

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

|                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                    |                                  |                                                                 |  |                                                 |  |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------|--|-------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                              |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>09/20/2023 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BROOKDALE GRANGER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>430 CLEVELAND RD, GRANGER, , 46530 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                 | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID PREFIX<br>TAG                                                                   | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00413497 completed on 8/01/2023.</p> <p>Complaint IN00413497 - Corrected</p> <p>Survey date: September 20, 2023</p> <p>Facility number: 002656</p> <p>Residential Census: 33</p> <p>Brookdale Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00413497.</p> <p>Quality review completed 9/21/2023.</p> | R 0000                                                                             |                                  |                                                                 |  |                                                 |  |
| R 0052                                                | <p>Residents' Rights - Offense</p> <p>410 IAC 16.2-5-1.2(v)(1-6)</p> <p>(v) Residents have the right to be free from:</p>                                                                                                                                                                                                                                                                                                                                                       | R 0052                                                                             |                                  |                                                                 |  |                                                 |  |

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

|        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |  |  |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--|--|
|        | <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        |  |  |
| R 0090 | <p>Administration and Management - Deficiency</p> <p>410 IAC 16.2-5-1.3(g)(1-6)</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a</p> | R 0090 |  |  |

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

call shall be made to the emergency telephone number published by the division.

(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from

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

|                                                                                                                               |       |           |
|-------------------------------------------------------------------------------------------------------------------------------|-------|-----------|
| correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) |       |           |
| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                   | TITLE | (X6) DATE |