STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/18/2025

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 Complaint IN00452241. Complaint IN00452241 - State deficiencies related to the allegations are cited at R0090. Survey date: February 17 & 18, 2025 Facility number: 012229 Residential Census: 126 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 2/20/2025	R 0000	3/12/25 – To Whom It May Concern: On February 17th and 18th, 2025, a complaint survey was conducted at StoryPoint Granger. Attached is the plan of correction for tag R090. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey revisit. Thank you for your time and consideration, Martin Lebbin Executive Director StoryPoint Granger	

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (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: (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: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a 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.	R 0090	**R090 – Administration and Management - Deficiency** It is the practice of this provider to immediately report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The policy on “Resident Incident/Accident Reporting” was reviewed with staff regarding the immediate reporting of any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix A.) Staff were re-educated, by the ED/DNS/Designee, regarding the need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a resident, “immediately” to the ED/DNS. (Appendix B.)	03/12/2025

(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

Based on interview and record review, the facility failed to implement their policy related to the investigating and reporting allegations of abuse for 1 of 3 residents review for abuse, (Resident B)

Finding includes:

During a telephone interview on 2/17/2025 at 2:00 P.M., Certified Nurse Aide (CNA) 2,

The resident did not experience any unexpected outcome related to the deficient concern.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:

All residents have the potential to be affected.

The policy on “Resident Incident/Accident Reporting” was reviewed with staff regarding the immediate reporting of any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix A.) Staff were re-educated, by the ED/DNS/Designee, regarding the need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a resident, “immediately” to the ED/DNS. (Appendix B.)

Residents did not experience any negative outcomes related to the deficient concern.

What measures will be put into place or what systemic

	indicated on 1/1/25 between the evening and night shifts, CNA 3 came into Resident B's room to help him place a wedge under the residents mattress while the resident was in the bed. CNA 2 indicated CNA 3 yanked the mattress up causing Resident B to fall back and hit his head against the wall. CNA 2 indicated CNA 3 was yelling at the resident for "shitting all over himself " the previous night. CNA 2 indicated CNA 3 indicated the resident's head was not "hurt" but that he (the resident) had "pissed her off last night," and that the resident had, "Shit" all over himself and she had to clean him up and that "pissed her off." CNA 2 indicated he reported the incident to the Assistant Director of Nursing (ADON), two days after the event had occurred. CNA 2 indicated he did not intend to report abuse, because the resident was not injured and the action was not intentional, but he did not feel CNA 3 should have spoken to the resident or about the resident, the way she had spoken. CNA 2 indicated CNA 3 was not suspended pending an investigation and no follow-up was done by management. CNA 2 indicated he had made a referral to Adult Protective Services on 1/13/2025. During an interview on 2/18/25		***changes will be made to ensure that the deficient practice does not recur:*** The policy on “Resident Incident/Accident Reporting” was reviewed with staff regarding the immediate reporting of any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix A.) Staff were re-educated, by the DNS/ED/Designee, regarding the need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a resident, “immediately” to the ED/DNS. (Appendix B.) If concerns are noted, the ED/DNS/Designee will be notified immediately for corrective action.	

	at 10:05 A.M., an Adult Protective Services Representative (APS), indicated CNA 2 had filed a report with the APS office on 1/13/25, alleging abuse in the form of battery from CNA 3 toward Resident B. The APS representative indicated she had visited the facility on 1/14/25 and had spoken with the Director of Nursing, who indicated a report had been made, the resident was assessed with no findings and investigation had been completed without findings. The APS representative indicated their office had not substantiated the allegation, but was concerned the facility had failed to report the allegation to the State Authorities. The APS representative indicated she had filed a report to the State Agency following her 1/14/25 facility visit. During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 were working together on the evening of 1/1/24 when CNA 2 asked CNA 3 to help with Resident B. The Director of Nursing indicated CNA 2 indicated CNA 3 was putting a bolster mattress under Resident B's mattress when the resident hit his head against the wall. CNA 2 indicated he did not like the way CNA 3 had spoken to the resident afterwards. He		To ensure timely reporting, the ED/DNS/Designee will be notified “immediately”, per policy, of any resident incidents. Any staff not reporting any unusual occurrence or allegations of abuse that directly threatens the welfare, safety, or health of any resident, will be reprimanded per policy up to and including termination. A timely investigation and the required reporting will be conducted by the ED/DNS. As soon as an allegation is reported the ED/DNS will proceed with an investigation per policy. (Appendix A.) The “Internal Incident Report Form” (Appendix D) will be used to track the investigation of the allegation. This will be ongoing. In order to ensure timely reporting, the ED/DNS/Designee will immediately be notified of any resident incidents. The ED/DNS will follow up and submit to the state per policy. This will be ongoing.	

	indicated CNA 3 had stated the resident had "shit" himself and made a mess and that the statement was made in the presence of the resident. The Director of Nursing indicated CNA 3 had denied saying anything in the presence of Resident B. The Director of Nursing indicated both Qualified Medication Administration Aide,(QMA) 4 and QMA 7 were present at the time of the incident and both employees denied hearing CNA 3 speak that way in the presence of the resident and they also denied the resident had hit his head on the wall. The Director of Nursing indicated she was off work during the time of the allegation and did not return to work until 1/6/25, when the allegation of abuse was first reported to her. The Director of Nursing indicated the allegation of abuse should have been immediately reported to her and to the Administrator and a State Report should have been submitted, CNA 3 should have been suspended pending an investigation at the time the allegation of abuse was reported the the ADON. The Director of Nursing indicated CNA 2 should have reported the allegation of abuse immediately to the Supervisor, Director of Nursing and Administrator immediately, but had not. During an interview on 2/18/25		***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The policy on “Resident Incident/Accident Reporting” was reviewed with staff regarding the immediate reporting of any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix A.) Staff were re-educated, by the DNS/ED/Designee, regarding the need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a resident, “immediately” to the ED/DNS. (Appendix B.) In order to ensure timely reporting, the ED/DNS/Designee will question staff daily for 2 weeks, weekly for 2 weeks, and monthly for 6 months to ensure staff know they need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, immediately per policy. (Appendix C.) Any staff not being aware of the policy will be identified and retrained	

	at 11:01 A.M., the Assistant Director of Nursing indicated on 1/3/25 at the beginning of second shift, CNA 2 reported to her that on 1/1/25, CNA 3's actions were abusive to Resident B. The Assistant Director of Nursing indicated she had not documented the conversation with CNA 2 so she could not say what all he had reported, but she had suspended CNA 3 pending an investigation and had started an investigation regarding the resident hitting his head. The Assistant Director of Nursing indicated she had not reported the allegation to the Director of Nursing nor the Administrator until 1/6/25. The Assistant Director of Nursing indicated she should have reported the allegation to the Director of Nursing and the Administrator immediately.		and/or reprimanded, per policy up to and including termination. All new employees will be trained before they start work. If a threshold of 100% is not met, an action plan for the employee will be implemented. Starting with retraining and proceeding to being reprimanded per policy up to and including termination. Findings will be submitted to the Executive Director for review and follow-up. A timely investigation and the required reporting will be conducted by the ED/DNS. As soon as an allegation is reported the ED/DNS will proceed with an investigation per policy. (Appendix A.) The “Internal Incident Report Form” (Appendix D) will be used to track the investigation of the allegation. This will be ongoing. In order to ensure timely reporting, the ED/DNS/Designee will immediately be notified of any resident incidents. The ED/DNS will follow up and submit to the state per policy. This will be ongoing. **By what date the systemic changes will be**	

During an interview on 2/18/25 at 11:14 A.M., the Administrator indicated he was on vacation during the time of the alleged abuse and was not notified that an allegation of abuse had occurred until he returned to work on 1/6/25 and at that time, he had completed an internal incident report form. The Administrator indicated he had not reported the allegation of abuse to the State Agency because the allegation had been unsubstantiated and there was nothing to report.

A review of CNA 3's timesheets indicated the CNA was not immediately suspended pending an investigation and continued to work, on 1/3/2025 and on 1/3/2025, following the allegation of abuse reported to the Assistant Director of Nursing.

On 2/17/24 at 1:05 P.M., the facility's abuse investigation documentation was reviewed and included the following:

An undated written statement by CNA 2, who indicated on 1/1/25 he went into Resident B's room with CNA 3 because he could not place a wedge under the resident's mattress by myself and CNA 3 said she could. CNA 3 then grabbed the resident's mattress and lifted it, causing the resident to roll over and hit his head on the wall. CNA 3

completed: Compliance date: 3/12/25

said "and that's how you do it." CNA 2 indicated he asked the resident if he was alright and placed a pillow between him and the wall. CNA 2 indicated CNA 3 said to the resident, "Oh he's alright but you pissed me off last night didn't you. He shit all over the bed and I had to clean it up God D *** Was I pissed." CNA 2 told CNA 3 that the resident had not done it on purpose and CNA 3 stated, "I don't care it was a lot of shit and I had to clean it up!"

Resident B's clinical record was reviewed on 2/17/25 at 3:04 P.M. Diagnoses included Dementia, Parkinson's Disease, encephalopathy, and anxiety.

The Resident's Service Plan dated 8/2/24, indicated Resident B required full staff assistance for: toileting due to incontinence, dressing and grooming, bathing, and transfers. The resident had moderate cognitive impairment and required assistance with communication, and reasoning.

Review of a Nurses Progress Note dated 1/3/25 at 3:2., indicated the Assistant Director of Nursing had documented that staff had reported a possible occurrence of injury due to the resident hitting his head during care in the previous 48 hours. The residents' skin was assessed for injury, with no

abnormal findings, and Resident B's wife and the physician had been present at the time of the assessment.

The facility policy titled, "Abuse, Neglect, or Exploitation," dated 6/7/23 indicated, "...Initial Response...Staff should report all incidents immediately to the supervisor on duty...If a staff member is accused or suspected of abuse, neglect or exploitation, the staff member will be immediately removed from the community and work schedule pending the outcome of the investigation...'immediately' means as soon as possible, but will not exceed twenty-four (24) hours after the incident...The investigation should be documented...Results of the investigation will be reported to the appropriate licensing agencies..."

This Citation is related to Complaint IN00452241.

Based on interview and record review, the facility failed to implement their policy related to the investigating and reporting allegations of abuse for 1 of 3 residents review for abuse, (Resident B)

Finding includes:

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During an interview on 2/18/25

at 10:05 A.M., an Adult Protective Services Representative (APS), indicated CNA 2 had filed a report with the APS office on 1/13/25, alleging abuse in the form of battery from CNA 3 toward Resident B. The APS representative indicated she had visited the facility on 1/14/25 and had spoken with the Director of Nursing, who indicated a report had been made, the resident was assessed with no findings and investigation had been completed without findings. The APS representative indicated their office had not substantiated the allegation, but was concerned the facility had failed to report the allegation to the State Authorities. The APS representative indicated she had filed a report to the State Agency following her 1/14/25 facility visit.

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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