

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER		STREET ADDRESS, CITY, STATE, ZIP CODE 6330 N FIR RD GRANGER, IN 46530		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00410972 and IN00410392.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00409063, IN00408412 and IN00408053 completed on May 25, 2023.</p> <p>Complaint IN00410972 - No deficiencies related to the allegations are cited. Complaint IN00410392 - No deficiencies related to the allegations are cited. Complaint IN00409063 - Corrected. Complaint IN00408412 - Corrected. Complaint IN00408053 - Corrected.</p> <p>Survey dates: June 26 & 27, 2023</p> <p>Facility number: 012229</p> <p>Residential Census: 119</p> <p>Storypoint Granger was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00410972 and IN00410392.</p> <p>Quality review was completed 7/5/2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE