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	04/16/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455933. Complaint IN00455933 - No deficiencies related to the allegations are cited. Survey dates: 4/15/25- 4/16/25 Facility number: 014253 Residential Census: 34 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 21, 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 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA), who was employed to work in the facility in the nursing department, had a valid Indiana Nurse Aide certification (CNA 3). This deficient practice had the potential to impact 34 of 34 residents who resided in the facility. Finding includes: Employee records were reviewed 4/16/25. CNA 3 was listed on the "Employee Records" form completed by the facility. The form indicated the	R 0118	We request paper compliance for this alleged deficiency. 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. No residents experienced adverse reactions or distress from the deficient practices. Employee was immediately removed from schedule and ultimately**	04/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Drey	RCA, Executive Director	04/25/2025

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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	employee's job title as caregiver. The form indicated the CNA had been employed by the facility since 11/4/24. The facility-provided binder containing licenses and certifications for facility employees indicated the following: for CNA 3: "Florida Department of Health", License Type- CNA. The verification form listed the license as valid with an expiration date of 5/31/26. The form included an Indiana address for CNA 3. The facility's 4/7/25 to 4/20/25 schedules, provided following the entrance conference on 4/15/25, indicated CNA 3 was scheduled to work as a certified nursing assistant, during the 2:00 p.m. to 10:00 p.m. and the 10:00 p.m. to 6:00 a.m. shifts, on 4/10/25, 4/11/25, 4/12/25, and 4/14/25. During an interview, on 4/16/25 at 10:34 a.m., the Administrator indicated an employee listed as caregiver was either a CNA or a Home Health Aide (HHA). Review of CNA 3's schedule from 3/4/25- 4/14/25, provided by the Administrator on 4/16/25 at 1:43 p.m., indicated the employee worked 42 shifts during that time. During an interview, on 4/16/25 at 1:43 p.m., the Administrator indicated CNA 3 needed to take the appropriate steps to secure an Indiana Nurse Aide certification within the appropriate time frame. The facility policy covered record storage and the items included in an employee file only. The facility followed Indiana Residential Rules in regards to employee licensure.		**terminated.** 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 alleged deficient practice. No residents experienced adverse reactions or distress from the deficient practices. Employee was immediately removed from schedule and ultimately terminated on April 17, 2025.** 3 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 **Upon onboarding employees with out of state licenses, Administrator or designee will indicate a license expiration date of 120 days from date of hire in the employee's file. Administrator or designee will audit all staff's licenses to confirm no employees with an out of state license are working past the allowance of 120 days, or that any other employee is working with an expired license for a**	

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			minimum of 2x/week for one (1) month, then 1x/week for two (2) months, then continuing monthly indefinitely. All staff hired with an out of state license shall be informed of this policy during orientation via a signed acknowledgment. 4 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 **Upon onboarding employees with out of state licenses, Administrator or designee will indicate a license expiration date of 120 days from date of hire in the employee's file. Administrator or designee will audit all staff's licenses to confirm no employees with an out of state license are working past the allowance of 120 days, or that any other employee is working with an expired license for a minimum of 2x/week for one (1) month, then 1x/week for two (2) months, then continuing monthly indefinitely. All staff hired with an out of state license shall be informed of this policy during orientation via a signed acknowledgment.**	