STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT GRANGER	6330 N FIR 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 Intake IN00465429. Intake IN00465429 - State deficiencies related to the allegations are cited at R0052. Survey date: October 16 and 17, 2025 Facility number: 012229 Residential Census: 134 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/27/2025	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	This Plan of Correction is submitted in response to the Statement of Deficiencies issued by the Indiana Department of Health. This plan does not constitute an admission of fault or wrongdoing by the facility but	11/07/2025

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on interview, observation and record review, the facility failed to ensure the safety of 1 of 3 residents reviewed for elopement. (Resident D). This resulted in a cognitively impaired resident eloping from a secured Memory unit and wandering unattended in a parking lot.

Finding includes:

A review of a facility self-reported incident, on 10/16/2025 at 2:30 P.M., indicated Resident D had eloped on 10/11/2025 from the South Memory Care unit.

During and interview on 10/16/2025 at 2:35 P.M., the ED indicated on 10/11/2025 Resident D had left the facility through Door 14, was believed to have been outside for less than 2 minutes, and never left the sidewalk, according to video surveillance. A Life Enrichment Aide who had been walking to her car, saw the resident and took her back inside the facility. Door 14 was locked but was accessible with the key fob that

represents our continued commitment to compliance and the safety, dignity, and rights of all residents.

The facility respectfully requests a desk review in lieu of post-survey revisit.

1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

Resident D was immediately redirected back into the secured unit
by staff and assessed by nursing.

Resident D did not sustain any injury related to the deficient practice.

was given to all employees. The key fob allowed staff to enter the North and South Memory Care Units directly. At the time of the incident, staff used Door 14 as an entrance/exit to the employee parking lot. The Administrator indicated the door may not have latched/closed properly at the time of Resident D's elopement. He indicated the access to outside doors on both Memory Care Units had been changed since the elopement and staff no longer opened those doors as an entrance/exit door to the employee parking lot. In addition, a "Turn, Push/Pull" program had been instituted to ensure secured doors latched properly. The program instructed employees that had gone through a door, to turn and push or pull the door to ensure it was latched. The current audits indicated the employees had demonstrated an 80% compliance rate with the program. Those that failed to meet the expectation had received remedial training. The goal for the program was 100% compliance after 4 weeks and the audit was completed on all shifts.

During an interview on 10/17/2025 at 2:38 P.M., the ED indicated there had been no alarm on Door 14 at the time of the elopement. He indicated that the missing door checks, on 10/12/2025 between 2 P.M. and

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents residing in secured units in the facility have the potential to be affected by the deficient practice

3. Measures or systemic changes to ensure the deficient practice does not recur:

- Door 14 was removed from FOB access for entry/exit.

-Additional elopement drills conducted on 10/16/2025

8 P.M., was due to to employees being lax. Those employees had been reeducated. Employees had been using Door 14 to access the employee parking lot for several years.

During an observation, on 10/17/2025 at 10:00 A.M., the door Resident D had eloped from, Door 14 was observed. The door was located near the Memory care unit dining area and faced an employee parking lot. There was a window located in he top portion of the door. There was a lock and alarm located on the door.

A record review for Resident D was completed on 10/17/2025 at 10:05 A.M. Diagnoses included, but were not limited to, age related decline and mood disorder due to known physiological condition with depressive features. A Wellness Evaluation, dated 10/4/2025, indicated Resident D required supervision when outside on campus or on outings off campus. The Service Plan did not indicate the resident was an elopement risk and the record did not contain any evaluations of elopement risk. No other documentation of elopement incidents found in the record.

Nursing progress note, dated 10/11/2025 indicated Resident D had exited the building and

- Staff educated on the Secured Door Verification, policy Secure Door Alignment
policy, and Elopement procedure.

- Door verification Sheets updated to reflect door numbers in secured units.

- Education on 1st, 2nd, 3rd shift on facility
protocol of Turn, Push, Pull for entering/exiting secured units conducted.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):

- The Executive Director or Designee will conduct daily reviews of secure door verification sheets for four weeks, followed by weekly reviews for three additional months to ensure consistent completion and compliance.

was found in the employee parking lot area by a Life Enrichment staff member. There was no documentation of any injuries and the resident was easily redirected back inside the building by the staff member.

During an observation on 10/17/2025 at 10:10 AM, Resident D was in bed and indicated she had been asleep and sounded groggy when she answered the knock with "Come in." She was fully dressed and laying on top of the bedspread, covered by a smaller blanket.

During an observation of the South Memory Care Unit on 10/17/2025 at 11:19 A.M., the ED was completing an audit of the door to ensure staff were following the protocol of "Turn, Push/Pull/"

During an observation of lunch on the South Memory Care Unit on 10/17/2025 at 11:35 A.M., staff was serving lunch to 17 residents but Resident D was not present. QMA 4 indicated it was not unusual for the resident to stay in her room at lunch and staff would take a tray to her.

On 10/17/2025 at 9:01 A.M., the Maintenance Director (MD) indicated nursing staff completed every 2 hour checks on all exit doors. After the elopement incident involving Resident D, he verified all

- Any deviation or missed documentation will result in immediate follow-up and re-education of the responsible staff member.

- Sustained 100% compliance for four consecutive weeks will indicate
resolution.

- The Executive Director or Designee will audit 10 employees weekly for safely entering/exiting secured units using facility protocol of Push, Pull, Tun for
four weeks, then 5 employees weekly for three additional months to ensure
consistent completion and compliance. Audits will consist of staff from all 3
shifts.

- Any deviation will result in immediate follow-up and re-education of the responsible staff member.

5. Completion date for systemic changes:

All corrective actions and systemic changes will be fully

	entry/exit doors on both Memory Care Units were secured. The Quantum report (electronic report of doors that are not secured) indicated he had changed doors that had previously been accessible with employee key fobs so they were not able to accessed as entry/exit to the outside. On 10/17/2025 at 9:24 A.M., the ED indicated every 2 hour checks of the door was not a written policy but a standard for the facility and was in place before the elopement incident. The checks were to continue as required by facility standard. During an observation and interview on 10/17/2025 at 11:57 A.M., QMA 2 was observed checking the door to the driveway by pushing/pulling on it. QMA 2 indicated the system would have sent a notification to her phone a door if a secured door was breached. During an observation of the North Memory Care Unit on 10/17/2025 between 11:20 A.M. and 11:59 A.M., no residents were observed wandering aimlessly or exit seeking. During an interview on 10/17/2025 at 2:38 P.M., the Wellness Director (WD) indicated there were usually three employees scheduled during the day shift on the		implemented and in place by 11/7/2025	

South Memory Care Unit. She indicated there were three employees working on 10/11/2025 during the time Resident D had eloped. She indicated all employees were oriented on the "Turn/Push/Pull" process during onboarding and the orientation was documented in their personnel files. She indicated some employees, that had been hired prior to the current ownership purchasing the building may not have completed training in their files, but since Resident D's elopement, all employees had been retrained on the "Turn/Push/Pull" process for doors.

During an interview on 10/17/2025 at 3:04 A.M., QMA 4 indicated she checked the doors every 2 hours and if she was near a door she just checked it even if it was not necessarily time for the 2 hour check. If she suspected a resident had eloped, she would go out the door to see if she saw the resident and then would complete a head count on the unit. If someone was missing, she would have notified administration, and if directed, would cal a "Raggedy Ann" code and the room number to alert others in the facility that a resident has eloped.

During an interview on 10/17/2025 at 3:08 P.M., CNA 3

indicated she performed door checks every 2 hours using the push/pull method. If there was an elopement, an alert would have been sent to all staff who immediately would complete a head count.

On 10/16/2025 at 3:00 P.M. the ED provided a current policy dated 7/27/2022 and titled, "Secured Door Verification." The policy indicated, "...One caregiver per side, per shift, will be identified as the designee and will check the door every two hours during their shift.... and ...The Secured Door Verification sheet will be completed and kept in the wellness office....

On 10/16/2025 at 3:00 P.M. the ED provided a current policy dated 2/10/2022 and titled, "Memory Care and Assisted Living Secure Door Alignment." The policy indicated, "...When inspecting a secure door, perform the following checklist:

-Approach the door and swipe fob at location.

-Magnet will disengage.

-Open door completely and release.

-Determine if the door closes and latches without pushing.

-Determine if the magnet re-engages by pulling on

door...."

This citation relates to Intake IN00465429.

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14 as an entrance/exit to the employee parking lot. The Administrator indicated the door may not have latched/closed properly at the time of Resident D's elopement. He indicated the access to outside doors on both Memory Care Units had been changed since the elopement and staff no longer opened those doors as an entrance/exit door to the employee parking lot. In addition, a "Turn, Push/Pull" program had been instituted to ensure secured doors latched properly. The program instructed employees that had gone through a door, to turn and push or pull the door to ensure it was latched. The current audits indicated the employees had demonstrated an 80% compliance rate with the program. Those that failed to meet the expectation had received remedial training. The goal for the program was 100% compliance after 4 weeks and the audit was completed on all shifts.

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the employee parking lot for several years.

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Nursing progress note, dated 10/11/2025 indicated Resident D had exited the building and was found in the employee parking lot area by a Life Enrichment staff member. There was no documentation of any injuries and the resident was

easily redirected back inside the building by the staff member.

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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 SIGNATURECraig Clemons	TITLEExecutive Director	(X6) DATE11/07/2025