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	09/07/2023

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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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00414443. Complaint IN00414443 - No deficiencies related to the allegations are cited. Survey dates: September 6 and 7, 2023. Facility number: 014376 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 12, 2023.	R 0000		
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference checks were completed for a new employee before they started working for 1 of 3 newly hired employees reviewed. (Qualified Medication Aide 11) Findings include:	R 0116	R 116 – All employee files have been checked for documentation of reference checks. All files are currently in compliance. On the first of every month the ED will print the compliance report for all employees. This will be done for 6 months. Compliance reports will	09/22/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherri Dawson	Executive Director	09/25/2023

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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	Upon the survey entrance, on 9/7/23 at 9:30 a.m., 5 employees were selected for review. 3 were selected as new hire reviews. Qualified Medication Aide (QMA) 11 was hired on 6/14/23. Her employee file lacked documentation of references checks completed before and/or upon hire. During an interview, on 9/7/23 at 4:00 p.m., the Administrator (ADM) indicated she did not have a business office manager, and she had hired QMA 11 without completing any references checks. She forgot to follow-up to complete the reference checks. The ADM indicated the facility followed sate rules.		be reviewed at each monthly operational meetings ongoing with no end date.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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			

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	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. Based on record review and interview, the facility failed to ensure full shift coverage was available for 1st aid and Cardiopulmonary Resuscitation (CPR) certified staff during the week of August 14-20, 2023, as evidence by the working schedule review for 10 of 221 observations. Findings include: Upon the survey entrance, on 9/7/23 at 9:30 a.m., an actual worked nursing schedule was requested. On 9/7/23 at 12:00 p.m., the Administrator (ADM) provided a copy of the nursing schedule from August 14-20, 2023, which was reviewed at that time and revealed there was missing coverage for 10 of 221 observations as follows: On 8/14/23, the scheduled lacked documentation of 1st aid coverage for the night shift. On 8/16/23, the scheduled lacked documentation of 4 hours of coverage for 1st aid on the evening shift. On 8/17/23, the scheduled lacked documentation of 1st aid coverage for the night shift. On 8/18/23, the scheduled lacked documentation of 4 hours of coverage for 1st aid on the evening shift and 1st aid coverage for the night shift. On 8/19/23, the scheduled lacked documentation of 4 hours of coverage for 1st aid and CPR for the	R 0117	R 117 – All CNAs will be required to have CPR and first aid certifications within 60 days of employment. CPR and First Aid classes will be offered annually. A CPR and First Aid class is being offered on 9/29/23 to bring all current employees into compliance. The monthly employee compliance report will be run on the first of the month ongoing with no end date. Compliance reports will be reviewed at monthly operational meetings for compliance for the next 12 months.	09/29/2023

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	evening shift. On 8/20/23, the scheduled lacked documentation of 4 hours of coverage for 1st aid and CPR for the evening shift and lacked coverage for 1st aid on the night shift. During an interview, on 9/7/23 at 1:27 p.m., the AMD indicated she had provided all the 1st aid and CPR certifications there were, and if there was missing coverage, she did not have additional information to provide. The ADM indicated, there should be always full coverage of 1st aid and CPR for all shifts.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually			

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	thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure annual in-service training was provided for 2 of 5 employees reviewed. (Licensed Practical Nurse 9 and Certified Nursing Aide 10) Findings include: Upon the survey entrance, on 9/7/23 at 9:30 a.m., 5 employees were selected for review. Licensed Practical Nurse (LPN) 9 was hired on 11/14/21. Her employee file lacked documentation of annual in-service training on Resident's Rights, dementia, and abuse. Certified Nursing Aide (CNA) 10 was hired on 9/14/19. Her employee file lacked documentation of annual in-service training on Resident's Rights, dementia, and abuse. During an interview, on 9/7/23 at 4:00 p.m., the Administrator (ADM) indicated both of the above employees worked mostly evening/night shifts and she could never catch them for in-service training. The ADM had just conducted a recent in-service and CNA 10 had not attended, but the	R 0120	R 120 – In-services are being done monthly at each all staff meeting. All staff must complete the required in-services by October 15 or risk being removed from schedule. Compliance reports will be run the 1st day of each month to insure compliance. Compliance reports will be reviewed at monthly operational meetings for compliance for the next 12 months.	10/16/2023

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	ADM had not followed up with her yet. The ADM indicated the facility followed state rules.			
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to obtain a copy and/or order a new chest x-ray for a resident, (Resident H) for 1 of 5 residents reviewed for chest x-rays. Finding includes: On 9/7/23 at 10:00 a.m., Resident H's medical record was reviewed. She admitted to the facility on 11/21/22 as a transfer from another long-term care facility. She had a diagnosis which included, but was not limited to, dementia. On 9/7/23 at 2:50 p.m., the Assistant Director of Nursing (ADON) provided a copy of a fax which was sent to Resident H's previous facility as a request for supplemental medical record documentation. The fax request indicated "...information to be released...chest x-ray, indicating no tuberculosis or active disease (from last 6 months, per state requirement..." The record lacked documentation of follow-up to obtain Resident H's chest x-ray from the previous facility. The record lacked documentation of facility follow-up to obtain a new chest x-ray for Resident H.	R 0408	R 408 – Compliance report for all residents indicate that all current residents have provided a chest x-ray upon admission. No residents identified to have missing admission chest xrays at this time. During the admission process the Director of Healthcare will not approve the admission until the xray has been ordered or provided. This documentation will be uploaded in the EMR (ALIS) for review by the Executive Director. The ED will review admission compliance for chest xrays for the next 6 months to ensure the director of health care is properly reviewing and approving admissions to be compliant with a chest xray.	09/25/2023

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	During an interview, on 9/7/23 at 2:55 p.m., the ADON indicated upon her review of the resident's electronic and hard chart, she could not find a chest x-ray and it seemed that it fell through the cracks and was not completed.			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a process was in place to ensure a tuberculosis ([TB]a highly contagious bacterial disease which affects the lungs) infection prevention program was in place by utilization of the two-step skin test and/or alternative laboratory testing was conducted in combination with a chest x-ray for a complete diagnostic determination for 3 of 5 residents reviewed. (Residents B, G and H)	R 0410	R410 – All resident will receive tuberculin skin tests within the first week of admission. All current residents have received a tuberculin skin test. The director of health care is responsible for ensuring the skin test is completed in the appropriate time. The director of health care will audit all new admission's EMR	09/28/2023

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	Findings include: On 9/7/23 at 10:30 a.m., Residents B, G and H's medical records were reviewed for evidence of TB diagnostic screening. a. Resident B admitted to the facility on 1/25/22, and her record lacked documentation an initial TB skin test, and/or alternative laboratory testing had been completed. b. Resident G admitted to the facility on 12/15/22, and his record lacked documentation an initial TB skin test, and/or alternative laboratory testing had been completed. c. Resident H admitted to the facility on 11/21/22, and her record lacked documentation an initial TB skin test, and/or alternative laboratory testing had been completed. On 9/7/23 at 11:00 a.m., evidence of initial/admission TB skin tests were requested. During an interview, on 9/7/23 at 2:55 p.m., the Assistant Director of Nursing (ADON) indicated she did not think residents were required to receive a skin test upon admission, that the chest x-rays were all that was needed. She indicated it was too difficult to give TB skin tests to the residents because they were all Memory Care residents and often combative with approached with a needle. It was her understanding, per the owners of the facility, that only a chest x-ray was required. During an interview, on 9/7/23 at 4:00 p.m., the Administrator (ADM) indicated she did not think there was a policy for TB skin tests since they		withing 7 days of admission to ensure all compliance items are done for admission to the community. The Executive Director will review compliance reports on the 1st of every month to ensure compliance for the next 6 months	

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	were not completing them, but the facility followed the state rules.			