

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014253</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAND BROOK MEMORY CARE OF FISHERS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9796 EAST 131ST STREET FISHERS, IN 46038</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00382440.</p> <p>Complaint IN00382440 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: August 26, 2022</p> <p>Facility number: 014253</p> <p>Residential Census: 35</p> <p>Grand Brook Memory Care of Fishers was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00382440.</p> <p>Quality review completed August 26, 2022</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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