

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

PRINTED: 10/17/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/09/2024	
NAME OF PROVIDER OR SUPPLIER GRAND EMERALD PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 4010 S IRONWOOD DR SOUTH BEND, IN 46614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
R 0000 Bldg. 00	This was an offsite Licensure Investigation Survey Survey Date: July 9, 2024 Facility: #013555 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 9, 2024			R 0000			
R 9999 Bldg. 00	16.2-5-1.1 Licenses (1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license. This state rule was not met as evidenced by: Based on document review, the facility failed to ensure it had timely renewed their license to operate as a residential care facility before their current license expired on June 30, 2024 The agency received the facility's renewal application and payment post marked July 3, 2024, which was not at least 45 days of the current license expiration date of June 30, 2024.			R 9999	The Facility has the potential to be affected by the alleged deficiency. The license renewal application was completed immediately upon notification of the license not being renewed. The licensure renewal application was completed immediately upon notification of ISDH not receiving. Mail regarding licensure status has been changed to the Corporate office address to avoid further issues. The Executive Director will be responsible to notify the home office of the need for license renewal 60 days prior to license		09/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Leigh Keirn

RN, RCA

09/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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					expiration. Corporate RN has placed renewal times on outlook Calander.		