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	11/14/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00446324, IN00445359, IN00445068. Complaint IN00446324 - No deficiencies related to the allegations are cited. Complaint IN00445359 - No deficiencies related to the allegations are cited. Complaint IN00445068 - No deficiences related to the allegations are cited. Survey dates: Novemeber 12, 13 & 14, 2024. Facility number: 012229 Residential Census: 122 These State Residential Findings are cited in accordamce with 410 IAC 16.2-5. Quality Review completed on 11/22/2024	R 0000	12/4/24 – To Whom It May Concern: On November 12th to November 14th, 2024, an annual survey was conducted at StoryPoint Granger. Attached is the plan of correction for tags R217, R273, R407 and R410, 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 relative low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey revisit. Thank you for your time and consideration, Martin Lebbin, HFA Executive Director StoryPoint Granger	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to obtain a signature from the resident or resident'ts representative, on the service plan for 1 of 7 residents whose records were reviewed. (Resident 3) Finding includes: A record review was completed on 11/12/2024 at 1:50 P.M. for Resident 3. The record lacked a	R 0217	**R217 – Evaluation** It is the practice of this provider to assure that the completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility. **What corrective action(s) will be accomplished for those**	12/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martin Lebbin	Executive Director	12/04/2024

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	signature from the resident or resident's representative, on service plans dated 6/12/2024 and 10/1/2024. During an interview on 11/14/2024 at 9:26 A.M., the DON indicated the service plans had not been signed by the resident or resident's representative, and should have been signed and dated. On 11/14/2024 at 10:30 A.M. the DON provided a current policy, dated 2/24/2023, and titled "Resident Evaluation and Service Plan." The policy indicated, "...9. A current copy of the Service Plan is to be reviewed and signed by the resident and/or responsible party, and the Wellness Leader or Designee...."		**residents found to have been affected by the deficient practice:** Resident 3's record lacked a signature from the resident or resident's representative, on service plans dated 6/12/24 and 10/1/24. 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. Resident 3's record lacked a signature from the resident or resident's representative, on service plans dated 6/12/24 and 10/1/24. Residents 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:** Nursing will review service plans and meet with the resident or resident's representative to assure service plans are signed. The DNS/Designee will run the "Evaluation Scheduled Audit Report" (Appendix A) identifying any resident(s) requiring a service plan update and review the service	

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			plans for signatures. Existing resident service plans will be reviewed by 12/6/24 for signatures. If a signature is missing, the DNS/Designee will follow up with the resident or resident's representative for signatures by 12/13/24. **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:** Nursing will review service plans, run the "Evaluation Scheduled Audit Report" (Appendix A) and meet with the resident and/or resident's representative to assure service plans are signed. The DNS/Designee will retrieve reports for any resident(s) requiring a service plan update and review the service plans for proper completion. This will be done/reviewed weekly for 4 weeks, monthly for 4 months and then ongoing monthly. The DNS/Designee will be responsible for the review and completion of resident records. Reviewing service plans to make sure they contain updated signatures. This will be ongoing. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic**	

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			chances will be completed: Compliance date: 12/13/24	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review and interview, the facility failed to ensure food was stored in a sanitary manner for 1 of 1 kitchens. This had the potential to affect 122 of 122 residents who consumed food from the kitchen. Finding includes: During a tour of the kitchen, conducted on 11/12/2024 at 10:22 A.M. with the Executive Chef, the following was observed: - a measuring cup was laying on top of the sugar in the storage bin - an opened bag of cheese was undated -a thawed out bag of berries and a container of mini eclairs was undated - gallon sized containers of poppy seed dressing, ranch dressing, French dressing and Italian dressing, plus a large container of sour cream were undated. During an interview on 11/12/2024 at 10:30 A.M., the Executive Chef indicated a cup should not have been in the bin with the sugar and all refrigerated items that were opened should have had a date on them. On 11/12/2024 at 11:03 A.M., provided a policy titled, "Food Dating Guide," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...All food once it is opened, or has the manufactory's seal broken, or has been prepped in any way, needs to be labeled and dated with the correct shelf life	R 0273	**R273 – Food and Nutritional Services** It is the practice of this provider to assure all food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The dietary staff were re-educated by the Executive Chef/Designee regarding the proper storage of measuring cups, and open and undated products. Residents 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. The dietary staff were re-educated by the Executive Chef/Designee regarding the proper storage of measuring cups, and open and undated products.	12/06/2024

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	from the Food Dating Guide. This Guide is used as a quick reference. We MUST have a label that containers the following: item name, date and time, used by date, initials of person labeling the item, securely cover food item, use the same label at all times and in all areas. A label must be made immediately when the food product is going into storage, this is nonnegotiable....."		Residents 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:*** The dietary staff were re-educated by the Executive Chef/Designee regarding the proper storage of measuring cups, and open and undated products (Appendix B). The Executive Chef/Designee will monitor the storage areas daily for 2 weeks, weekly for 2 weeks, and monthly for 2 months to ensure staff are properly storing measuring cups and dating all necessary open products. A tracking tool will be utilized (Appendix C). ***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 dietary staff were re-educated by the Executive Chef/Designee regarding the proper storage of measuring cups, and open and undated products (Appendix B). The Executive Chef/Designee will monitor the storage areas daily for 2 weeks, weekly for 2 weeks, and monthly for 2 months to ensure staff are properly storing measuring cups and dating all necessary open products. A tracking tool will be utilized	

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			(Appendix C). Any staff not following the protocol will be identified. If a threshold of 100% is not met, an action plan for the employee will be developed. This will be ongoing. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 12/6/24	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to establish an infection control program that included, but was not limited to, a system that enabled the facility to analyze patterns of known infection symptoms and conduct ongoing analysis and surveillance data and review the data and document any follow-up activities. This had the potential to affect 122 of 122 residents who reside in the facility. Finding includes: During a review of the facility's Infection Control and Surveillance book for the months of March - September 2024, conducted on 11/13/2024 at 11:02 A.M. with the Wellness Director, the pages in the log book were blank. During an interview with the Wellness Director, during the review, she indicated she had not filled out the log book for those months and should have been monitoring and trending infections. On 11/14/2024 at 10:28 A.M., the Wellness Director indicated that she did not have a policy	R 0407	**R407 – Infection Control** It is the practice of this provider to establish and maintain an infection control program. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** It was identified that the months of March – September 2024 did not have any infection control data. The DNS/Designee will complete the “Infection Control Logbook” monthly identifying any trends. If there are no trends identified in the “Infection Control Logbook” it will be reflected. Residents did not experience any unexpected outcome related to the deficient concern. ***How other residents having the potential to be affected by the same deficient practice will be***	12/13/2024

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	on antibiotic surveillance, but the facility followed the State regulations.		***identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. It was identified that the months of March – September 2024 did not have any infection control data. The DNS/Designee will complete the "Infection Control Logbook" (Appendix D) monthly identifying any trends. If there are no trends identified this will be reflected. Residents did not experience any unexpected outcome 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:*** It was identified that the months of March – September 2024 did not have any infection control data. The DNS/Designee will complete the "Infection Control Logbook" (Appendix D) monthly identifying any trends. If there are no trends identified this will be reflected. To ensure timely reporting, the DNS/ED/Designee will run the "Medication Classification Audit Report" (Appendix E) to identify any residents that received new antibiotic orders. ***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 DNS/Designee will complete	

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			the "Infection Control Logbook" (Appendix D) monthly identifying any trends. If there are no trends identified this will be reflected. To ensure timely reporting, the DNS/Designee will run the "Medication Classification Audit Report" (Appendix E) to identify any residents that received new antibiotic orders. Information from the audit report will be logged on to the surveillance line list to identify any trends. This will be done weekly for 4 weeks, monthly for 4 months, and then ongoing. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance date: 12/13/24	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to complete a second step tuberculosis (TB) skin test after admission for 1 of 7 residents whose records were reviewed. (Resident 7) Finding includes: A record review was completed on 11/13/2024 at 11:12 A.M. for Resident 7. The record lacked documentation when the first step had been completed and the second step had not been completed.	R 0410	**R410 – Infection Control** It is the practice of this provider to make sure new residents receive a tuberculin skin test within 3 months prior to admission or upon admission and read at least forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. **What corrective action(s) will be accomplished for those**	12/13/2024

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	During an interview on 11/14/2024 at 9:26 A.M., the DON indicated a 2nd step TB skin test should have been done but the test was not administered. On 11/14/2024 at 10:44 A.M., the DON provided a current policy, dated 8/23/2024 and titled, "Tuberculosis Infection Control Plan." The policy indicated, "...Testing may include TST (tuberculosis skin test), BAMT (blood assay for Mycobacterium tuberculosis), or other as accepted by public health...."		**residents found to have been affected by the deficient practice:** The DNS/Designee will review resident records for compliance with tuberculin skin testing. Any resident(s), having been identified as noncompliant will receive a tuberculin skin test with follow up. The residents 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. The DNS/Designee will review resident records for compliance with tuberculin skin testing. Any resident(s), having been identified as noncompliant will receive a tuberculin skin test with follow up. The residents 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:** The DNS/Designee will review resident records for compliance with tuberculin skin testing. Any resident(s), having been identified as noncompliant will receive a tuberculin skin test with follow up. To ensure timely reporting, the	

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			DNS/Designee will run the "Evaluation Scheduled Audit Report" (Appendix F) to identify any residents requiring tuberculin skin testing. **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 DNS/Designee will review resident records for compliance with tuberculin skin testing. Any resident(s), having been identified as noncompliant will receive a tuberculin skin test with follow up. To ensure timely reporting, the DNS/Designee will run the "Evaluation Scheduled Audit Report" (Appendix F) to identify any residents requiring tuberculin skin testing. This will be done weekly for 4 weeks, monthly for 4 months, and then ongoing. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic chances will be completed:** Compliance date: 12/13/24	