

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

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|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------|--|-------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>02/14/2024 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>STORYPOINT SCHERERVILLE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>7770 BURR STREET, SCHERERVILLE, ,<br>46375 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                       | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                      | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the PSR completed on 10/24/23 to the Investigation of Complaints IN00412422 and IN00412687 completed on 7/19/23.</p> <p>This visit was done in conjunction with the PSR to the State Residential Licensure Survey completed on 10/24/23.</p> <p>This visit was done in conjunction with the Investigation of Complaints IN00421503 and IN00426914.</p> <p>Complaint IN00412422 - Corrected.</p> <p>Complaint IN00412687 - Corrected.</p> <p>Complaint IN00421503 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00426914 - No deficiencies related to the allegations are cited.</p> | R 0000                                                                                     |                                  |                                                                 |  |                                                 |  |

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Survey Date: February 14, 2024

Facility Number: 013825

Residential Census: 81

Storypoint of Schererville was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the PSR to the Investigation of Complaints IN00412422 and IN00412687.

Quality review completed on 2/16/24.

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This visit was done in conjunction with the Investigation of Complaints IN00421503 and IN00426914.

Complaint IN00412422 - Corrected.

Complaint IN00412687 - Corrected.

Complaint IN00421503 - No deficiencies related to the allegations are cited.

Complaint IN00426914 - No

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allegations are cited.

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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