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	06/24/2024

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

(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: June 21 and 24, 2024 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 3, 2024.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherri Dawson	Executive Director	07/19/2024

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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	(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to ensure a new outbreak of COVID-19 was reported to Indiana Department of Health for 3 of 3 residents reviewed for COVID-19. Findings include: 1. On 6/24/24 at 10:00 a.m., Resident 6's medical record was reviewed for Infection Control Prevention, immunizations and infections. Resident 6 tested positive for Covid-19 on 5/15/24.	R 0090	R 090, the Administrator/Executive Director will report all new cases of COVID-19 to ISDH within 24 hours of the positive COVID test. Beginning immediately. Flu and Covid vaccine clinics are held annually. Resident's healthcare representatives are notified and authorizations are sent.	07/01/2024

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	His record lacked documentation of Covid-19 initial and/or booster vaccination series. The record lacked documentation of attempts to obtain/request his Covid-19 vaccination status, and the record lacked documentation of education provided to resident/representative of the benefits of vaccinations. 2. On 6/24/24 at 10:00 a.m., Resident 14's medical record was reviewed for Infection Control Prevention, immunizations and infections. Resident 14 tested positive for Covid-19 on 5/15/24. Her record lacked documentation of a booster series vaccinations. The record lacked documentation of attempts to educate or offer the most recent Covid-19 booster series vaccinations. 3. On 6/24/24 at 10:00 a.m., Resident 37's medical record was reviewed for Infection Control Prevention, immunizations and infections. Resident 37 tested positive for Covid-19 on 5/18/24. The record lacked documentation of attempts to educate or offer the most recent Covid-19 booster series vaccinations. During an interview on 6/24/24 at 1:45 p.m., the Executive Director (ED) indicated she was not aware that a new Covid-19 outbreak should be reported to local and state health departments. On 6/24/24 at 2:00 p.m., the Director of Health Services (DHS) provided a copy of the current, but undated and untitled facility policy. The policy indicated, " ...2. COVID-19 Plan ... Company Representative identified for communications with public health authorities during outbreak-Community ED ... 6. Identification and Management of Ill Residents ... Local Health		Resident 6 was vaccinated 4 times for COVID, records available. Resident 14 was vaccinated 2 times for COVID, records available. Resident 37 was vaccinated 3 times for COVID, records available.	

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	Department and State Regulatory agency should be notified immediately of COVID-19 illness ...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure all foods were labeled and dated with open and expiration dates, large trash can were covered, hand hygiene in the kitchen was completed correctly, lunch foods were maintained at a safe temperature before serving, the thermometer was cleaned it a sanitary way between foods, for two of two observations. These deficiencies had the potential to affect 36 of 36 residents served from the facility kitchens. Findings include: 1. On 6/21/24 at 9:50 a.m., Certified Nurse Aide (CNA) 5 started the Lakeside kitchen tour. She provided the gluten-free bread's manufacturer's expiration date of 7/30/24, there was no open date for the bread. On 6/21/23 at 9:53 a.m., the Maintenance Director (MM) indicated there were no culinary staff to provide the kitchen tours. He indicated the yellow and Devil's food cake mix both had open dates of 5/1/24, but no expiration dates. In the Lakeside freezer, plastic bags of unlabeled and undated tortellini and egg omelets with no open or expiration dates and hash browns and hot dogs with no expiration dates were observed.	R 0273	R 273, the Culinary Manager will check food supply for open dates and expiration dates 2 times weekly. Beginning immediately. In-services will be conducted for all culinary staff on the importance of labeling food with the open date and expiration date. The In-service will include the proper storage of food. In-service on trash can covers and cleaning the food thermometer to maintain sanitation. In-service on correct food temperatures for serving. In-service on hair nets being worn in the kitchen at all times. All employees will be in-serviced that personal items are not allowed in our refrigerators and freezers in the kitchen. Culinary Manager will check freezers and refrigerators 4 times weekly to make sure employees are not using for personal use. Beginning immediately. A handwashing in-service was completed on 6/27/24 for all staff. Food labeling and food temperatures in-service will be	07/25/2024

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	In the Lakeside refrigerator, an unlabeled container, dated 6/17/24, had no expiration date. The MM indicated he thought it was pudding. A plastic bag of prepared salad was not sealed. Several items had open dates, but no expiration dates: ham quiche, lasagna, large package of ham, whipped cream, barbequed pork, and 2 bags of carrots. 2. On 6/21/24 at 10:15 a.m., the Cabin kitchen was observed with the MM. He did not wear a hair net while in the kitchen. White bread with no open date, had a manufacturer's expiration date of 2/12/24. Toasted oats cereal was not sealed and only rolled down. In the Cabin freezer, cookies dated 6/12/24 and whipped cream dated 6/11/24, had open dates but no expiration dates. A plastic bag of chicken patties, had an illegible open date and no expiration date. An employee's smoothie was observed in the resident freezer. On 6/21/24 at 11:26 a.m., a large open trash can was observed in the Cabin kitchen. On 6/21/24 at 12:16 p.m., a large open trash can was observed in the Cabin kitchen. On 6/21/24 at 12:18 p.m., Chef 9 was observed arriving with covered containers of resident's lunch foods. She had prepared them in the Lakeside kitchen and brought them to the Cabin kitchen to serve. She was observed to wash her hands, but turned the faucet off with her bare hands, then dried them on paper towels. She threw the paper towels in the large open trash can. On 6/21/23 at 12:22 p.m., Chef 9 indicated the temperature of the barbequed meatballs were 160		done by 7/25/24 In-service on hair nets will be completed 7/25/24 In-service for food items in refrigerators and freezers will be 7/25/24	

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	degrees Fahrenheit (F), the macaroni and cheese was 161 degrees F, and the cole slaw was 52 degrees F. She was observed to wipe the thermometer on a kitchen towel between taking the temperatures of the foods. During an interview, on 6/21/23 at 12:50 p.m., Chef 9 indicated she should have had ice under the cole slaw bowl to keep it cold, but didn't think of it. She did not know if the trash cans should have had lids on them, but the food should have been dated correctly. A current policy, titled, "Food Storage," with no date, was provided by the Executive Director (ED), on 6/24/24 at 2:44 p.m. A review of the policy indicated, " ...All containers must be labeled with the contents and date food items was placed in storage as well as the food expiration date ...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under, "410 IAC 7-24-138: Effectiveness of hair restraint., Sec. 138.... (b) food employees shall wear hair restraints, ...that are designed and worn to effectively keep hair from contacting: (1) exposed food; (2) clean equipment, utensils...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under, "410 IAC 7-24-392 Covering receptacles Sec. 392. (a) Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (1) inside the retail food establishment if the receptacles and units: (A) contain food residue and are not in continuous use; or (B) after they are filled; and (2) with tight-fitting lids or doors if kept outside the retail			

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	food establishment ...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under, "410 IAC 16.2-5-5.1 Food and nutritional services, Sec. 5.1. (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident's room. (d) All modified diets shall be prescribed by the attending physician. (e) All food shall be served at a safe and appropriate temperature. (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to date medications when opened and	R 0300	R 300, a. The lorazepam for resident #27	07/08/2024

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	labeled over the counter (OTC) medication for 1 of 1 medication room and 1 of 1 medication room refrigerator. Findings include: On 6/21/24 at 10:32 a.m., the Lake Side medication room was observed. The following medications lacked a date to indicate when it was opened or a label. a. Resident 27 had a bottle of lorazepam 2 mg/ml (milligram/milliliter). The bottle lacked a date to indicate when it was opened. b. Observed bisacodyl (used for constipation) 10 mg and acetaminophen (pain reliever) inside the same plastic bag without a name or label. c. Resident 9 had a bottle of latanoprost (use to treat glaucoma). It lacked a date to indicate when it was opened. d. Resident 10 had four bottles of vitamin D3 without a label on the bottles. e. Resident 10 had two boxes of Systane (used for dry eyes) without a label on the boxes. f. Resident 11 had a bottle of acetaminophen without a label on the bottle. g. Resident 12 had three bottles of AREDS (vitamin) with no label, only her name. h. Resident 13 had a bottle of advil (used for pain) with her name only. She had two bottles of acetaminophen 500 mg with her name and apartment number. She had a bottle of ibuprofen with just her name on it. A policy titled, "Medication Storage," was provided by the Director of Nursing (DON) on 6/24/24 at 2:32 p.m. It indicated, " ... All medications are to be stored ...If a resident has other medications other than those taken orally they will be kept ..."		was discarded and a new bottle has arrived for use. Open date, and labeled with Dr. name, resident name and dob. b. The biscodyl and acetaminophen have been separated and labeled. Labeled with Dr. name, resident name and dob. c. Resident 9's bottle of latanoprost has been dated. Labeled with Dr. name, resident name and dob. d. Resident 10's bottles of vitamin D3 have been labeled. Labeled with Dr. name, resident name and dob. e. Resident 10's bottles of Systane have been labeled. Labeled with Dr. name, resident name and dob. f. Resident 11's bottle of acetaminophen has been labeled with Dr. name, resident name and dob. g. Resident 12's bottles of AREDS have been labeled with Dr. name, resident name and dob. h. Resident 13's bottle of Advil, acetaminophen, ibuprofen have been labeled with Dr. name, resident name and dob. All medications in the medication rooms have been identified and labeled with resident's name, Dr. name, and dob. All over-the-counter medications are properly labeled.	

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			Weekly medication room audits will be done by the Director of Health and ongoing in-services on medication storage will be held with clinical team monthly. The first clinical meeting took place on July 8, 2024.	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation and interview, the facility failed to maintain infection control practices while passing a sublingual (SL) for 1 of 1 resident (Resident 8). Findings include: On 6/24/24 at 9:30 a.m., during a medication pass with licensed practical nurse (LPN) 13, she was prepping medications for Resident 8. Resident 8 had an order for lorazepam 2mg/ml (milligram/milliliter) take 0.5mg/0.5ml SL every 6 hours. LPN 13 took a syringe, that had previously been used, from a cup that was sitting on the sink, rinsed it, and drew up resident's medication. When asked about the used oral syringes in the clear plastic cup with water in it, LPN 13 indicated another nurse will disinfect the syringes with a wipe. She indicated she will typically get a new syringe, but she did not during medication pass.	R 0406	R 406, Single use oral syringes have been ordered. Clinical staff have been in-serviced on the single use oral syringes. All medications needing to be given with an oral syringe are given with individually wrapped oral syringes and disposed immediately after use. In-service done on 7/8/24.	07/08/2024

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	During an interview with the director of nursing services (DON) on 6/24/24 at 2:32 p.m., she indicated she would not have a policy on re-using oral syringes because that is not their practice.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (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 residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. A. Based on observation and interview, the facility failed to maintain infection control practices while passing a sublingual (SL) for 1 of 1 resident (Resident 8). B. Based on interview and record review, the facility failed to ensure an infection control system was implemented to analyze new/ongoing infections throughout the facility in order to identify trends for 4 of 6 months of infection control reviewed. This deficient practice had the potential to affect 36 of 36 residents who resided in the facility. Findings include: A. On 6/24/24 at 9:30 a.m., during a medication pass with Licensed Practical Nurse (LPN) 13, she was prepping medications for Resident 8.	R 0407	R 407, The facility has established an infection control system that identifies patterns of known infectious symptoms. Infection control tracking binder is updated and located in Director of Health's office. Every 30 days when our pharmacy sends our antibiotic report the binder will go to the Administrator for compliance verification. When we obtain cultures for UTI infections, they are reported in electronic medical records. Due to many of our residents being on hospice services, the cultures are not obtained and only symptoms are treated.	07/01/2024

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	Resident 8 had an order for lorazepam 2 milligrams per milliliter (mg/ml) to take 0.5mg/0.5ml sublingual (SL) every 6 hours. LPN 13 took a syringe, that had previously been used, from a cup that was sitting on the sink, rinsed it in the sink, and drew up resident's medication. When asked about the used oral syringes in the clear plastic cup with water in it, LPN 13 indicated another nurse will disinfect the syringes with a wipe. She indicated she will typically get a new syringe, but she did not during medication pass. During an interview with the Director of Health Services (DHS) on 6/24/24 at 2:32 p.m., she indicated she would not have a policy on re-using oral syringes because that was not their practice. B. During an interview on 6/24/24 at 10:23 a.m., the Director of Health Services (DHS) indicated she was in charge of the Infection Control program. At that time, she provided a binder for review which was titled, "Infection Control." The binder contained master copy materials of infection tracking logs which were blank, and other miscellaneous educational materials. When asked about her infection tracking procedures, the DHS indicated, it was kept in a separate binder, and she would have to find it. On 6/24/24 at 1:23 p.m., the DHS provided a second binder for review, titled, "Infection Control," which was reviewed at that time. The binder was separated by month back to January 2024. The months of January, February and March were blank. No infections were documented either on the map or on the surveillance log.		The suspected UTIs are being tracked in the infection control binder. Ongoing in-services on infection control will be held with all staff one time per quarter. Our families will be given infection control information in our monthly newsletter every quarter. Reporting communicable diseases to ISDH is ongoing. They will be reported within 24 hours. Resident 6 was vaccinated 4 times for COVID, record available. Resident 14 was vaccinated 2 times for COVID, record available. Resident 37 was vaccinated 3 times for COVID, record available.	

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	In April, one urinary tract infection (UTI) was noted, but lacked documentation that a culture of the bacteria which had caused the infection had been obtained so that a targeted antibiotic was prescribed. In May, there was an increase in UTIs as two new infections were documented. The surveillance log lacked documentation that cultures of the bacteria which had caused the infections had been obtained so that targeted antibiotics were prescribed. On 6/24/24 at 10:00 a.m., Residents 6, 14, and 37's medical records were reviewed for Infection Control Prevention, immunizations and infections and it was revealed all three residents had tested positive for COVID-19. Residents 6 and 14 had both tested positive for Covid-19 on 5/15/24, and Resident 37 tested positive for COVID-19 on 5/18/24. The May infection surveillance log lacked documentation of the COVID-19 outbreak. During a follow up interview on 6/24/24 at 1:30 p.m., the DHS indicated she did not have information to provide for the months of January, February, and March and she had not included the COVID-19 outbreak on her infection log and there was not a separate respiratory infection surveillance log. The DHS did not know if cultures had been obtained for the above-mentioned UTIs and she had not provided targeted education to staff regarding the increase in number of UTIs. On 6/24/24 at 1:35 p.m., the DHS provided a copy of current, but undated facility policy titled,			

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	06/24/2024

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

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	"Infection Control." The policy indicated, "Purpose: to prevent the spread of infections from one resident to another, to protect staff from infections, to prevent the transfer of communicable diseases, to prevent the spread of infections through blood and body secretions ... Monitoring Staff/Resident for Infections/Disease: to track infections/diseases of staff and residents and provide information to evaluate trends or patters of infection and intervene if necessary ...." Cross reference R90.			