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	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND BROOK MEMORY CARE OF FISHERS	9796 EAST 131ST STREET FISHERS, IN 46038

(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 the Investigation of Complaint IN00462471. Complaint IN00462471 - State deficiencies related to the allegations are cited at R0091. Survey date: July 7, 2025 Facility number: 014253 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 8, 2025.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance Based on observation, interview, and record review, the facility failed to implement their policy for protecting resident rights by failing to report to the Administrator or designee the observed use of a physical restraint applied by a third party caregiver for 1 of 1 resident reviewed for physical restraints. (Resident C) Findings include: A 6/27/25 facility reported incident indicated an independently hired caregiver CNA had attached Resident C to her wheelchair using a gait belt as a	R 0091	**1 Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** a All residents had the potential to be affected by the alleged deficient practice. Following removal of the restraint, resident C experienced no known long-term adverse effects or distress from the alleged deficient practice. Third party CNA was	07/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Drey	RCA, Executive Director	07/16/2025

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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	restraint. The facility had intervened, removed the hired third party CNA (not a facility employee) from the facility, notified all parties, and filed a report with the Indiana Department of Health. The facility's investigation of the 6/27/25 physical restraint event involving Resident C contained witness statements and documents as follows: a. RN 3's, 6/30/25, written statement indicated she had seen the gait belt strapped around the resident in a chair on two separate days 6/26/25 and 6/27/25. She had spoken to Third Party CNA 4. Third Party CNA 4 had stated the DON had authorized the use of a gait belt as a physical restraint. b. DON's written statement indicated Third Party CNA 4 had asked permission to use a gait belt as a restraint on 6/27/25 and was informed the facility did not use restraints. That same day the DON walked into the dining room to find Resident C attached to a wheelchair using a gait belt as a physical restraint. The DON assisted in removing the restraint and asked Third Party CNA 4 to leave the premises while informing her she could not longer provide contracted services in the facility. c. The investigation indicated RN 3 had received training and corrective action for failure to notify the DON when she first observed the physical restraint on 6/26/25. During an interview on 7/7/25 at 11:08 a.m., RN 3 indicated she had not reviewed Resident C's orders to ensure she had an order for a gait belt restraint while in a wheelchair nor had she contacted the DON to clarify the use of the gait belt as a restraint. She indicated she should not have simply accepted Third Party CNA 4's		removed from facility and skin assessment completed for resident C, family/MD notified of happenings, and resident was placed on short-term monitoring to ensure no long-term adverse effects noted. Upon reporting of restraint, RN 3 was immediately re-educated on resident rights, facility abuse policy, types of abuse, ISDH reporting policy and expectations, and facility restraint/seclusion policy. Additionally, all-staff received immediate education on facility restraint/seclusion policy. **2 Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.** All residents had the potential to be affected by the alleged deficient practice. No additional residents were found to be affected by the alleged deficient practice. Following removal of the restraint, resident C experienced no known long-term adverse effects or distress from the alleged deficient practice. Third party CNA was removed from facility and skin assessment completed for resident C, family/MD notified of happenings, and resident was	

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	statement and instead spoken to facility leadership. She had received re-education to ensure she understood the correct actions for any future concerns. RN 3's employee record indicated the employee received training on 8/7/24 as a new hire regarding, reporting abuse and neglect, resident rights, behavior management, fall prevention, and restraint use. Resident C's clinical record was reviewed on 7/7/25 at 10:51 a.m. Current diagnoses included dementia and hypertension. A 6/27/25 at 7:00 p.m. Nurses Note indicated a caregiver from a hired provider had asked permission to use a gait belt to secure the resident in the wheelchair and been told the facility did not permit restraints. Later that same day, the resident was observed restrained in the wheelchair using a gait belt. The gait belt was removed. The resident was assessed and found to have no injuries. The hired care giver was asked to leave the facility. On 7/7/25 at 10:28 a.m., Resident C was observed walking restlessly with a shuffled gait in the lounge TV area. The resident needed redirected on three occasions. She was offered a treat and encouraged to sit safely in a chair and eat her snack. The resident sat in the chair as she ate her treat. A current, undated, facility document containing resident rights information, which was provided by the Administrator on 7/7/25 at 11:00 a.m., indicated: "...Residents have the right to be free from physical or chemical restraints imposed for purpose of discipline or convenience..."		placed on short-term monitoring to ensure no long-term adverse effects noted. Upon reporting of restraint, RN 3 was immediately re-educated on resident rights as they relate to restraints, facility abuse policy, types of abuse, ISDH reporting policy and expectations, and facility restraint/seclusion policy. Additionally, all-staff received immediate education on facility restraint/seclusion policy. **3 Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.** a Administrator or designee will ensure all current staff will be re-educated on resident rights as they relate to restraints, types of abuse, facility abuse policy, facility restraint and seclusion policy and ISDH reportable incident policy/expectations no later than 7/31/25 and all new staff will receive the same training upon hire at the facility. Additionally, all current staff will receive re-education on each of these topics on a rotating basis a minimum of 3x/calendar year. **4 Describe how the corrective actions(s) will be**	

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	This citation relates to complaint IN00462471.		**monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place).** a Administrator or designee will ensure all current staff will be re-educated on resident rights as they relate to restraints, types of abuse, facility abuse policy, facility restraint and seclusion policy and ISDH reportable incident policy/expectations no later than 7/31/25 and all new staff will receive the same training upon hire at the facility. Additionally, all current staff will receive re-education on each of these topics on a rotating basis a minimum of 3x/calendar year. Administrator or designee will audit/interview staff members to ensure understanding and knowledge of the following: resident rights as they relate to restraints, types of abuse, facility abuse policy, facility restraint and seclusion policy and ISDH reportable incident policy/expectations. These audits will include a minimum of ten (10) staff members on a weekly basis for one (1) month, then ten (10) staff members every other week for two (2) months, then ten (10) staff members on a monthly basis for three (3) months, then ongoing as needed.	