resident 10 had calcium 600 mg, B complex vitamin, and melatonin 5 mg with no physician name on the labels. f. Resident 11 had vitamin C 500 mg, Viactive, vitamin D and Culturelle with no physician name on the label. g. Residetn 12 had aspirin 81 mg with no physician name on the label. h. Resident 13 had a bottle of atropine 1% eye drops with no date to indicate when it was opened. i. Resident 14 had a bottle of refresh eye drops with no date to indicate when it was opened. j. Resident 3 had a bottle of latanoprost 0.005% eye drops with no date to indicate when it was opened. A policy titled, "Medication Storage" was provided by the Director of Health (DOH) on 7/22/25 at 10:20 a.m. There was no mention of labeling over the counter medications and dating eye drops.			
R 0329	Activities Programs - Noncompliance 410 IAC 16.2-5-7.1(d)(1-3)	R 0329	Activity Director has been enrolled in the class and will have all hours completed by 9/30/25.	09/30/2025

(d) After July 1, 1984, any person who has not completed an activities director course approved by the division shall receive consultation until the person has completed such a course. Consultation shall be provided by:

(1) a recreation therapist;

(2) an occupational therapist or occupational therapist assistant; or

(3) a person who has completed a division approved course and has two (2) years of experience.

Based on record review and interview, the facility failed to ensure the Activity Director obtained a 90-hours state approved Activity Director Certification within the required timeframe after she was hired as the facility's Activity Director. This deficient practice had the potential to affect 36 of 36 residents residing at the facility.

Findings include:

On 7/21/25 at 1:00 p.m., The Activity Director's employee record was reviewed and lacked documentation of a state-approved certification.

On7/22/25 at 9:10 a.m., the Administrator provided a document dated April 2025 which indicated the Activity Director had some Continuing Education from the Activity Professionals National

Credentialing Center (APNCC), but did not specify the content of the course, and/or the hours obtained.

On 7/22/25 at 11:00 a.m., the Administrator indicated she called APNCC and confirmed the Activity Director had completed a continuing education "Chat," but she had not signed up for or started the full 90-hour accreditation certification process. The Administrator indicated she told the Activity Director to sign up for the correct class and get it done. The Administrator indicated the facility followed the Residential and State Regulations.

Based on record review and interview, the facility failed to ensure the Activity Director obtained a 90-hours state approved Activity Director Certification within the required timeframe after she was hired as the facility's Activity Director. This deficient practice had the potential to affect 36 of 36 residents residing at the facility.

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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