| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 09/05/2019 |

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

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| R 0000<br><br>Bldg. 00 | This visit was for an Initial State Residential Licensure Survey.<br><br>Survey dates: September 4 and 5, 2019.<br><br>Facility number: 014376<br><br>Residential Census: 7<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on September 13, 2019. | R 0000 | | |
| R 0033<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(h)(1-2)<br>Residents' Rights - Noncompliance<br>(h) The facility must furnish on admission the following:<br>(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.<br>(2) The most recently known addresses and telephone numbers of the following:<br>(A) The department.<br>(B) The office of the secretary of family and social services.<br>(C) The ombudsman designated by the division of disability, aging, and rehabilitation services.<br>(D) The area agency on aging.<br>(E) The local mental health center.<br>(F) Adult protective services.<br>The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | appropriate.<br>Based on observation, interview, and record review, the facility failed to post contact information, for the Ombudsman, in an area accessible to residents. This deficient practice had the potential to affect 7 of 7 residents residing at the facility.<br><br>Findings include:<br><br>On 9/4/19 at 10:12 a.m., during an observation, and interview, the Director of Nursing (DON) indicated Resident rights, and the Ombudsman's contact information was posted in the entry way, outside the locked door. The DON indicated the information was accessible to visitors, when they entered the building, but not residents. Residents could not go into that area of the building, it required a security code.<br><br>On 9/4/19 at 10:31 a.m., the DON placed a black binder on a table inside the entry way. The binder was labeled State Survey Results and Resident Rights. He indicated residents were able to see the information in the binder. The facility followed state regulations in regard to the posting of information.<br><br>On 9/4/19 at 10:35 a.m., the Survey Results and Resident Right's binder was reviewed. It did not contain contact information for the State Ombudsman.<br><br>On 9/5/19 at 9:36 a.m., the DON provided a current, undated copy of the Resident Rights, which indicated "...The facility must furnish...the ombudsman...addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate...." | R 0033 | In response to R 0033. No residents have been negatively affected by this deficient practice although potential for harm could exist.<br><br>The Resident Rights and Ombudsman contact information was posted in the foyer prior to the state visit. All responsible parties of the residents have access to the information upon entry to the facility at all times.<br><br>On 9/5/19 the DON placed a black binder on the table inside the main living room area. The binder is labeled State Survey Results and Resident Rights and will be accessible at all times to the residents and their Power Of Attorney(POA) with contact information for local ombudsman.<br><br>Facility will host a family and resident informational meeting on 9/25/19 to discuss how to access the resident rights, survey results and to contact local ombudsman if they wish to review.<br><br>All new residents, POA, and responsible parties upon admission will be informed where to locate the ombudsman contact information, resident rights, and survey results in the black binder in the main lobby. Date of completion 09/05/19 and ongoing. | 09/05/2019 |

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| R 0055<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(y)(1-4)<br>Residents' Rights - Deficiency<br>(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:<br>(1) Bathing.<br>(2) Personal care.<br>(3) Physical examinations and treatments.<br>(4) Visitations.<br>Based on observation, interview, and record review, the facility failed to treat a resident as an individual with consideration, and respect for their privacy (Resident 5), by subjecting the resident to a physical examination, conducted in the common area, during a group activity for 1 of 1 random observations.<br><br>Findings include:<br><br>On 9/4/19 at 1:43 p.m., during a random observation, Resident 5 was seated in a group with 4 other residents, in the common area. The Activities Director was reading a story out loud, to the group.<br><br>Resident 5 was approached by the Nurse Practitioner (NP). She introduced herself and then proceeded to perform a physical assessment on Resident 5, as the resident was seated in the group activity. She addressed the Resident as she performed the assessment, talking over the Activity Director. She had a large rolling bag with medical supplies at her side.<br><br>The NP was observed as she took Resident 5's vital signs (temperature, pulse, blood pressure, and oxygen saturation). She then put on gloves, | R 0055 | Per additional request from ISDH more information letter dated 10/1/19 in response:<br>Director of Healthcare and Executive Director will monitor visits of third party providers to ensure compliance with the service provider access agreement weekly. This will be standard protocol going forward with no end date to ensure compliance with our third party providers.<br>In response to R 0055 no residents have been negatively affected by this deficient practice although potential harm did exist. Reviewed provider agreement section labeled “House Rules of Conduct” with NP to re-educated on the privacy and failure to honor resident rights. Arranged meeting with NP’s Practice Manager and addressed concerns stated in Survey document on 9/17/19. On 9/18/19 NP’s Practice Manager stated training is provided during provider orientation, on how to conduct a visit in a patient home | 10/07/2019 |

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| | and checked the resident's mucous membranes (eyes, mouth, and nose). She listened to the resident's chest, back and abdomen, with a stethoscope, palpated (pressed and touched) Resident 5's abdomen, and asked her about her bowel movements, and pain. A specimen sample cup was labeled and handed to an unidentified staff member, who was present in the activity, and the staff member was instructed to obtain a urine specimen from Resident 5.<br><br>On 9/4/19/19 at 2:00 p.m., during an interview, the NP indicated she normally took residents to their rooms to do an assessment. She didn't know why she didn't do that today. The resident might have needed to go to her room if she had to draw some blood.<br><br>On 9/5/19 at 9:24 a.m., during an interview with the Director of Nursing (DON) and the Administrator, they indicated the NP should not have performed a physical assessment on Resident 5, in the common area, during a group activity.<br><br>On 9/5/19 at 9:36 a.m., the DON indicated the facility did not have a policy or procedure for Resident Assessment. He provided a current, undated copy of the Resident Rights, which indicated "...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality...Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments...." | | which includes ALF, ILF, group home, etc. It is trained, and will be re-iterated and an re-education provided, that visits need to be conducted in a private/non-public setting at all times.<br>Said NP's agency were required on 6/27/19 to sign a "Service Provider Access Agreement" that outlines the expectations of provider agents/employees are to abide by access agreement and the "House Rules of Conduct for Outside Services Providers" prior to executing services to facility's residents. The House Rules of Conduct… states that provider/agents agree to honor resident rights and refrain from any other conduct not deemed to be in the best interests of the Community or its residents.<br>Director will provide a Service Provider Access Agreement to any prospective or contracted service providers to review and sign prior to access the facility's residents.<br><br>Date completed: 06/27/19 and ongoing. | |
| R 0095<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(l)(1-2)<br>Administration and Management<br>-Noncompliance | | | |

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| | (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:<br>(1) meet the needs or preferences, or both, of cognitively impaired residents; and<br>(2) gain understanding of the current standards of care for residents with dementia.<br>Based on record review and interview, the facility failed to ensure the Alzheimer's/Dementia Care Director obtained the minimum required training hours within the first three months of their hire date. This deficient practice had the potential to effect 7 of 7 residents who resided in the locked Dementia Care Facility.<br><br>Findings include:<br><br>On 9/4/19 at 12:37 a.m., the Administrator indicated she was the Dementia Care Director and had the required Health Facility Administrators | R 0095 | In response to R 0095 no residents have been negatively affected by this deficient practice although potential for harm did exist<br>Alzheimer's/Dementia Care Director obtained the remaining 2 hours of the required dementia 12 hours of training.<br>Director will monitor ongoing in-service training requirements through electronic record system, to include new hire orientation and | 09/08/2019 |

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| | License, an earned degree in Business Administration Management, and had dementia training hours.<br><br>On 9/4/19 at 2:30 p.m., the Administrator's employee file was reviewed.<br><br>The Administrator was hired on 3/22/19. She had 10 of the 12 minimum required training hours on record within the first three months of her employment.<br><br>On 9/5/19 at 10:30 a.m., the Administrator reviewed her file, added the dementia training hours, and indicated she was 2 hours short, per the state regulation. | | annual in-service training. Monthly required in-services will continue to be offered, attendance monitored and documented. Those unable to attend the scheduled in-services will complete the self-study portion to ensure appropriate training occurs. Date of completion: 9/08/19 and ongoing. | |
| R 0116<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(a)<br>Personnel - Noncompliance<br>(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.<br>Based on record review and interview, the facility failed to obtain criminal background checks through the Indiana central repository for 7 of 7 employee records reviewed.<br><br>Findings include:<br><br>On 9/4/19 at 2:30 p.m., 7 randomly sampled employee records were reviewed.<br><br>The Administrator (ADM) was hired on 3/22/19, and did not have a criminal background check through the Indiana central repository. | R 0116 | In response to R 0116 - no residents have been negatively affected by this deficient practice although potential harm did exist. Director will audit all staff personnel files to ensure that they obtain the criminal background checks through the Indiana Central repository and will continue to utilize national, county, and state background checks through national criminal background database system. | 09/05/2019 |

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| | The Director of Nursing (DON) was hired on 5/13/19, and did not have a criminal background check through the Indiana central repository.<br><br>The Activity Director (AD) was hired on 5/29/19, and did not have a criminal background check through the Indiana central repository.<br><br>Qualified Medication Aide (QMA) was hired on 5/14/19, and did not have a criminal background check through the Indiana central repository.<br><br>The Lead Cook was hired on 8/20/19, and did not have a criminal background check through the Indiana central repository.<br><br>Certified Nursing Aid (CNA) 13 was hired on 8/22/19, and did not have a criminal background check through the Indiana central repository.<br><br>QMA 14 was hired on 8/13/19, and did not have a criminal background check through the Indiana central repository.<br><br>During an interview on 9/4/19 at 3:00 p.m., the Administrator indicated the facility contracted with [name of company] to run their employee background checks. She did not know if the Indiana central repository was part of the database.<br><br>During an interview on 9/5/19 at 10:15 a.m., the Administrator indicated she re-ran the employees background checks through the Indiana State Police Department, because the original background checks had not been through the required data base. There was no facility policy, but the facility followed state regulation. | | Director obtained criminal background check through the Indiana Central repository for the 7 employee records reviewed in the survey document.<br>Director will process criminal background checks through the Indiana central repository for any staff found to be non-complaint in addition to any new hires during the pre-employment screening process.<br>Date of completion 9/5/19 and ongoing. | |

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| R 0121<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight | | | |

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| | loss) shall not be permitted to work until tuberculosis is ruled out.<br>Based on record review and interview, the facility failed to ensure second step tuberculosis (TB) skin tests were performed for 2 of 7 employee records reviewed.<br><br>Findings include:<br><br>On 9/4/19 at 2:30 p.m., 7 randomly sampled employee records were reviewed.<br><br>The Activity Director (AD) was hired on 5/29/19, and did not have a second step second step tuberculosis (TB) skin test on record.<br><br>The Lead Cook (LC) was hired on 8/20/19, and did not have a second step TB on record.<br><br>During an interview on 9/5/19 at 10:15 a.m., the Administrator indicated, the facility followed state regulations which indicated second step skin tests should have been placed 1-3 weeks after the first step. The AD's and LC's second step TB tests were not placed on time. | R 0121 | In response to R 121 – no residents have been negatively affected by this deficient practice although potential harm did exist.<br><br>Director will audit all staff personnel files to ensure they have met the TB Screening requirements.<br><br>TB screening process to restart for any staff found to be non-complaint with testing.<br><br>Unable to obtain Activity Director (AD)for TB screen as she was not scheduled to work. Restart TB screen (AD) first available date for the 1st Step on 9/10/19 and read negative results on 9/12/19. 2nd step will be administered per policy in 1-3 week after 1st step.<br><br>The Lead Cook (LC) was administered the 2nd step TB screening on 9/5/19 as scheduled within the 3 weeks following the 1st step administered on 8/20/19.<br><br>Date of completion: 09/12/19 and ongoing. | 09/12/2019 |
| R 0193<br><br>Bldg. 00 | 410 IAC 16.2-5-1.6(q)(1-2)<br>Physical Plant Standards - Deficiency<br>(q) The facility shall have laundry services either in-house or with a commercial laundry | | | |

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| | by contract as follows:<br>(1) If a facility operates its own laundry, the laundry shall be designed and operated to promote a flow of laundry from the soiled utility area toward the clean utility area to prevent contamination.<br>(2) Written procedures for handling, storage, transportation, and processing of linens shall be posted in the laundry and shall be implemented.<br>Based on observation, interview, and record review, the facility failed to post, and implement written procedures for handling, storage, transportation, and processing of linens, in the laundry room. This deficient practice had the potential to affect 7 of 7 residents residing at the facility.<br><br>Findings include:<br><br>On 9/5/19 at 8:50 a.m., during a tour of the laundry room, with the Director of Nursing (DON), the DON indicated Certified Nursing Assistants (CNA) did all the laundry, for the facility, and the residents. They were shown how to do laundry when they were hired. They did not have a policy or procedure posted, or available for reference, in the laundry room.<br><br>The observation revealed nothing posted on the walls, and no policies or procedures were available in the laundry room for reference.<br><br>On 9/5/19 at 8:57 a.m., the DON provided a current, undated policy, titled "Personal Laundry." This policy indicated "...It will be determined on the move-in day who will be primarily responsible for doing laundry- the family or the community?...." | R 0193 | In response to R 0193 – no residents have been negatively affected by this deficient practice although potential harm did exist.<br><br>Director will post copies in the laundry room of the "Linen Laundry" and the "Stripping and Remaking Bed" procedure from the facility operational guideline policy for all staff.<br><br>In-service education will be provided immediately for all staff found to be lacking in any required material.<br><br>Director and DON will monitor in-service requirements through sign-in sheet, and participation attendance signatures, to include new hire orientation and annual in-service training.<br><br>New-Hire orientation and annual required in-services will be offered, attendance monitored and documented. Those who are unable to attend the scheduled in-services will complete the | 09/10/2019 |

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| | On 9/5/19 at 8:57 a.m., the DON provided a current, undated policy, titled "Linen Laundry." This policy indicated "...Personal linens will be washed and returned to the resident's apartment...Residents will be encouraged to participate, as appropriate, throughout the procedure...." | | self-study portion to ensure appropriate training occurs.<br><br>Date of completion 09/10/19 and ongoing. | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br><br>Based on observation, interview, and record review, the facility failed to ensure food was thawed in a manner to prevent bacteria growth, food was labeled and dated, kitchen equipment was kept clean, and a lid covered a kitchen trash receptacle. These deficiencies had the potential to affect 7 of 7 residents who consumed foods from the kitchen.<br><br>Findings include:<br><br>On 9/4/19 at 9:40 a.m., the Culinary Manager (CM) indicated she followed the Indiana State Guidelines and Serve Safe.<br><br>At 9:45 a.m., the following was observed: 13 chicken thighs in a plastic container with cold water and covered with plastic wrap, a dirty waffle maker, and a kitchen trash receptacle with no lid.<br><br>At 9:50 a.m., the lettuce in the refrigerator had an illegible label and the CM threw it away. A large plastic bag of shredded cheese had an illegible date, the CM decided to keep it. | R 0273 | In response to R 0273 no residents have been negatively affected by this deficient practice although potential harm did exist.<br><br>Director and Culinary Manager will complete an audit of all food storage areas, thawing procedures, and cleaning and sanitizing equipment using the Food Safety Checklist audit tool.<br><br>All compromised food items will be discarded and any equipment not cleaned will be cleaned and sanitized immediately.<br><br>Culinary Manager and all lead cooks to be re-educated on proper storage, labeling of all food products, thawing foods, and cleaning and sanitizing of equipment. Education and attendance will be monitored and documented. | 10/22/2019 |

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| | At 9:57 a.m., the CM pulled a plastic wrapped package out of the freezer, she indicated she thought it was hash browns with no label or date. Five breaded fish filets were in a plastic bag with an illegible label. She over-wrapped the fish filets with plastic wrap and indicated she was going to re-date the package because she knew they came in 2 weeks ago. A large box of frozen chocolate chip cookies had no open date, but she believed they came in on 8/7/19. She was going to re-date the frozen cookies because they were still good. Three dozen frozen assorted fruit Danish had no open date. The Danish came in last week, and she was going to date the box.<br><br>At 10:12 a.m., the CM indicated she was taught to put chicken in cold water to thaw it.<br><br>At 10:20 a.m., an observation of the waffle maker with cooked drips of waffle batter on the outside and the CM indicated the waffle maker should not have been left dirty after it was used over the weekend.<br><br>At 10:25 a.m., the CM indicated the trash receptacle should have had a lid.<br><br>At 10:38 a.m., the 13 chicken thighs covered in cold water were still on the kitchen counter.<br><br>At 1:52 p.m., the CM indicated she read the facility policy for thawing meat and was thawing the chicken in cold water because there was no sink to thaw foods in running water. The sink needed to be used for other things, but she should not have been thawing the chicken on the counter. It could have grown bacteria and been a risk for the residents. The trash receptacle in the kitchen should have had and lid on it. The food in the | | Monthly required in-services will be offered, attendance monitored and documented. Those who are unable to attend the scheduled in-services will complete the self-study portion to ensure appropriate training occurs.<br><br>For the next 4 weeks, and continuing monthly thereafter, the Director and DON will audit all food storage areas; and ensure proper procedures for thawing food, and cleaning and sanitizing equipment.<br><br>Date of completion: 10/22/19 and ongoing. | |

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| | refrigerator and freezer should have had correct labels and dates. The waffle maker should have been cleaned right after it was used.<br><br>At 2:00 p.m., the Administrator (ADM) indicated the chicken should not have been thawed on the kitchen counter because it could have been a risk for salmonella or other bacteria. The kitchen trash receptacle should have had a lid, but she was unable to find a policy. The facility did follow the Indiana State Guidelines and Serve Safe. All foods should have been labeled correctly with an open and use by dates on them. All equipment should have been cleaned after use.<br><br>A current policy, titled, "Thawing Food," with no date, was provided by the ADM on 9/4/19 at 11:50 a.m. A review of the policy indicated, "...Under refrigeration. (Preferred Method) Food to be thawed will be placed in the refrigerator one, two or three days before it is needed to allow it to be thawed ...Submerging in running water. Food being thawed by running water must be completely submerged in running water ...."<br><br>A current policy, titled, "Food Storage," with no date, was provided by the ADM on 9/4/19 at 11:50 a.m. A review of the policy indicated, " ...All container must be labeled with the contents and date food item was placed in storage as well as the food expiration date ...."<br><br>A current policy, titled, "Cleaning," with no date, was provided by the ADM on 9/4/19 at 11:50 a.m. A review of the policy indicated, " ...All equipment, food contact surfaces and utensils shall be cleaned ...Whenever contamination may have occurred ..." | | | |

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| R 0297<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(1)<br>Pharmaceutical Services - Noncompliance<br>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.<br>Based on record review and interview, the facility failed to administer medications as ordered, which resulted in increased anxiety and paranoia for a resident that eventually eloped from the facility (Resident 7).<br><br>Findings include:<br><br>On 9/4/19 at 11:15 a.m., Resident 7's medical record was reviewed.<br><br>Resident 7 was newly admitted to the facility on 8/22/19, from a skilled nursing facility.<br><br>A list of Resident 7's medications, was sent from the skilled nursing facility to the current facility which indicated, the following psychotropic medications had been discontinued on 8/21/19:<br>Buspirone (an anti-anxiety medication) 10 mg (milligrams) scheduled 2 times a day for anxiety.<br>Depakote (an anti-seizure medication that can treat Bipolar disorder) 125 mg scheduled 2 times a day for a mood stabilizer.<br>Olanzapine (an anti-psychotic medication) 5 mg scheduled 1 time a day for a mood stabilizer.<br>Olanzapine 5 mg every 6 hours as needed for agitation/aggression.<br><br>A Nurse Practitioner (NP) note, dated 7/26/19, from (name of the discharging facility) indicated Resident 7 "...had recent geri-psych stay at [a | R 0297 | Response to R0297- ISDH<br>Follow-up response to 10/1/19<br><br>Preferred pharmacy in place for residents who choose to elect these pharmacy services. Orders faxed to pharmacy will be delivered within the pharmacy protocol times and if medication is needed sooner than the standard delivery time, Director of Healthcare will call and speak with the pharmacy to request a STAT delivery to arrive within 4 hours.<br><br>If a resident chooses to not use, the preferred pharmacy it will be the responsibility of the responsible party to provide the medication as soon as possible. Pharmacy services are available if a family needs to create a one-time only emergency use account with the preferred pharmacy to ensure services are available in the event the responsible party is unavailable to provide the medication.<br><br>The Director of Healthcare will communicate monthly with the | 09/05/2019 |

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| | Psychiatric hospital]... nursing states high anxiety... does not like large groups of people, waves of anxiety...."<br><br>A second NP note, dated 7/31/19 from (name of the discharging facility) indicated Resident 7 "...has a lot of anxiety...."<br><br>A pre-admission nursing assessment was completed by the DON on 8/19/19. The pre-admission assessment indicated, Resident 7 had a history of major depressive disorder, anxiety, psychotic disorder with delusions, and insomnia. Her medication listed indicated to refer to the Medication Administration Record, but was not attached or provided, and the psychosocial assessment indicated, Resident 7 had no history of in-patient treatment.<br><br>A NP note, dated 8/23/19, after Resident 7 admitted to the facility indicated, "...the patient also presented with anxiety. It is described as agitation. The symptom is ongoing. The symptom moderately limits activities. The frequency of episodes is hourly. Pertinent medical conditions include precipitating event for anxiety (PTSD) facility change. Significant medications include benzodiazepines [a class of psychoactive drugs] and includes SSRI's [a class of antidepressant and anti-anxiety drugs]. Symptoms are made worse by stress...the patient complained of agitation, anxiety, depression, memory loss and paranoia related to staff watching her... patient with a known history of insomnia, anxiety and dementia currently on mirtazapine [an antidepressant medication], Trazadone [an antidepressant medication], and Depakote. Patient having paranoia with recent change of environment which is causing increased anxiety and insomnia at this time...spoke with pharmacy directly | | director of the pharmacy to discuss any concerns regarding medication delivery and timeliness of this service. This will be ongoing to ensure quality control for both Grand Brook and the preferred pharmacy. The Director of Healthcare will also ensure daily orders are filled and delivered on time by following up on new orders the next business day as they are ordered from the pharmacy; this will be ongoing with no end date.<br><br>In response to R0297 - no residents have been negatively affected by this deficient practice although potential harm could exist.<br><br>Therefore, facility is request for an IDR for this deficiency because medications were administered upon receipt.<br><br>DON ensures all medications received are administered as per the physician's orders.<br><br>Grand Brook administers all medications per physician's orders. | |

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| | regarding need for Xanax [a sedative used to treat anxiety and panic disorders] ASAP to prevent withdrawal symptoms. Spoke with [family member] and discussed restarting medications abruptly stopped prior to transport- in agreement with resume...." To resume Resident 7's medication regimen, the NP gave orders during this visit to re-start Resident 7's psychotropic medications which included but were not limited to:<br>buspirone 10 mg scheduled 2 times a day<br>Depakote 125 mg scheduled 2 times a day<br>olanzapine 5 mg scheduled 1 time a day<br><br>Resident 7's MAR was reviewed.<br>She did not receive her Depakote until 8/27/19 at 8:00 p.m.<br>She did not receive her olanzapine until 8/27/19 at 9:00 p.m.<br>She did not receive her Buspirone until 8/28/19 at 5:00 p.m.<br><br>An Incident Report for Resident 7 dated, 8/28/19 at 9:30 a.m., indicated, "...upon looking for resident to perform vital signs Nurse (1) did not find her in the living room. Nurse (1), CNA (1) and CNA (2) went to resident's suite and noticed she was not there. Nurse (1) had CNA (1) and CNA (2) check all of the rooms while Nurse (1) reviewed the cameras after not being able to locate the resident on the inside of the community. Staff began searching outside of the building perimeter... resident eloped after breakfast by raising safety lock window and cutting her window screen in her apartment. Resident was located without incident but was showing signs of paranoia and was transported by ambulance to [name of hospital]... Resident's suite window was raised and screen was cut with an ink pen and she was not found in the suite. We found her foot prints leading to neighboring housing addition...." | | | |

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| | During an interview on 9/4/19 at 12:22 p.m., Resident 7's family member indicated they were upset over the incident of Resident 7's elopement because the whole event could have been avoided. Resident 7 was originally at [a skilled nursing facility] and that facility had discontinued all her psych medications, and she took a lot. When she got to the current facility, staff were really good about getting the NP in to see her the next day, and the NP put an order in to re-start all her previous medications. Apparently those medications never came. So Resident 7 went without her anti-psychotic, anti-anxiety, and anti-depressant medication for several days, after being abruptly pulled off them. She had never had delusions and paranoia like she experienced, she was afraid someone was trying to kill her, so it was understandable she wanted to escape out the window. The family member indicated they really had to push the facility for information about why the medications were late, and never got a good answer.<br><br>During an interview on 9/5/19 at 12:00 p.m., the DON indicated, the facility's NP saw Resident 7 on 8/23/19. Because the 3 medications were not ordered "stat," the earliest they would be delivered was on Monday the 26th after 10:00 p.m. The medication was received on the 26th, and available for administration on the 27th. Resident 7 went 4 days without her psychotropic medication.<br><br>During the entrance conference on 9/4/19 at 9:30 a.m., the DON provided a copy of the facility's Operation Guidelines. This guideline included an undated policy titled, "Facilitating Adjustment to New Environment." The policy indicated, "...staff will be given notice of a new resident in advance | | | |

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| | by the Executive Director. Staff will be briefed on the resident's status and care needs during the days prior to moving in... staff will take time to listen to new residents' concerns and will assist in preventing loneliness, isolations, or depression...." The guideline included a second undated policy tiled, "New Resident Orientation" which indicated, "...The transition from one's previous residence to Assisted Living may be difficult physically, emotionally, and mentally. It is our goal to reduce the stress that is common during transitions by responding sensitively to each person's feelings and needs by setting a pace and time that relaxes the resident and promoted a positive adjustment to his/her new homes...." The guideline included a third undated policy titled, "Health Promotion Services" which indicated, "... purpose: to promote good health, to identify problems before they develop into major concerns/illnesses... The nurse will provide health promotion services. These wellness services will include but not be limited to: ... medication counseling...." | | | |