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	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE GRANGER	430 CLEVELAND RD GRANGER, IN 46530

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00430785. Complaint IN00430785 - No deficiencies related to the allegations are cited. Survey dates: April 1 & 2, 2024 Facility number: 002656 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/8/24.	R 0000	b>	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Carney	Executive Director	04/17/2024

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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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to complete a fire drill every quarter on each shift. Finding includes: On 4/1/2024, the Plant Operations Manager provided 12 months of fire drills completed for the past year. The Fire Drill Report Sheets lacked documentation to show a Fire Drill had been conducted on the evening and night shift for the first quarter (January, February & March), evening shift for the third quarter (July, August, & September), night shift for the second quarter (April, May & June), and night shift for the fourth quarter (October, November, & December). During an interview, on 4/1/2024 at 3:15 P.M., the Maintenance Director indicated he had not completed a fire drill each quarter on a different shift as required. On 4/2/2024 at 1:45 P.M., the Maintenance Director provided the policy titled," Fire Drills", dated 4/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...Fire drills shall be conducted on a monthly basis with every shift participating at least once per quarter, or as per state regulation...."	R 0092	**R 092 Based on observation, record review and interview, the facility failed to complete a fire drill every quarter on each shift. This deficient practice had the potential to affect 39 of 39 residents who resided in the community.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Maintenance Director will immediately begin monthly fire drills, rotating between 1st, 2nd, and 3rd shift each month of the quarter per community policy. No residents were affected by the alleged deficient practice. · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; alleged deficient practice had the potential to affect all residents. Maintenance Director in-serviced to fire drill policy on 4/4/24 by the Executive Director. No**	04/15/2024

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			residents were affected by the alleged deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Maintenance Director will create an annual fire drill schedule verifying proper rotation of shifts. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED or designee will monitor Fire Drills are done appropriately each month x 12 months.· By what date the systemic changes will be completed. 4.15.24	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were approved by a licensed nurse prior to	R 0246	**R 246 Based on observation, record review and interview, the facility failed to ensure PRN medications administered by**	04/15/2024

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	administration, for 4 of 8 residents reviewed for medications. (Residents B, C, D, 7, & 8) Findings include: 1. A record review was completed on 4/2/2024 at 8:46 A.M. Resident B's diagnoses included, but were not limited to Parkinson's disease, dementia, anxiety and overactive bladder. The MAR (Medication Administration Record), dated March 2024, indicated a PRN (as needed) Acetaminophen (Tylenol) had been administered on 3/23/2024 at 11:29 A.M. & 5:07 P.M., and on 3/24/2024 at 11:42 A.M., by QMA 4, without documentation of a licensed nurse approving the administration of the Acetaminophen. 2. A record review was completed on 4/2/2024 at 9:48 A.M. Resident C's diagnoses included, but were not limited to asthma, congestive heart failure, and pulmonary fibrosis. The MAR, dated March 2024, indicated a PRN Morphine (narcotic) had been administered on 3/13/2024 at 7:58 P.M., by QMA 4, without documentation of a licensed nurse approving the administration of the narcotic. 3. A record review was completed on 4/2/24 at 10:05 A.M. Resident D's diagnoses included, but were not limited to dementia, hypertension, and anxiety. The MAR, dated March 2024, indicated a PRN Tylenol Extra Strength had been administered on 3/9/2024 at 2:48 P.M., and on 3/24/2024 at 5:44 P.M., by QMA 4 and on 3/17 and 3/30/2024 by QMA 6, without documentation of a licensed nurse approving the administration of the Tylenol.		**QMA were approved by a licensed nurse prior to administration. This deficient practice had the potential to affect 13 of 13 residents who have a doctor's order for PRN medication.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A review of records of current prn medications was complete on 4.4.24; with 4 instances of prn medications given without approval documentation from a licensed nurse. In-service for PRN medication administration completed for qualified medication aides (QMA's) on 4.5.24; 4 of 13 residents were affected by alleged deficient practice .** **· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; alleged deficient practice had the potential to affect residents with PRN medication orders. HWD or designee to review PRN medication audit report to verify medications given by QMA were approved by a**	

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	During an interview, on 4/2/2024 at 12:20 P.M., the Director of Nursing indicated the QMA's should have documented in the record the nurse's approval was received.4. The record for Resident 7 was reviewed on 4/1/2024 at 10:42 A.M. Physician's Orders, dated 1/24/2024, indicated Tylenol ES 500 milligrams (mg), give 1 tablet by mouth every 6 hours as needed for pain. The Medication Administration Record (MAR) for January 2024, indicated on 1/30/2024 at 11:05 P.M., Qualified Medication Aide (QMA) 6 administered Tylenol 500 mg to Resident 7. Documentation of authorization from a licensed nurse could not be found in the record. During an interview, on 4/2/2024 at 9:59 A.M., the DON indicated QMA's were to get authorization from a licensed nurse and document it in the Progress Notes. 5. The record for Resident 8 was reviewed on 4/1/2024 at 2:36 P.M. Physician's Orders, dated 11/30/2023, indicated Tylenol ES 500 mg, give 1 tablet by mouth every 24 hours as needed for chronic pain syndrome. The Medication Administration Record (MAR) for December 2023, indicated on 12/15/2023 at 7:52 P.M., QMA 6 administered Tylenol 500 mg to Resident 8. Documentation of authorization from a licensed nurse could not be found in the record. During an interview, on 4/2/2024 at 9:59 A.M., the DON indicated QMA's are to get authorization from a licensed nurse and document it in the Progress Notes.		**licensed nurse prior to administration.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; HWD or designee will add additional instructions in EMAR for ~~all~~ PRN medications to state "QMA may not administer unless prior approval is received by a licensed nurse ".** **· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; HWD or designee will monitor PRN medications 5x weekly for 4 weeks; then 1xweekly for 4 weeks then 1x monthly for 3 months to verify that QMA's are receiving prior approval from a licensed nurse for all PRN medications.** **· By what date the systemic changes will be completed. 4.15.24** !--[if !supportAnnotations]-->	

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	On 4/1/2024 at 3:20 P.M., the DON provided a current policy, titled, "Medications & Treatments - P.R.N.", dated 5/2005. The policy included, but was not limited to, "...PRN medications may be administered by a Qualified Medication Aide (QMA) only upon authorization by a a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician should be documented in the resident's record indicating the time/date of the contact...."			
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, record review, and interview, the facility failed to store food under sanitary conditions, related to foods not tightly sealed, undated foods, and general cleanliness of the kitchen and kitchen equipment, for 1 of 1 kitchen observed. This issue had the potential to affect all residents who resided in the facility and received food from this dietary kitchen. Findings include: 1. On 4/1/2024 at 9:30 A.M., a kitchen tour was conducted with Cook 2. a. The following was observed in the dry storage area: - A bottle of sesame oil was not dated. - A container of vanilla icing was not dated. - A box of gluten free pasta was open, not sealed properly, and not dated. - Various types of canned goods were not dated.	R 0273	**R 273 Based on observation, record review and interview, the facility failed to store food under sanitary conditions, related to foods not tightly sealed, undated foods, and general cleanliness of the kitchen and kitchen equipment, for 1 of 1 kitchen observed. This deficient practice had the potential to affect 39 of 39 residents who consumed food.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;- Outdated food was disposed of 4.3.24**	04/15/2024

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	b. The following was observed in the walk-in refrigerator: - A bag of cheese cubes was open, not sealed properly, and not dated. - A package of cheese slices was open, not sealed properly, and not dated. c. The following was observed in the walk-in freezer: - A package of vegetable burgers was open, not sealed properly, and not dated. - A package of vegetable crumbles was open, not sealed properly, and not dated. - A package of catfish was open, not sealed properly, and not dated. d. The following was observed in the stand alone refrigerator: - A gallon container of milk was open and not dated. - 2 containers of leftovers that were not identified or dated. e. The following was observed on the stove and a shelf above a prep table: - 3 pots that were dark brown and black on the outside. - 4 small and 1 large non-stick pans missing the Teflon coating. During an interview, on 4/1/2024 at 9:50 A.M., Cook 2 indicated food should be dated when received from the vendor, and dated and sealed when opened. 2. On 4/2/2024 at 10:15 A.M., a follow up kitchen tour was conducted with the Dietary Services Supervisor (DSS) and the following was observed: - A trash can near the handwashing sink had a		**remaining food was labeled, dated, and sealed. Kitchen cleaned. No residents affected by alleged deficient practice.** **· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; alleged deficient practice had the potential to affect current residents. Deep clean of the kitchen including equipment completed on 4.4.24. Community audited-food in fridges, freezers and dry pantry on 4.3.24. Food is dated labeled and appropriately stored per community policy.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DSM (Dining service manager-verify that is his title on job description)to be retrained on dating and labeling food per community policy. DSM created a cleaning schedule for community, sanitation walk through and general sanitation of dining department on 4.8.24.** **· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	whitish substance dripped down the side. - A hand sanitizer dispenser next to the handwashing sink was dusty. - A floor fan near the food prep area was dusty. - 2 vents in the ceiling and the ceiling surrounding them were dusty. - All of the walls had areas of brownish-yellow grime. During an interview, on 4/2/2024 at 10:17 A.M., the DSS indicated walls, ceilings, fan, vents, trash can, and hand sanitizer should be clean. Pots and pans should be clean and he will order new non-stick pans. On 4/2/2024 at 12:18 P.M., the Administrator provided a current policy titled, "Labeling", dated 2005. The policy included, but was not limited to, "...All food items upon receipt from food vendors must have a date marked before putting in any storage...." and "...All prepared items)i.e. leftovers or prepared for next meal) must have a label with the name of item, date prepared, by whom, and date of discard...." On 4/2/2024 at 12:18 P.M., the Administrator provided a current policy titled, "Cleaning Schedule", dated 2005. The policy included, but was not limited to, "...In order to serve food in a safe and sanitary manner, a cleaning schedule must be posted and initiated to ensure that all cleaning tasks are completed...." and "...The Dining Services Management reviews the cleaning schedule to be certain that the cleaning is thoroughly completed...." On 4/2/2024 at 12:18 A.M., the Administrator provided a current policy titled, "Sanitation Checklist", dated 2005. The policy included, but was not limited to, "...All sanitation checklists		**assurance program will be put into place; ED or designee will monitor kitchen 5x weekly for 4 weeks; then 1xweekly for 4 weeks then 1x monthly for 3 months to verify that foods are properly dated and labeled, proper handwashing techniques are utilized and that a cleaning/sanitation schedule in the kitchen is implemented and utilized.** **· By what date the systemic changes will be completed. 4.15.24**	

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	(CIR, SEW etc) should be completed on a timely basis by Dining Services Management or designee...." 410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.			
R 0295 Bldg. 00	Based on observation, interview, and record review, the facility failed to secure medications appropriately in a resident's room, for 1 of 1 resident who was reviewed for self-administration of medication. (Resident 6) Finding includes: During an observation, on 4/1/2024 at 2:22 P.M., Resident 6 had prescription and over the counter medication bottles stored in a plastic container sitting next to his recliner. During an interview, on 4/1/2024 at 2:22 P.M., Resident 6 indicated he self-administered all his medications and did not lock his medications in his room. A record review for Resident 6 was completed on 4/1/2024 at 3:00 P.M. Resident 6's current Physician's Orders included an order to self-administer medications, dated 3/8/2024. During an interview, on 4/1/2024, QMA 4 indicated the resident self-administered his medications and she was under the assumption that, as long as the resident was not on a narcotic, then the medications did not need to be secured	R 0295	**R 295 Based on observation, record review and interview, the facility failed to secure medications appropriately in a resident's room. This deficient practice had the potential to affect 3 of 3 residents who self-administer medication.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents who self-administer medications will be provided with a lock box inside of apartment to house their medications.** **· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Residents that self-administer medications have the potential to be affected by the alleged**	04/22/2024

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	inside the room. QMA 4 indicated the resident was not on a narcotic medication, and if he was, then it would have to be double locked, and the administrator would have the other key. She indicated since the resident was alert and oriented, they had considered the lock on his door to be sufficient to keep residents from getting into his medications, but was unaware if his door was always kept locked. On 4/1/2024, at 2:40 P.M., QMA 4 provided the policy titled, "Resident Self-Administration of Medications," dated 03/2019, and indicated it was the policy currently being used by the facility. The policy indicated,"...Self-administered medications must be stored in a safe and secure place, which is not accessible to other residents...."		**deficient practice. In-service staff on lock box use for residents that self-administer medications on 4.17.24** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Provide residents, who are appropriate for self-administering medications, with a lock box. Educate residents with a lock box on use.** **· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ·HWD/designee to inspect proper use of lock box for residents that self-administer medications 5x's weekly for 4 weeks; 1 x weekly for 4 weeks; 1 x monthly for 3 months** **By what date the systemic changes will be completed. 4.22.24**	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication			

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	assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure Controlled Substance Audit Sheets were signed by the on-coming and off-going nursing staff, for 1 of 1 Controlled Substance Audit Sheet book reviewed. Finding includes: During an observation, on 4/2/2024, at 10:45 A.M., the Controlled Substance Audit Sheets, dated 3/15/2024 to 4/2/2024, had 11 missing signatures from both on-coming and off-going nursing staff. During an interview, on 4/2/2024, at 10:49 A.M., LPN 5 indicated nurses should have been signing to verify counts in the narcotic logbook before coming on to shift and when leaving. On 4/2/2024 at 1:43 P.M., the Director of Nursing provided the policy titled, "Medication and Treatments Controlled Substances Count", dated 4/2022, and indicated it was the policy currently used by the facility. The policy indicated, " ...An on-coming associate and an out-going associate should count each controlled substance and verify the amount of controlled substances remaining against the amount listed on the Individual Narcotic Log page .... If the number of controlled substances counted matches the number of doses, then the on-coming associate and an out-going associate should sign the Controlled Substance/MAR Change of Shift Audit Form ...."	R 0296	**R 296 Based on observation, record review and interview, the facility failed to ensure Controlled Substance Audit Sheets were signed by on-coming and off-going nursing staff. This deficient practice had the potential to affect 1 of 1 Controlled Substance Audit Sheet book.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. In-service completed 4.5.24 for nursing staff on Medication and Treatment Controlled Substances Count policy. No residents were affected by alleged deficient practice.** **· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; HWD completed audit of Controlled Substance count on 4.4.24, alleged deficient practice had the potential to effect current residents with a narcotic order. HWD or designee to review controlled substance count sheet to verify**	04/15/2024

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			signatures are in place. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Current nursing staff retrained to Medication and Treatment Controlled Substance Count Policy on 4.4.24 and on an ongoing basis. New nursing staff to be trained to the Medication and Treatment policy at hire and on an ongoing basis. On-coming nursing staff will review controlled substance count sheet to verify it is signed by out-going nursing staff.** **· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; HWD or designee will monitor controlled substance count sheet 5x weekly for 4 weeks; then 1xweekly for 4 weeks then 1x monthly for 3 months to verify controlled substance count sheet is signed per policy.** **· By what date the systemic changes will be completed 4.15.24**	

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	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE GRANGER	430 CLEVELAND RD GRANGER, IN 46530

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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, interview, and record review, the facility failed to ensure a medication refrigerator was clean, and failed to ensure staff foods were not stored in a medication refrigerator, for 1 of 1 medication refrigerator observed. Finding includes: During a medication storage observation, on 4/2/2024 at 11:00 A.M., the following was observed in the medication refrigerator: - the freezer section had a red substance stuck to the bottom of the shelf. - a plate of half eaten baked potatoes, sausage and vegetable salad. - 2 plastic containers of a red substance. - a small plastic container of a white sauce. During an interview, on 4/2/2024 at 11:02 A.M., LPN 5 indicated the staff foods should not be in the medication refrigerator and it should have been cleaned. On 4/2/2024 at 12:06 P.M., the Director of Nursing provided the policy titled," Medication & Treatment-Storage Policy", dated 10/2006, and indicated the policy was the one currently used by the facility. The policy indicated"... Medications and treatments should be stored in an organized manner under proper conditions of sanitation...1...The designated areas should be clean and orderly...7. Medications requiring	R 0300	**R 300 Based on observation, record review and interview, the facility failed to ensure a medication refrigerator was clean, and failed to ensure staff foods were not stored in a medication refrigerator. This deficient practice had the potential to affect 4 of 39 residents with medication stored in the medication refrigerator.** **· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 4.3.24 the food was removed from medication refrigerator. In-service completed for nursing staff on medication and treatment storage policy. No residents were affected by alleged deficient practice .** **· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/15/2024

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	refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly....		**taken; alleged deficient practice had the potential to affect 4 residents with medication stored in the medication refrigerator. On-coming nurse will check medication refrigerator to verify it's not being utilized for food storage during each shift report.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; nursing staff educated on medication and treatment storage policy on 4.4.24 and on an ongoing basis. New hires will be educated on medication and treatment storage policy at hire and on an ongoing basis. Medication refrigerator will be checked by Nurse/ QMA each shift to ensure food is not being stored in medication refrigerator.** **· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; HWD or designee will monitor medication refrigerator 5x weekly for 4 weeks; then 1xweekly for 4 weeks then 1x monthly for 3 months to verify medication**	

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		A. BUILDING 00 B. WING	04/02/2024

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			refrigerator is free from food per policy. **· By what date the systemic changes will be completed 4.15.24**	