

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 04/16/2025	
NAME OF PROVIDER OR SUPPLIER GRAND BROOK MEMORY CARE OF FISHERS		STREET ADDRESS, CITY, STATE, ZIP CODE 9796 EAST 131ST STREET, FISHERS, , 46038					
(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 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	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited	R 0118	We request paper compliance for this alleged deficiency. 1.Describe what the facility did to correct the		04/17/2025		

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FORM APPROVED

OMB NO. 0938-0391

assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.

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 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

deficient practice for each client cited in the deficiency.

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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.

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.

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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.

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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.

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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

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Finding includes:

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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.

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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.

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).

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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