STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT GRANGER	6330 N FIR RD GRANGER, IN 46530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414012, IN00413416 and IN00412030. Complaint IN00414012 - No deficiencies related to the allegations are cited. Complaint IN00413416 - State deficiency related to the allegations is cited at R0245. Complaint IN00412030 - No deficiencies related to the allegations are cited. Survey date: July 31 & August 1, 2023 Facility number: 012229 Residential Census: 119 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed 8/3/2023.	R 0000	8/15/23 – To Whom It May Concern: On July 31st to August 1st, 2023, a complaint survey was conducted at StoryPoint Granger. This Plan of Correction refers to a plan created for a prior survey ending May 25th. Since the May Plan of Correction was approved, no new QMAs have been hired or are involved in the current findings. Attached is the plan of correction for tags R245, 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 initial Plan of Correction being submitted for the May 25th 2023 survey regarding the same QMA and subsequent termination, 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 0245 Bldg. 00	410 IAC 16.2-5-4(e)(5) Health Services - Offense (5) Injectable medications shall be given only by licensed personnel. Based on record review, the facility failed to	R 0245	**R245 – Health Services -**	08/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martin Lebbin	Executive Director	08/15/2023

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	ensure a Qualified Medication Aide (QMA) did not administer insulin in 1 of 5 residents who received injectable insulin. (Resident C) Finding includes: A facility self-reported incident #257, dated 7/19/23, indicated QMA 2 administered insulin to the Resident C, on 7/13/23, and was not certified to administer the insulin. QMA 2 was suspended pending the investigation. Incident investigation note, dated 7/13/23, indicated CNA 3 witnessed QMA 2 administer Resident C's insulin, in front of his family, on 7/13/23. A Corrective Action Form, dated 7/20/23, indicated "...Previous Counseling...On May 25, 2023, during a state complaint survey, it was identified that employee was not certified to administer insulin in the state of Indiana. Employee received training in Michigan for insulin administration. Employee was counseled at that time, she was not allowed to give insulin under Indiana State Regulations for our community due to not having proper Indiana State licensure. Statement of Behavior...Upon investigation of missing signatures on the eMar [electronic Medication Administration Record] for 7/13/23 8 pm insulin had a hole where it was not signed out. Upon investigation of missing signature, staff reported the the HS [night time] insulin was given by non-insulin certified QMA employee, [name of QMA 2]. [Name of QMA] was placed on suspension on 7/19/23, until investigation was completed and admitted to having given the insulin on the date and time...Our expectation... Employee was terminated on 7/20/23...."		**Offense** It is the practice of this provider to assure injectable medications are given only by licensed personnel. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** QMA 2 was immediately suspended pending investigation. Resident C had their insulin administration reviewed. The resident did not experience any negative outcomes 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. QMA 2 was immediately suspended pending investigation. Resident C had their insulin administration reviewed. The resident did not experience any negative outcomes related to the deficient concern. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** QMA 2 was counseled regarding the findings of the survey completed on 5/25/23. They were told NOT to administer insulin to residents in the state of Indiana,	

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	On 7/31/23 at 11:49 A.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: diabetes and dementia. The Medication Administration Record (MAR) for July indicated the resident was to be administered Glargine insulin, 6 units subcutaneously (under the skin), at bedtime. The MAR was left undocumented for 7/13/23. On 7/31/23 at 11:43 A.M., the Administrator provided a policy titled "Medication Administration", dated 4/11/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Administration: 1. Medications are administered only by licensed nursing , medical, pharmacy or other persons authorized by state laws and regulations to administer medications...." This State Residential Finding relates to complaint IN00413416.		as a result of NOT being certified to administer insulin in the state. QMA 2 was instructed to sign up for an insulin administration course and obtain their certification. **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;** After the 5/25/23 survey, to date, there have not been any new QMA's added to the StoryPoint Granger Staff. On 8/2/23 an insulin in-service was conducted for QMAs. (See attachment 1.) The same Plan of Correction is being followed from the 5/25/23 survey. As a result of prior counseling and violation of StoryPoint Policy and State Regulations, QMA 2 was terminated. **By what date the systemic chances will be completed:** Compliance date: 8/3/23	