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	08/01/2023

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 IN00412712. Complaint IN00412712 - State deficiencies related to the allegations are cited at R0148. Survey date: 8/1/2023 Facility number: 014253 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 4, 2023.	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 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Drey	Executive Director	08/18/2023

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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	electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation, record review, and interview, the facility failed to ensure secure storage of hand sanitizer for a cognitively impaired resident who drank from the container (Resident 3) and failed to ensure proper storage of hazardous chemicals for 23 of 23 ambulatory residents in the memory care facility. Findings include: During the facility tour with the DON on 8/1/23 at 10:11 a.m., Resident 24 was ambulating independently. During the facility tour with the DON, on 8/1/23 at 10:15 a.m., the Cabin side kitchen had a spray bottle labeled as disinfectant next to an uncovered bucket filled with soapy water, located by the sink, directly accessible by ambulatory residents. Residents 2 and 3 were ambulating independently nearby. During the facility tour with the DON, on 8/1/23 at 10:30 a.m., the Lake side kitchen had two bottles of hand sanitizer, two spray bottles of cleaner, a bottle of unidentified blue liquid, and an uncovered bucket filled with soapy water, located by the sink, directly accessible to ambulatory residents. On 8/1/23 at 10:45 a.m., the Cabin side kitchen was observed with the spray bottle labeled disinfectant on the far side of the uncovered bucket filled with soapy water, by the sink, directly accessible to ambulatory residents.	R 0148	1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency: No adverse effects for any resident were identified from the alleged deficient practice. Resident 2 and 3 experienced no adverse effects from the alleged deficient practice. Hand sanitizer and all chemicals were immediately removed from the observed area and placed in a secured location where they are not accessible to independently ambulatory residents. 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 24 independently ambulating residents had the potential to be affected by the alleged deficient practice. no residents were adversely affected by the alleged deficient practice. Hand sanitizer and all chemicals were immediately removed from the observed area and placed in a secured location where they are	09/15/2023

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	A review of facility documents provided by the DON on 8/1/23 at 10:30 a.m., indicated there were 23 ambulatory residents. Resident 3's clinical record was reviewed on 8/1/23 at 10:57 a.m. His diagnosis included dementia, glaucoma, arthritis of the hands and history of prostate cancer. A current service plan, dated 5/11/23, indicated he could ambulate independently and had behaviors to include wandering. A progress note, dated 7/11/23 at 2:53 p.m., indicated he was observed attempting to drink hand sanitizer. A facility incident report provided by the Administrator, on 8/1/23 at 1:00 p.m., indicated that Resident 3 was observed attempting to drink hand sanitizer. Preventative measures included securing the hand sanitizer and a staff in-service to include chemical storage and procedures in the event of consumption no later than 7/31/23. A facility in-service log provided by the Administrator on 8/1/23 at 1:13 p.m., indicated the training included chemical storage and procedures on 7/26/23. The policy included, titled, "Accident Safety Prevention" was used for this in-service. Resident 2's clinical record was reviewed on 8/1/23 at 11:05 a.m. Her diagnosis included Alzheimer's dementia and hypertension. A current service plan, dated 3/31/23, indicated she could ambulate independently, was an early riser, and was a fall risk.		not accessible to ambulatory residents. Administrator and DON began educating staff immediately and ongoing regarding safe storage of chemicals. Describe the steps or systemic changes the facility has 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: All staff will be in-serviced on proper hand sanitizer and chemical storage no later than September 15th, 2023. Administrator or designee will provide ongoing training for all new hires and continue training if and as needed for current employees. Administrator or designee will conduct regular audits of the facility to ensure that all sanitizers and chemicals are properly and securely stored. 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): All staff will be in-serviced on proper hand sanitizer and chemical storage no later than September 15th, 2023. Administrator or designee will	

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	Resident 24's clinical record was reviewed on 8/1/23 at 11:25 a.m. Her diagnosis included mild cognitive impairment, dementia, and muscle weakness. A current service plan, dated 8/23/22, indicated she could ambulate independently and requires close monitoring related to exit seeking behaviors. During an interview, on 8/1/23 at 11:49 a.m., LPN 3 indicated the facility had a lot of wandering residents that picked up things. Staff made attempts to prevent them from picking up something dangerous or inappropriate. She had heard about an incident involving a resident drinking the hand sanitizer, which was kept at the kitchen countertop for when staff was passing lunch trays. During an interview, on 8/1/23 at 12:12 p.m., QMA 4 indicated she was informed of the incident involving Resident 3 drinking hand sanitizer as she came on shift that evening. The facility had a lot of residents that wandered around and picked up items. During an interview on 8/1/23 at 12:30 p.m., the DON indicated the disinfectant spray bottle left on the Cabin side unit counter this morning should not have been placed there. The two hand sanitizer bottles and two spray bottles of cleaner left on the Lake side unit counter this morning should not have been placed there. Review of video footage provided by the Administrator on 8/1/23 at 12:45 p.m., showed the incident dated 7/11/23 at approximately 2:30 p.m. The video showed Resident 3 approach the Lake side unit kitchen counter, reach over the counter top and remove a pump top bottle of hand		monitor sanitizer and chemical storage 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 4 weeks, then 1x/week for 4 weeks. Results will be reviewed at monthly QI/safety meeting as needed. fd	

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	sanitizer. He carried the bottle over to a dining table, unscrewed the top, removed the pump apparatus, and drank some of the liquid. He replaced the top, set the bottle on the dining room table, and walked out of camera view. No staff members were observed in the area. During a phone interview on 8/1/23 at 1:03 p.m., HHA 5 indicated she saw Resident 3 lift the hand sanitizer bottle to his mouth and tip it back as if drinking. He then he placed the bottle on the dining room table. The resident followed her as she went to report the incident immediately. The facility staff always left the hand sanitizers on the kitchen countertops for when staff needed them and believed he got the bottle from there. During an interview, on 8/1/23 at 1:09 p.m., the Administrator indicated she covered the chemical storage in the all staff in-service, but a lot of information was shared. There was not a specific policy for chemical storage. The cleaning chemicals and hand sanitizers, seen out on the countertops in both the Cabin side and Lake side unit kitchens on the initial tour, should not have been in a place accessible by residents. A current, undated, facility policy, titled, "Accident Safety Prevention" provided by the Administrator on 8/1/23 at 1:13 p.m., indicated the following: "...Procedure: It is the responsibility of all Grand Brook employees to recognize and remove any potential hazards that may result in injury to residents, visitors, and employees. Examples include but are not limited to the following:...Keeping tools and chemicals within employee reach or in a locked area...." This state residential finding relates to Complaint IN00412712.			

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