STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/03/2022

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 the Investigation of Complaint IN00374273. Complaint IN00374273 - Substantiated. State Residential Findings related to the allegations are cited at R117 & R241. An unrelated deficiency was cited. Survey date: March 3, 2022. Facility number: 014376 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 17, 2022.	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b)	R 0117	In response to R 117, The Executive Director asked Guardian	03/14/2022

	(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, 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.		Pharmacy 3/04/22 to conduct CPR and first aid classes to ensure nursing staff on duty have current First Aid certification, as well as CPR certification. Classes were completed on 3/14/22. The schedules will have a red asterisk* beside the name of staff member who is first aid certified to ensure at least one person on each shift has the certification. This will be ongoing with no end date.	

	Based on interview and record review, the facility failed to ensure at least once person on a shift was first aid certified when a resident (Resident C) sustained a severe skin tear which required first aid treatment for 1 of 1 shift reviewed for first aid training and effected 1 of 36 residents who resided in the facility. Findings include: On 3/3/22 at 11:15 a.m., Resident C's medical record was reviewed. A nursing progress note, dated 2/4/22 at 7:23 p.m., indicated, Resident C sustained another skin tear to her leg as the aid was trying to put her into bed for the night. The Assistant Director of Nursing (ADON) was notified and gave instructions to contact Hospice. On 3/2/22 at 2:48 p.m., the contracted Hospice Agency provided documentation of an on-call visit and assessment. The progress note was dated 2/4/22 at 8:25 p.m. and indicated, "...[visit] due to new skin tear to LLE [left lower extremity]. Facility staff were putting [Resident C] to bed and noticed the skin tear. [Facility staff] cleaned the wound and applied bacitracin and covered it with gauze ... requested a prophylactic antibiotic be ordered due to the skin tear			

being so large. Skin tear is about 8 inches long ... NP [Nurse Practitioner] ordered Keflex (antibiotic) 500 mg 1 cap (capsule) twice a day for 7 days ...New wound care orders: Wound care to LLE; etiology skin tear; cleanse with wound cleanser and sterile gauze, allow to dry, apply bacitracin (antibiotic), apply rolled gauze and secure with tape. To be completed by facility nurse in hospice nurse absence. 2x (two times) week and/or if soiled/dislodged. May d/c (discontinue) when healed ...."

During an interview, on 3/3/22 at 1:20 p.m., the ADON indicated she had been notified of the skin tear Resident C obtained on 2/4/22. QMA 8 (Qualified Medication Aid) sent her a picture of the skin tear, which the ADON sent to the Director of Nursing (DON). The ADON indicated, QMA 8 cleaned and dressed the wound and put a temporary bandage on it until Hospice could come out.

On 3/3/22 at 3:17 p.m., the Executive Director (ED) provided a copy of a certificate for QMA 8. The certificate indicated QMA 8 had completed a CPR (cardiopulmonary resuscitation) course, but the certificate did not include First Aid training.

During an interview, on 3/3/22 at

	3:30 p.m., the ED indicated QMA 8 and 9 were both in the building the night Resident C obtained the skin tear and were the designated "nurses" to provide first aid if needed. The ED was unable to produce documentation that neither QMA 8 nor 9 had completed first aid training because they were under the impression, the CPR course included first aid as well. The ED indicated, the facility followed state regulations which required at least one person who was CPR and first aid certified to be on every shift. This state residential finding relates to Complaint IN00374273. Based on interview and record review, the facility failed to ensure at least once person on a shift was first aid certified when a resident (Resident C) sustained a severe skin tear which required first aid treatment for 1 of 1 shift reviewed for first aid training and effected 1 of 36 residents who resided in the facility. Findings include: On 3/3/22 at 11:15 a.m., Resident C's medical record was reviewed. A nursing progress note, dated 2/4/22 at 7:23 p.m., indicated, Resident C sustained another skin tear to her leg as the aid was trying to			

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	This state residential finding relates to Complaint IN00374273.			
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure all restrooms the memory care (MC) residents had access to had restroom water temperatures less than 120 degrees Fahrenheit (F) for 36 of 36 residents residing in the facility. Findings include: During a tour with the Maintenance Director (MM), on 3/3//22 at 1:53 p.m., hot water temperatures were checked with the facility's ambient digital thermometer: a. Resident E's restroom hot water temperature was 126.5 degrees F.	R 0187	In response to R 187, Maintenance Director adjusted hot water heater and rechecked on 3/3/22 to ensure the water was not hotter than 120 degrees Fahrenheit. The water was checked again on 3/4/22 and will be checked weekly thereafter. A digital probe thermometer has been purchased. A log page will be entered into the maintenance book and all weekly water temps will be documented. The book will be checked by the executive director for the next 6 months to ensure the water temps are being logged as required.	03/03/2022

b. Resident F's restroom hot water temperature was 125 degrees F.

c. Resident G's restroom hot water temperature was 125.7 degrees F.

d. Resident H's restroom hot water temperature was 121.1 degrees F.

f. Resident J's restroom hot water temperature was 121.8 degrees F.

g. The unlocked public restroom hot water temperature was 126.5 degrees F.

On 3/3/22, several MC residents were observed walking past the unlocked public restrooms.

During an interview, on 3/3/22 at 2:30 p.m., the MM indicated the resident and public restroom's hot water temperatures should not have been more than 120 degrees F. The MC residents had access to the public restrooms. He did not have a digital water temperature probe thermometer; he used an ambient digital thermometer. He was told to use the ambient air thermometer and point the red dot in the pool of water. He indicated he did not wait for the water temperature to get to the hottest point. The facility had three hot water heaters, only one had a thermometer on it. It was set for 130 degrees before

	the mixing valve, he indicated he turned it down to 122. He had worked here two weeks and wasn't sure how to do the hot water temperatures. During an interview, on 3/3/22 at 2:39 p.m., the MM indicated he had turned the temperature down on all the hot water heaters. During an interview, on 3/3/22 at 2:30 p.m., the Executive Director (ED) indicated the hot water temperatures should have been no higher than 120 degrees F. A policy, titled, Water Temperature Log," dated February 2022, was provided by the MM, on 3/3/22 at 2:20 p.m. He indicated the policy for hot water temperatures was stated at the bottom of the page. A review of the document, indicated, " ...Abide by Specific State Regulation for Water Temperatures. Water temperature need to be between 100-120 degrees. Notify your E.D. if temperatures are not at state specified temperatures ...." Based on observation, interview, and record review, the facility failed to ensure all restrooms the memory care (MC) residents had access to had restroom water temperatures less than 120			

degrees Fahrenheit (F) for 36 of 36 residents residing in the facility.

Findings include:

During a tour with the Maintenance Director (MM), on 3/3//22 at 1:53 p.m., hot water temperatures were checked with the facility's ambient digital thermometer:

a. Resident E's restroom hot water temperature was 126.5 degrees F.

b. Resident F's restroom hot water temperature was 125 degrees F.

c. Resident G's restroom hot water temperature was 125.7 degrees F.

d. Resident H's restroom hot water temperature was 121.1 degrees F.

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R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure protective sleeves were in place as the physician ordered for a resident with a history of skin tears sustained during transfers which resulted in actual harm when the resident sustained an 8-inch-long skin tear during a transfer for 1 of 3 residents reviewed for quality of care (Resident C).	R 0241	All doctor ordered treatments will be followed and if DME is unavailable we will contact the physician. All DME will be entered into the EMAR as a scheduled treatment and the nursing staff will implement any physician orders. This will be ongoing, no end date. If third party providers fail to/or are unable to provide supplies or services that have been ordered by physician, we will contact physician for alternative options. However, we will have geriatric sleeves available for use with residents who may be susceptible to skin tears.	03/04/2022

Findings include:

On 3/3/22 at 11:15 a.m., Resident C's medical record was reviewed.

Resident C was a 90-year-old female who admitted to the facility, on 8/20/2021, with diagnoses which included, but were not limited to vascular dementia. Resident C also received services from a contracted Hospice Agency.

The most recent service plan was, dated 10/18/22, and indicated Resident C was fully dependent on staff for several activities of daily living, which included, but was not limited to: dressing, transfers and eating.

A nursing progress note, dated 1/11/21 at 9:05 a.m., indicated Resident C sustained a skin tear during a transfer to her wheelchair. Hospice had been notified and would be out that day to take care of the skin tear.

On 3/2/22 at 3:29 p.m., the contracted Hospice Agency provided a physician order, dated 1/11/22 at 10:44 a.m., which indicated, " ...wound care to RLE [right lower extremity] wound; etiology [cause] skin tear; 2 times a week and as needed if dislodged/soiled, cleanse wound with wound cleanser, allow to dry, apply self-adhesive dressing, if wound bleeding, place gauze on

exterior of dressing and wrap with Coban, may d/c [discontinue] when healed. To be completed by facility nurse in hospice nurse absence, "...Additionally, the physician order indicated ...Protective arm and leg sleeves on during the day off at night...."

Resident C's January and February Treatment Administration Records (TAR) were reviewed. The TARs lacked documentation of Resident C's protective sleeve use.

A nursing progress note, dated 1/11/22 at 7:10 p.m., indicated Resident C needed footrests put back on her wheelchair as she was no longer able to lift her legs.

A nursing progress note, dated 2/4/22 at 7:23 p.m., indicated, Resident C sustained another skin tear to her leg as the aid was trying to put her into bed for the night. The ADON (Assistant Director of Nursing) was notified and gave instructions to contact Hospice.

On 3/2/22 at 2:48 p.m., the contracted Hospice Agency provided documentation of an on-call visit and assessment. The progress note was dated 2/4/22 at 8:25 p.m. and indicated, "...[visit] due to new skin tear to LLE [left lower

extremity]. Facility staff were putting [Resident C] to bed and noticed the skin tear. [Facility staff] cleaned the wound and applied bacitracin and covered it with gauze ...requested a prophylactic antibiotic be ordered due to the skin tear being so large. Skin tear is about 8 inches long ...NP [Nurse Practitioner] ordered Keflex (antibiotic) 500 mg 1 cap (capsule) twice a day for 7 days ...New wound care orders: Wound care to LLE; etiology skin tear; cleanse with wound cleanser and sterile gauze, allow to dry, apply bacitracin (antibiotic), apply rolled gauze and secure with tape. To be completed by facility nurse in hospice nurse absence. 2x (two times) week and/or if soiled/dislodged. May d/c when healed ...."

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On 3/3/22 at 1:30 p.m., the Executive Director (ED)

provided a copy of the printed picture of Resident C's skin tear. The picture was observed. The picture captured Resident C's legs from the knees to her ankles. Her legs were crossed, and her pants legs were pulled up to reveal the skin tear. The skin tear ran vertically on the outside of her left leg, from near the bottom of her knee, to the middle of her calf. It was oblong in shape, with a slightly curved hook at the bottom. The edges of the tear were clean, and a skin flap was visible. A bandage with initials and dated 2/2/22 was also noted on Resident C's right leg. At this time, the DON indicated the bandage pictured on her right leg was from the healing skin tear she received on 1/11/22.

During an interview, on 3/3/22 at 1:45 p.m., the DON indicated they were not able to identify what caused the skin tear but thought she must have got snagged on a part of her wheelchair during the transfer.

During an interview, on 3/3/22 at 2:13 p.m., with the ED and DON present, the picture of Resident C's skin tear from 2/4/22 was observed a second time. The ED and DON concurred, Resident C's protective sleeves were not in place as ordered, due to the previous skin tear she received during the same type of transfer. The ED

indicated, Resident C should have had her protective sleeves on to help prevent the possibility of sustaining additional skin tears, and/or reducing the severity of new skin injuries.

During an interview, on 3/3/22 at 3:06 p.m., the DON indicated, when Hospice places a new order, such as Resident C's protective sleeves, whether it is a medication or treatment, the order should be added to the Medical Record Software so that it would generate the order and instructions for the nurse to complete. Resident C's protective sleeves had not been placed on the TAR and should have been.

This state residential finding relates to Complaint IN00374273.

Based on observation, interview, and record review, the facility failed to ensure protective sleeves were in place as the physician ordered for a resident with a history of skin tears sustained during transfers which resulted in actual harm when the resident sustained an 8-inch-long skin tear during a transfer for 1 of 3 residents reviewed for quality of care (Resident C).

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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