DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	11/15/2022

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 a State Residential Licensure Survey. Survey dates: November 14 and 15, 2022 Facility number: 014253 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 17, 2022.	R 0000		
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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Drey	Executive Director	11/30/2022

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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	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 interview and record review, the facility failed to ensure fire drills were conducted quarterly on each shift for 8 of 12 months reviewed. (November 2021, December 2021, January 2022, February 2022, March 2022, May 2022, July 2022, August 2022, and September 2022). Findings include: Review of the fire drill log for 10/2021 through 10/2022 indicated the following: November 2021, December 2021, January 2022, February 2022, March 2022, May 2022, July 2022, August 2022, and September 2022 all lacked fire drills. During an interview, on 11/15/22 at 9:15 a.m., the Administrator indicated she had began her position in October 2022 and had recently identified the lack of documented fire drills each month. She indicated she was aware of the missing drills and the facility did not have any documentation for the eight months in which the drills were lacking. . Review of an undated policy titled, "Procedure: Fire (1-170)", provided by the Administrator on 11/15/22 at 11:15 a.m., indicated the following: "...Fire drills must be done once every month and at least once per quarter on each shift...."	R 0092	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 deficient practice. No residents experienced adverse reactions from the deficient practices. Fire drill for 1st shift was completed 10.31.22; fire drill for 3rd shift scheduled to be completed no later than 11.30.22. Fire department will be invited to 2nd shift fire drill for December 2022.** 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. a. **All residents had the potential to be affected by the deficient practice. No residents experienced adverse reactions from the deficient practices. Fire drill for 1st shift was completed 10.31.22; fire drill for 3rd shift scheduled to be completed no later than 11.30.22. Fire department will be invited to 2nd shift fire drill for December 2022.**	12/31/2022

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			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 conduct monthly fire drills on rotating shifts to ensure all drills are completed timely. Administrator or designee will audit Fire Drill documentation a minimum of 1x/month to ensure timely completion according to regulation and will include local fire department as required by regulations.** 4. Describe how the corrective actions(s) will be 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 conduct audit of Fire Drill binder a minimum of 1x/month to ensure timely completion of fire drills according to regulation and will include local fire department as required by regulations.**	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific			

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	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 obtain references for new employees for 5 of 5 employee files reviewed. (CNA 5, CNA 6, HHA 7, LPN 8 and CNA 9) Findings include: A review of the Residential Care Employee Records form was completed on 11/15/22 at 11:08 a.m. Certified Nursing Assistant (CNA) 5, CNA 6, CNA 9, Home Health Aide (HHA) 7, and Licensed Practical Nurse (LPN) 8's employee files lacked documentation of references being obtained prior to employment with the facility. During an interview, on 11/15/22 at 12:35 p.m., the Administrator indicated she was aware the references had not been documented. She was unsure if they had been completed. The facility had no policy regarding new hire reference checks.	R 0116	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 deficient practice. No residents experienced adverse reactions from the deficient practices.** 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. a. **All residents had the potential to be affected by the deficient practice. No residents experienced adverse reactions from the deficient practices. Upon hire, Executive Director completed reference checks for all employees hired after 10.3.22 (Executive Director date of hire). Executive Director is completing reference checks prior to hire for newly hired employees.** 3. Describe the steps or	01/15/2023

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			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. **Executive Director or designee will conduct reference checks in accordance with RCF regulations prior to new employee hire moving forward. Executive Director or designee will conduct employee file audit to determine which current employees are missing reference checks. Any employees found to be missing reference checks will have reference checks completed no later than January 15th, 2023.** 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. **Executive Director or designee will conduct reference checks in accordance with RCF regulations prior to new employee hire moving forward. In addition, Executive Director or designee will audit new hire files within 30 days of hire to ensure compliance with regulations as they pertain to**	

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			reference checks.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview, the facility failed to provide general and job specific	R 0119	1. Describe what the facility	01/31/2023

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	orientation to employees hired to work at the facility for 5 or 5 employee files reviewed. (CNA 5, CNA 6, HHA 7, LPN 8 and CNA 9) Findings include: A review of the Residential Care Employee Records form was completed on 11/15/22 at 11:08 a.m. Certified Nursing Assistant (CNA) 5, CNA 6, CNA 9, Home Health Aide (HHA) 7, and Licensed Practical Nurse (LPN) 8's employee files lacked documentation of general orientation for the facility and lacked job specific orientation. During an interview, on 11/15/22 at 12:35 p.m., the Administrator indicated she was aware the orientations had not been completed. The employees should have completed these orientations prior to working with the facility's residents. The facility has no policy regarding new hire orientation.		did to correct the deficient practice for each client cited in the deficiency. a. **All residents had the potential to be affected by the deficient practice. No residents experienced adverse reactions from the deficient practices.** 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. a. **All residents had the potential to be affected by the deficient practice. No residents experienced adverse reactions from the deficient practices. Upon hire, Executive Director ensured and verified completion of general orientation and job-specific orientation for all employees hired after 10.3.22 (Executive Director date of hire). Executive Director will continue to ensure completion of general orientation and job-specific orientation for all new hires moving forward.** 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,	

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			but this also should include any system changes you made. a. **Executive Director or designee will ensure completion of general orientation and job-specific orientation in accordance with RCF regulations upon new employee hire moving forward. Executive Director or designee will conduct employee file audit to determine which current employees need general orientation and job-specific orientation completed. Any employees found to be missing general and job-specific orientation will have general orientation and job-specific orientation completed no later than January 31st, 2023.** 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. **Executive Director or designee will conduct general orientation and job-specific orientation in accordance with RCF regulations upon to new employee hire moving forward. In addition, Executive Director or designee will audit new hire files within 30 days of hire to ensure compliance with regulations as they pertain to**	

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			general orientation and job-specific orientation.	
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 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.			

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	The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to provide education regarding the care of residents with dementia for staff working in a dementia care facility for 3 of 5 employee files reviewed. (HHA 7, LPN 8 and CNA 9) Findings include: A review of the Residential Care Employee Records form was completed on 11/15/22 at 11:08 a.m. and indicated the following: a. Certified Nursing Assistant (CNA) 9 had a start date of 5/11/22. Her employee file lacked documentation of six hours of dementia training. b. Home Health Aide (HHA) 7 had a start date of 5/2/22. Her employee file lacked documentation of six hours of dementia training. c. Licensed Practical Nurse (LPN) 8 had a start date of 5/5/22. Her employee file lacked documentation of six hours of dementia training. During an interview, on 11/15/22 at 12:35 p.m., the Administrator indicated employees should receive the required six hours of dementia training by the sixth month of employment. The facility had no policy regarding new hire dementia training.	R 0120	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 deficient practice. No residents experienced adverse reactions from the deficient practices.** 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. a. **All residents had the potential to be affected by the deficient practice. No residents experienced adverse reactions from the deficient practices. Upon hire, Executive Director ensured and verified completion of required six hours of dementia training for all employees hired after 10.3.22 (Executive Director date of hire). Executive Director will continue to ensure completion of general orientation and job-specific orientation for all new hires moving forward.** 3. Describe the steps or systemic changes the facility has made or will make to ensure that	01/15/2023

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			the deficient practice does not recur, including any in-services, but this also should include any system changes you made. a. **Executive Director or designee will ensure completion of six hours of dementia training in accordance with RCF regulations upon new employee hire moving forward. Executive Director or designee will conduct employee file audit to determine which current employees still need completion of six hours of dementia training. Any employees found to be missing the required six hours of dementia training will have training completed no later than January 15th, 2023.** 4. Describe how the corrective actions(s) will be monitored to ensure the deficient practice will not recur (i.e. what quality assurance program will be put into place). a. **Executive Director or designee will ensure completion of six hours of required dementia training in accordance with RCF regulations upon to new employee hire moving forward. In addition, Executive Director or designee will audit new hire files within 30 days of**	

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			hire to ensure compliance with regulations as they pertain to required six hours of dementia training.	