

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/16/2026	
NAME OF PROVIDER OR SUPPLIER STORYPOINT SCHERERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7770 BURR STREET, SCHERERVILLE, , 46375					
(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 State Residential Licensure Survey. Survey dates: July 15 and 16, 2026 Facility number: 013825 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/20/26.	R 0000					
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,	R 0120	R0120 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the			07/20/2026	

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safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge	facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the deficient practice How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: The Community realizes that all residents have the potential to be affected by the deficient practice. All employee files have been audited for compliance What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur: The Community will ensure that all required training courses are completed prior to the start of employment for any new hires. Any employees identified as non-compliant will not be	
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	attendance by written signature. Based on record review and interview, the facility failed to ensure a new employee received required training related to resident rights for 1 of 5 employee records reviewed. (CNA 1) Finding includes: The employee records were reviewed on 7/16/26 at 9:00 a.m. CNA 1 had been hired on 4/29/26. There was no documentation the CNA had received training related to resident rights. During an interview on 7/16/26 at 10:40 a.m., the Executive Director indicated the CNA had not completed the resident rights training.		permitted to start employment in the community. An employee checklist will be implemented for new hires that will include all required trainings are completed prior to start date. See Attachment A How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director/designee will review all new employee files monthly for three (3) months. Once 100% compliance is achieved in monthly audits, quarterly audits will be completed for one year. See Attachment B By what date the systemic changes will be completed: July 20, 2026	
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R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications	R 0217	R0217 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice: Residents 7 and 3 were affected by this deficient practice. The residents did not experience any negative consequences related to the deficient concerns. How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: All facility residents had the potential to be affected by this deficient practice. Residents did not experience any negative	07/23/2026
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or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 2. Resident 3's record was reviewed on 7/15/26 at 1:49 p.m. Diagnoses included dementia and hypertension. A Service Plan completed on 6/2/26 indicated the resident required assistance with communication and redirection due to confusion and impaired judgment. The Service Plan was not signed by the resident or their responsible party and did not include oxygen therapy. A Progress Note, dated 6/20/26 at 5:11 p.m., indicated the resident was receiving oxygen at three liters per minute via nasal cannula. A Progress Note dated, 6/21/26 at 7:10 a.m., indicated the resident was receiving oxygen at three liters per minute via nasal cannula. The resident was alert, breathing evenly and unlabored, and appeared anxious and restless. A Progress Note dated, 6/24/26 at 3:52 p.m., indicated the resident had oxygen in place via nasal cannula. During an interview on 7/16/26	outcomes related to the deficient concerns. What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur: Wellness Director/designee will review service plans and meet with the resident or resident's representative to ensure service plans are signed. Service plans for resident 3 has been corrected. Resident 7 no longer resides in the community. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Service plans will be audited once (1) monthly to ensure compliance by the Wellness Director/designee ensuring all orders being documented and in place. This practice will remain ongoing until 100% compliance is maintained for three (3) consecutive months. See Attachment A. By what date the systemic changes will be completed: July 23, 2026	
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at 12:54 p.m., the Director of Nursing indicated she was unable to locate a signed copy of the resident's Service Plan and the Service Plan should have been updated to include oxygen use.

Based on record review and interview, the facility failed to ensure Service Plans were updated related to oxygen use and signed by the resident or responsible party for 2 of 7 records reviewed. (Residents 7 and 3)

Findings include:

1. The closed record for Resident 7 was reviewed on 7/15/26 at 11:47 a.m. Diagnoses included, but were not limited to, diverticulitis. The resident was discharged from the facility on 6/12/26.

The most recent Wellness Evaluation was completed on 1/28/26. The Service Plans indicated the last Service Plan review was completed 3/26/26. There was no documentation the Service Plans had been reviewed and signed by the resident or their responsible party.

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	During an interview on 7/16/26 at 12:55 p.m., the Director of Nursing indicated she was unable to find a signed service plan for the resident.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure a Qualified Medication Aide (QMA) received authorization from a licensed nurse prior to administering an as needed (PRN) medication for 1 of 7 records reviewed. (Resident 3) Finding includes:	R 0246	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Staff re-educated on the scope of practice including proper protocol for PRN medications administration requiring nurse assessment and approval prior to administration. How other residents having the potential to be affected by the same deficient practice will be identified and what	07/20/2026

Record review for Resident 3 was completed on 7/15/26 at 1:49 p.m. Diagnoses included, but were not limited to, dementia.

The Physician's Order Summary, dated 7/2026, indicated orders for lorazepam (antianxiety medication) 2 milligrams (mg) per milliliter (ml) oral concentrate, 0.5 ml (1 mg) by mouth every 2 hours as needed.

The Medication Administration Record (MAR), dated 7/2026, indicated the PRN lorazepam was signed out as administered by QMA 1 on 6/25/26 at 7:18 a.m. There was no documentation to indicate QMA 1 had received authorization from a licensed nurse prior to administering the medication.

During an interview on 7/16/26 at 12:54 p.m., the Director of Nursing indicated a QMA administering a PRN medication should receive prior authorization from a nurse and document that in the progress notes.

corrective action(s) will be taken:

All residents who receive PRN medications have the potential to be affected. Staff were educated on PRN protocols and scope of practice.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

The Wellness Director/Designee will provide ongoing education to all current and newly hired QMA's on scope of practice, with emphasis on PRN medication protocols. A copy of the scope of practice guidelines will be reviewed and signed by all QMAs and filed in their personnel records.

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 Wellness Director or designee will audit PRN medication administration records for proper nurse authorization and documentation daily for 4weeks, then weekly for 4 weeks, then monthly for 3 months. Any discrepancies will be addressed immediately and reviewed

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			during monthly QA meetings to ensure ongoing compliance. See attachment A By what date the systemic changes will be completed: Compliance date: July 20, 2026	
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to no physician's order for oxygen therapy for 1 of 7 records reviewed. (Resident 3) Finding includes:	R 0349	R0349 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice: Resident 3 was affected by this deficient practice. The residents did not experience any negative consequences related to the	07/20/2026

A list received on 7/15/26 from the Administrator indicated Resident 3 received oxygen therapy.

On 7/16/26 at 11:05 a.m., Resident 3's room was observed. There were two oxygen canisters stored in the resident's room.

On 7/16/26 at 11:10 a.m., Resident 3 was observed sitting in a Broda chair in the common area watching television. The resident was not receiving oxygen therapy at the time.

Resident 3's record was reviewed on 7/15/26 at 1:49 p.m. Diagnoses included dementia and hypertension.

A Service Plan, completed on 6/2/26, indicated the resident required assistance with communication and redirection due to confusion and impaired judgment. The Service Plan did not include oxygen therapy.

The July 2026 Physician's Order Summary lacked an order for oxygen therapy.

A Progress Note, dated 6/20/26 at 5:11 p.m., indicated the resident was receiving oxygen at three liters per minute via nasal cannula.

A Progress Note, dated 6/21/26 at 7:10 a.m., indicated the

deficiency concerns. Clinical orders were checked for accuracy and following the physician's plan.

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

All facility residents had the potential to be affected by this deficient practice. Community will collaborate with physicians for proper communication on all future order changes. Staff reeducated, via in-service, on documenting all communication for new orders received.

What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur:

The Wellness Director/Designee will audit all new orders received for one (1) month. Orders will then be audited every other week for one (1) month. See attachment A

How will the corrective action(s) be monitored to ensure the deficient will not recur, i.e., what quality assurance program will be put into place:

Bi-weekly audits will remain

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resident was receiving oxygen at three liters per minute via nasal cannula. The resident was alert, breathing evenly and unlabored, and appeared anxious and restless.

A Progress Note, dated 6/24/26 at 3:52 p.m., indicated the resident had oxygen in place via nasal cannula.

During an interview on 7/16/26 at 12:54 p.m., the Director of Nursing indicated the resident received oxygen therapy as needed since her return from the hospital last month. The resident should have had orders for oxygen therapy.

ongoing until 100% compliance is maintained for two (2) consecutive months.

By what date the systemic changes will be completed:

July 20, 2026

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 SIGNATUREStephanie Peterson	TITLEExecutive Director	(X6) DATE07/28/2026
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