

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/25/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE GRANGER		STREET ADDRESS, CITY, STATE, ZIP CODE 430 CLEVELAND RD, GRANGER, , 46530					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00436418, IN00436368, IN00436026, and IN00433915. Complaint IN00436418 - No deficiencies related to the allegations are cited. Complaint IN00436368 - No deficiencies related to the allegations are cited. Complaint IN00436026 - No deficiencies related to the allegations are cited. Complaint IN00433915 - No deficiencies related to the allegations are cited. Survey date: June 25, 2024 Facility number: 002656 Residential Census: 39 Brookdale Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints	R 0000					

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

FORM APPROVED

OMB NO. 0938-0391

IN00436418, IN00436368, IN00436026, and IN00433915.			
Quality Review completed on 6/26/2024			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------