STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/26/2025

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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00463528 completed on 7/31/25. Complaint IN00463528 - Corrected Survey date: August 26, 2025. Facility number: 012229 Residential Census: 135 Storypoint Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00463528. Quality Review completed on 8/28/2025 This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00463528 completed on 7/31/25. Complaint IN00463528 - Corrected	R 0000		

	Survey date: August 26, 2025. Facility number: 012229 Residential Census: 135 Storypoint Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00463528. Quality Review completed on 8/28/2025			

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