STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND BROOK MEMORY CARE OF GREENWOOD	2444 SOUTH STATE ROAD 135, GREENWOOD, , 46143

(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 Intakes 466903 and 467327. Intake 466903 - No deficiencies related to the allegations are cited. Intake 467327 - State deficiencies related to the allegations are cited at R0052. Survey date: January 20, 2026 Facility number: 014426 Residential Census: 32 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed January 22, 2026.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	**R052 – Grandbrook Memory Care of Greenwood**	

free from:

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 3 residents reviewed for abuse. A CNA smacked a cognitively impaired resident's arms. (Resident B, CNA 1)

Findings include:

During an interview on 1/20/26 at 9:18 a.m., the Administrator indicated she had watched the security camera footage after an allegation of abuse was made against CNA 1. The Administrator watched CNA 1 smack Resident B's forearms down with force but could not hear any audio. At that time, the Administrator demonstrated on herself what she had watched on the video and used one arm to smack down her other arm and reiterated Resident B's arms had been smacked down with force.

During an interview on 1/20/26

PLAN OF CORRECTION

This Plan of Correction constitutes the written allegation of compliance for the R052 tag cited. The Plan of Correction is submitted to meet requirements established by state.

Immediate Action:

- Security cameras viewed to validate incident in common area.

- Immediate suspension of employee pending investigation and resident was assessed for injuries (no injuries), followed by notifying the physician, family, and reporting to IDOH.

Investigation Procedures:

- An internal investigation was conducted, including staff interviews and review of surveillance cameras, to verify the claim. Resident(s) not able to be interviewed due to memory loss.

Staff Training:

- Upon hire all staff go through rigorous trainings to help promote patience,

	at 9:30 a.m., CNA 2 indicated she witnessed CNA 1 grab Resident B's hand in a forceful way and attempted to pull her. CNA 1 smacked Resident B's hand repeatedly and said stop you attitude. CNA 1 was tired of Resident B's behavior, and CNA 1 was done with Resident B. When CNA 2 reported this to the Administrator, CNA 2 told them to watch the cameras because CNA 2 had heard a smacking sound but did not see everything. On 1/20/26 at 9:21 a.m., the Administrator provided a copy of the investigation into the allegation of abuse made against CNA 1. A review of the investigation indicated an employee observed CNA 1 slap down Resident B's arms on camera. Resident B had been resisting care and redirection and CNA 1 had become frustrated. CNA 1 was suspended pending the investigation and had been terminated immediately after the investigation for her behavior. An Employee Separation Form, dated 1/15/26, indicated CNA 1 was terminated because she had been observed on camera slapping down Resident B's arm and hand. The clinical record for Resident B was reviewed on 1/20/26 at 9:42 a.m. The diagnoses		professionalism and alternatives when working with an agitated resident. • Community offers virtual dementia training (hands on) to help staff understand behaviors and different ways to help combat behaviors with caring and dignity. • All community staff were re-educated on the Abuse/Neglect/Mistreatment policy, specifically focusing on different proper techniques of handling physical/verbal abuse altercations before they occur. • Conducted 2 in-services in January of this year. One was on January 21, 2026 and the other January 29, 2026. These will continue throughout the year. ***Preventative Measures:*** • The community updated the staff training curriculum to include dementia-specific communication techniques (virtual dementia training) to reduce situations that lead to, or are perceived as, physical and/or verbal abuse". The Virtual Dementia Training conducted November	

included, but were not limited to, Alzheimer's disease and paranoia.

On 1/20/26 at 9:06 a.m., the Director of Nursing provided a copy of an undated facility policy, titled Abuse Prevention, and indicated this was the current policy used by the facility. A review of the policy indicated the facility prohibits abuse.

This citation relates to Intake 467327.

Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 3 residents reviewed for abuse. A CNA smacked a cognitively impaired resident's arms. (Resident B, CNA 1)

Findings include:

During an interview on 1/20/26 at 9:18 a.m., the Administrator indicated she had watched the security camera footage after an allegation of abuse was made against CNA 1. The Administrator watched CNA 1 smack Resident B's forearms down with force but could not hear any audio. At that time, the Administrator demonstrated on herself what she had watched on the video and used one arm to smack down her other arm and reiterated Resident B's

19th, 2025 and arranging another in February, 2026.

- Security cameras in common areas to monitor for potential resident-to-resident or staff-to-resident mistreatment".
- Continue to provide abuse in-services consistently and virtual dementia training.
- Pre-employment background checks and nurse aid checks.

Corrective Measures:

- **Training:**Continue to Inservice all staff consistently on abuse, reporting requirements, and the community's policy.
- **Policy Review:**Reviewed policy with staff at all staff in-service conducted on January 29, 2026
- **Monitoring:**ED and/or designee will continue to monitor cameras consistently to help ensure there are no further incidents occur.

arms had been smacked down with force.

During an interview on 1/20/26 at 9:30 a.m., CNA 2 indicated she witnessed CNA 1 grab Resident B's hand in a forceful way and attempted to pull her. CNA 1 smacked Resident B's hand repeatedly and said stop you attitude. CNA 1 was tired of Resident B's behavior, and CNA 1 was done with Resident B. When CNA 2 reported this to the Administrator, CNA 2 told them to watch the cameras because CNA 2 had heard a smacking sound but did not see everything.

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	An Employee Separation Form, dated 1/15/26, indicated CNA 1 was terminated because she had been observed on camera slapping down Resident B's arm and hand. The clinical record for Resident B was reviewed on 1/20/26 at 9:42 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and paranoia. On 1/20/26 at 9:06 a.m., the Director of Nursing provided a copy of an undated facility policy, titled Abuse Prevention, and indicated this was the current policy used by the facility. A review of the policy indicated the facility prohibits abuse. This citation relates to Intake 467327.			

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 SIGNATUREMilissa Downs	TITLEExecutive Director	(X6) DATE02/08/2026