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	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND BROOK MEMORY CARE OF GREENWOOD	2444 SOUTH STATE ROAD 135 GREENWOOD, IN 46143

(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. This visit included the Investigation of Complaint IN00402041. Complaint IN00402041 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 27, 28, and March 1, 2023. Facility number: 014426 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 6, 2023.	R 0000	F000 Facility ID: 014426 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 03/29/23.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
brittany mckinney	HFA	03/25/2023

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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	responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure a copy of the residents' rights was available in a publicly accessible area for 2 of 3 days during the survey. This had the potential to affect 36 residents residing in the facility. Findings include: On 2/27/23 at 3:00 p.m., no posting of residents' rights was observed in the facility. On 2/28/23 at 10:30 a.m., no posting of the residents' rights was observed in the facility. A large sign was posted in the locked, foyer entry. The sign was titled, "Resident Rights for Housing with Services Establishments." The sign did not include the Residents' Rights nor was it accessible to residents. On 3/1/23 at 2:45 p.m., the Director of Quality & Training (DQT) provided a copy of the facility's policy, "Resident Protecting and Ensuring Resident Rights," undated, and indicated it was the policy currently being used. A review of the policy indicated, "...4. The list of resident rights will be posted for residents to review at any time..." During an interview at that time, the DQT indicated the large sign did not include the Indiana Residents' Rights and there was no posting of the rights in the facility.	R 0026	POC Facility ID: 014426 R 0026 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Staff education provided to Administrator and Director of Health services by Company Regional Nurse Consultant regarding correct postings to include “Resident Rights” of which to be posted in a publicly accessible area of which includes accessibility to residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice. Company RN Regional Consultant provided education and training to the Executive Director and Director of Healthcare to ensure accessibility of resident rights posting in public area. This posting was ordered by Executive Director from the IHCA. Upon delivery to the facility this Resident Rights posting will be posted in Publicly accessible	03/29/2023

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			area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: After posting is delivered to Community via mail and hung in designated area, the Executive Director, Director of Healthcare or designated persons will complete QA Audit Tool for correct facility postings. Resident council meeting resident rights to be discussed. Residents to be educated on location of resident rights posting upon arrival. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place**: The Director of Health Services/Designee will monitor daily or more often as necessary until compliance is maintained. The Director of Health services/designee will be responsible for the completion of resident rights education QA Tool weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide	

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			education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 03/29/23	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.			
	Based on observation, interview, and record review, the facility failed to ensure the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were posted in an area accessible to residents for 2 of 3 days during the	R 0033	POC Facility ID: 014426 R 0033 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Staff education provided	03/29/2023

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	survey. This had the potential to affect 36 residents. Findings include: On 2/28/23 at 11:00 p.m., no posting of the addresses nor telephone numbers were observed in the facility. On 2/28/23 at 2:30 p.m., no posting of the addresses nor telephone numbers were observed in the facility. A large sign which was posted in the activity room, behind a water cooler, approximately 36 inches off of the ground, had the omdubsman's information. The sign did not include the addresses or telephone numbers for the other aforementioned organizations. During an interview on 3/1/23 at 11:20 a.m., the Corporate Director of Quality and Training indicated the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were not posted in an area immediately accessible to residents. On 3/1/23 at 11:30 a.m., the Corporate Director of Quality and Training provided a copy of the facility's policy, "Resident Rights," undated, and indicated it was the policy currently being used. A review of the policy indicated, "...the facility must provide immediate access to...individuals representing state or federal agencies, the state and area long term care ombudsman, the agency responsible for the protection and advocacy system for developmentally disabled individuals, the agency responsible for the protection and advocacy system for mentally ill individuals..."		to Administrator and Director of Health services by Company Regional Nurse Consultant regarding correct postings to include “Resident Rights; ISDH address/telephone number; Office of the Secretary of Family & Social Services; Area agency on Aging; Local Mental Health center; Adult Protection services; all of which to be posted in a publicly accessible area of which includes accessibility to residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice. Company RN Regional Consultant provided education and training to the Executive Director and Director of Healthcare to ensure accessibility of aforementioned organizational postings/education posted in public area. These specific postings have been requested through the aforementioned organizations. Upon delivery of these stated postings to the facility all information as well as Resident Rights posting will be posted in the same Publicly accessible area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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			practice does not recur: After postings are delivered to Community via mail, ED to pick up information in person by several organizations to ensure state compliance they all will be hung in same designated area. The Executive Director, Director of Healthcare/designee will complete QA Audit Tool for correct facility postings. Resident council meeting to include resident rights as well as the aforementioned organizations, phone numbers, contacts, locations and all means of contact to organizations to be delivered and covered in detail. Residents to be educated on location of the designated area with all organizational information as required. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place**: The ED/Director of Health Services/Designee will monitor daily or more often as necessary until compliance is maintained. The Director of Health services/designee will be responsible for the completion of educational organizational information's, contacts, locations, phone numbers with all forms of communications. Along with direction and tour of the designated area as to where postings will reside within the	

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			community during resident counsel. Resident council meeting minutes to be maintained and reviewed during QA/QAPI with all committee personnel. These QA Tools will be completed and reviewed weekly x 4, monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 03/29/23	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to provide to the resident's a readily accessible location of the most recent annual State survey for 2 of 3 days during the survey. This had the potential to affect 36 residents residing in the facility. Findings include:	R 0042	POC Facility ID: 014426 R 0042 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/29/2023

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	On 2/27/23 at 11:30 a.m., the sign posted in the front entrance indicated the State survey book was to be on a cabinet by the chapel. There was not a cabinet by the chapel. The most recent annual State survey book was not observed to be the near the chapel. On 2/28/23 at 12:30 p.m., the sign posted in the front entrance indicated the State survey book was to be on a cabinet by the chapel. There was not a cabinet by the chapel. The most recent annual State survey book was not observed to be the near the chapel. During an interview on 3/1/23 at 2:45 p.m., the Director of Quality and Training indicated the State survey book was not readily accessible to residents. On 3/1/23 at 3:00 p.m., the Director of Quality and Training indicated they did not have a policy regarding the State survey book being readily accessible for the residents.		**practice**: Staff education provided to Administrator and Director of Health services by Company Regional Nurse Consultant regarding requirement of accessibility to provide the residents a readily accessible location of the most recent annual state survey for review at all times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice. Company RN Regional Consultant provided education and training to the Executive Director and Director of Healthcare to ensure readily accessibility of the Community's most recent state survey results to residents at all times. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: Two new signs have been posted in the Community with information as to where the location of the most recent annual state survey books are located. Two state survey books containing the most recent surveys to be maintained to ensure this information is readily accessible for both residents and families.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place: The ED/Director of Health Services/Designee will monitor five days per week or more often as necessary until compliance is maintained. The Director of Health services/designee will be responsible for visual inspection that survey books placements are correct. These QA Tools will be completed and reviewed daily x 5 days, weekly x 4 weeks , monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 03/29/23	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff			

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	members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview, and record review, the facility failed to ensure a resident was transferred using a gait belt per facility policy for 1 of 3 residents reviewed for wound care. (Resident 2) Findings include: On 2/28/23 at 10:15 a.m., Resident 2 was observed to be transferred from a broda chair (used to prevent falls) to the bed by Caregiver 1 and Caregiver 3 by placing their arms under the	R 0217	POC Facility ID: 014426 R 0217 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Staff education provided to ensure proper gait belt usage is utilized when required indicated by residents Plan of Care. All staff	03/29/2023

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	residents arm pits, grabbing on the back of her pants and transferring her to the bed. No gait belt was observed to be used during the transfer. Resident 2's clinical record was reviewed on 2/28/23 at 3:00 p.m., the diagnoses included, but were not limited to, Alzheimer's disease and anxiety. The individual Service Plan dated, 11/8/22 for Resident 2 indicated the resident was an assist of 2 persons during transfers. During an interview on 2/28/23 at 1:20 p.m., Caregiver 3 indicated the facility had not provided staff with gait belts in order to transfer residents. On 2/28/23 at 12:45 p.m., the Assistant Director of Nursing provided the facility policy, "Transfers" undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "... 4. Put the gait belt around the resident's waist securely and tell them what you are doing. The gait belt should be adjusted to fit snug ... 9. DO NOT grab the back of the resident's pants or grab under the resident's arms ..."		have been provided a gait belt for easy access to be utilized as needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice who have a plan of care that indicates specific use of a gait belt during transfers. Company RN Regional Consultant provided education and training to the Executive Director and Director of Healthcare to ensure review of all residents care plans to identify any residents who require gait belts to be used. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: Review of all resident's plan of care, notating on Care Assignment sheets which residents require use of a gait belt during transfers. Therapy Services to host a seminar on safety, proper use of gait belts, education on safe transfers of residents, proper use of all or any safety devices. This will include a return demonstration by staff and skills validation completed by Director of Heath Services. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recure, i.e., what quality assurance program will be put into place: The Director of Health Services/Designee will monitor one transfer per day for 5 days per week or more often as necessary until compliance is maintained. Skill validations will be completed and reviewed daily x 5 days, weekly x 4 weeks , monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 03/29/23	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene and changed gloves after performing perineal care for 1 of 3 residents	R 0414	POC Facility ID: 014426 R 0414	03/29/2023

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	observed for wound care. (Resident 2) Finding includes: On 2/28/23 at 10:15 a.m., perineal (cleaning the private areas of a patient) care was observed on Resident 2 by Caregiver 1 and Caregiver 2. No hand hygiene nor glove change was observed before placing a new clean brief and pulling up the residents clean pants. On 3/1/23 at 12:31 p.m., the Director of Nursing (DON) indicated Caregiver 1 and Caregiver 2 should have performed hand hygiene and changed their gloves prior to putting on a new brief and pulling up the clean pants for Resident 2. On 2/28/23 at 12:05 p.m., the Director of Community Relations provided the facility policy, "Infection Control" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Hands must be washed between direct contact with any residents ..."		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Staff education provided to ensure proper handwashing and infection control practices are performed with glove changing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken**: All residents had the potential to be affected by this alleged deficient practice. ED and Director of Healthcare to provide all staff education regarding proper handwashing techniques, along with proper glove changing. All staff will provide a return demonstration along with skills validation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: All staff to demonstrate handwashing and glove changes to Director of healthcare with a skills validation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place**: The Director of Health Services/Designee will monitor two random handwashing/glove change audits	

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	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND BROOK MEMORY CARE OF GREENWOOD	2444 SOUTH STATE ROAD 135 GREENWOOD, IN 46143

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			per day for 5 days per week or more often as necessary until compliance is maintained. Skill validations will be completed and reviewed for all staff. Handwashing/glove changing audits to be completed randomly daily x 5 days, weekly x 4 weeks , monthly x 3 months and quarterly thereafter for one year with results reported to the Quality Assurance Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update and provide education as needed. After six months the QAPI committee will re-evaluate the continued need for the audit. **By what date the systemic changes will be completed**: 03/29/23	