PRINTED: 12/13/2024 FORM APPROVED OMB NO. 0938-039

			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
			B. WI	NG		11/14/	2024
NAME OF PROVIDER OR SUPPLIER  STORYPOINT GRANGER		R	STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000						ļ	
Bldg. 00	Survey. This visit Complaint IN0044 The allegations are Survey dates: Nov Facility number: 0 Residential Census These State Reside accordance with 4	5359 - No deficiencies related to cited.  5068 - No deficiences related to cited.  remeber 12, 13 & 14, 2024.  112229  112229  1122 cential Findings are cited in	R 00	000	12/4/24 – To Whom It May Concern: On November 12th of November 14th, 2024, an announce survey was conducted at StoryPoint Granger. Attached the plan of correction for tags R217, R273, R407 and R410, creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. Due to the relative low scope severity of this survey, the community respectfully requested sk review in lieu of a post-servisit.  Thank you for your time and consideration, Martin Lebbin, HFA Executive Director StoryPoint Granger	is the is s t forth es, or and	
R 0217	410 IAC 16.2-5-2 Evaluation - Defic						
Bldg. 00	failed to obtain a si resident'ts represen of 7 residents whos (Resident 3) Finding includes:	view and interview, the facility ignature from the resident or stative, on the service plan for 1 se records were reviewed.  as completed on 11/12/2024 at dent 3. The record lacked a	R 02	217	R217 – Evaluation It is the practice of this provide assure that the completion of 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	an	12/13/2024

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

(X6) DATE

TITLE

Martin Lebbin Executive Director 12/04/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED
			B. W	ING		11/14/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>
NAME OF F	PROVIDER OR SUPPLIEF	<b>t</b>				
OTODY/D	ONT ODANOED				FIR RD	
STURYP	OINT GRANGER			GRANC	GER, IN 46530	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	signature from the	resident or resident's			residents found to have been	n
	representative, on s	ervice plans dated 6/12/2024			affected by the deficient	
	and 10/1/2024.	•			practice:	
					Resident 3's record lacked a	
	During an interview	v on 11/14/2024 at 9:26 A.M.,			signature from the resident or	
	_	the service plans had not been			resident's representative, on	
	signed by the reside	-			service plans dated 6/12/24 a	nd
		should have been signed and			10/1/24.	
	dated.	Č			The resident did not experience	ce
					any negative outcomes related	
	On 11/14/2024 at 1	0:30 A.M. the DON provided a			the deficient concern.	
		d 2/24/2023, and titled			How other residents having	the
		on and Service Plan." The			potential to be affected by the	
		.9. A current copy of the			same deficient practice will l	
		e reviewed and signed by the			identified and what corrective	
		onsible party, and the			action(s) will be taken:	
	Wellness Leader or				All residents have the potentia	al to
		S			be affected.	
					Resident 3's record lacked a	
					signature from the resident or	
					resident's representative, on	
					service plans dated 6/12/24 a	nd
					10/1/24.	
					Residents did not experience	any
					negative outcomes related to	-
					deficient concern.	
					What measures will be put ir	nto
					place or what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur:	
					Nursing will review service pla	ins
					and meet with the resident or	
					resident's representative to as	ssure
					service plans are signed.	
					The DNS/Designee will run th	e
					"Evaluation Scheduled Audit	
					Report" (Appendix A) identifyi	ng
					any resident(s) requiring a ser	·
					plan update and review the se	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/14/2024
	ROVIDER OR SUPPLIEI OINT GRANGER	₹	6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD GER, IN 46530	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				plans for signatures. Existing resident service plans will be reviewed by 12/6/24 for signal of a signature is missing, the DNS/Designee will follow up the resident or resident's representative for signatures 12/13/24.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place:  Nursing will review service plarun the "Evaluation Scheduled Audit Report" (Appendix A) armeet with the resident and/or resident's representative to asservice plans are signed.  The DNS/Designee will retriev reports for any resident(s) requiring a service plans for prompletion. This will be done/reviewed weekly for 4 wonthly for 4 months and the ongoing monthly.  The DNS/Designee will be responsible for the review and completion of resident records Reviewing service plans to make they contain updated signatures. This will be ongoin a threshold of 100% is not meaction plan will be developed. Findings will be submitted to the Executive Director for review follow-up.  By what date the systemic	with by  the  out  ans, d and ssure we and roper weeks, n  d s. ake ake ag. If et, an the

State Form Event ID: 9QDH11 Facility ID: 012229 If continuation sheet Page 3 of 10

PRINTED: 12/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING		11/14/			
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD			
OTODVO	OINT ODANOED				FIR RD			
STORYP	OINT GRANGER			GRANC	GER, IN 46530			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
					chances will be completed:			
					Compliance date: 12/13/24			
R 0273	410 IAC 16.2-5-5.	1(f)						
	Food and Nutrition	nal Services - Deficiency						
Bldg. 00								
		on, record review and	R 0	273	R273 – Food and Nutritional		12/06/2024	
		ty failed to ensure food was			Services			
	-	manner for 1 of 1 kitchens.			It is the practice of this provide	er to		
		ial to affect 122 of 122			assure all food preparation an	d		
	residents who const	umed food from the kitchen.			serving areas (excluding areas	s in		
					residents' units) are maintaine	d in		
	Finding includes:				accordance with state and loc	al		
					sanitation and safe food hand	ing		
	_	e kitchen, conducted on		standards.				
		2 A.M. with the Executive Chef,		What corrective action(s) will be		ll be		
	the following was o			accomplished for those				
		vas laying on top of the sugar		residents found to have been		n		
	in the storage bin				affected by the deficient			
	- an opened bag of				practice:			
		of berries and a container of			The dietary staff were re-educ			
	mini eclairs was un				by the Executive Chef/Design			
		ainers of poppy seed dressing,			regarding the proper storage of			
		nch dressing and Italian			measuring cups, and open an	d		
		ge container of sour cream			undated products.			
	were undated.				Residents did not experience			
		14/42/2024			negative outcomes related to	ihe		
	_	v on 11/12/2024 at 10:30 A.M.,			deficient concern.			
		indicated a cup should not			How other residents having			
		n with the sugar and all			potential to be affected by the			
		hat were opened should have			same deficient practice will l			
	had a date on them.				identified and what corrective	'e		
	On 11/12/2024 + 1	1.02 A.M. marrid-11:			action(s) will be taken:	.14-		
		1:03 A.M., provided a policy			All residents have the potentia	וו נס		
	_	g Guide," undated, and			be affected.	-4		
		was the one currently used			The dietary staff were re-educ			
		policy indicated "All food			by the Executive Chef/Design			
	_	r has the manufactory's seal			regarding the proper storage of			
		prepped in any way, needs to			measuring cups, and open an	a		
	pe labeled and date	d with the correct shelf life	1		undated products.			

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMI	e survey Pleted 4/2024
PROVIDER OR SUPPLIE	R	6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD GER, IN 46530	•	
SUMMARY (EACH DEFICIENT REGULATORY OF The Food Date as a quick reference containers the following time, used by date, item, securely cover at all times and in a secure of the following the secure of the following	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ing Guide. This Guide is used e. We MUST have a label that owing: item name, date and initials of person labeling the er food item, use the same label all areas. A label must be made the food product is going into	STREET . 6330 N	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION OF OF CORRECTIVE ACT	ence any ed to the educated esignee age of en and ensure engall s. A ed ed ence engal ence engal ence ence engal ence ence ence ence ence ence ence enc	(X5) COMPLETION DATE
			monitor the storage areas 2 weeks, weekly for 2 we monthly for 2 months to e staff are properly storing measuring cups and datin necessary open products tracking tool will be utilized.	eks, and ensure ng all s. A	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
			B. W	B. WING		11/14/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			FIR RD		
STORYP	OINT GRANGER				GER, IN 46530		
		CTATEMENT OF DEPOSITABLE			· 		(V.E.)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	REGULATURY OR	LSC IDENTIFYING INFORMATION	+	IAU	(Appendix C).		DATE
					Any staff not following the		
					protocol will be identified. If a		
					threshold of 100% is not met,	an	
					action plan for the employee v		
					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		
D 046-							
R 0407	410 IAC 16.2-5-12	, , , ,					
DI4-: 00	Infection Control -	Noncompliance					
Bldg. 00	Dagad am	days and internity st C11ie-	n ^	407	D407 Info of the Control		10/10/2024
		riew and interview, the facility ninfection control program	R 0	40/	R407 – Infection Control	or to	12/13/2024
		ras not limited to, a system that			It is the practice of this provide establish and maintain an infe		
		to analyze patterns of known			control program.	CilOII	
		and conduct ongoing			What corrective action(s) will	l be	
		lance data and review the data			accomplished for those	- 20	
		follow-up activities. This had		residents found to have		า	
	,	ct 122 of 122 residents who			affected by the deficient		
	reside in the facility	<i>.</i> .			practice:		
					It was identified that the month	ns of	
	Finding includes:				March – September 2024 did	not	
					have any infection control data		
	-	the facility's Infection Control			The DNS/Designee will compl		
		ok for the months of March -			the "Infection Control Logbook		
	-	onducted on 11/13/2024 at 11:02			monthly identifying any trends		
		ness Director, the pages in the			there are no trends identified i		
	_ ~	k. During an interview with the			"Infection Control Logbook" it	WIII	
		during the review, she ot filled out the log book for			be reflected.	onv.	
		nould have been monitoring			Residents did not experience unexpected outcome related to	-	
	and trending infection	_			the deficient concern.	U	
	and dending infection	0113.			How other residents having	the	
	On 11/14/2024 at 10	0:28 A.M., the Wellness			potential to be affected by the		
		hat she did not have a policy			same deficient practice will l		
		Po	1		adiididik pi addod Will k		l

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	-
STORYF	POINT GRANGER		GRAN	GER, IN 46530	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE
TAG		llance, but the facility followed	TAG	identified and what corrective action(s) will be taken:  All residents have the potential be affected.  It was identified that the monto March – September 2024 did have any infection control dato The DNS/Designee will compute "Infection Control Logbool (Appendix D) monthly identify any trends. If there are no treation to the deficient concern.  What measures will be put in place or what systemic charmillowers will be made to ensure that a deficient practice does not recur:  It was identified that the monto March – September 2024 did have any infection control dato The DNS/Designee will compute "Infection Control Logbool (Appendix D) monthly identify any trends. If there are no treation time the "Infection Control Logbool (Appendix D) monthly identify any trends. If there are no treation time the "Medication Classification August The DNS/ED/Designee will run the "Medication Classification August The Control Control Logbool (Appendix E) to idention the montored to ensure the deficient practice will not reation, what quality assurance program will be put into place program will be put into place program will be put into place program vill be put into place in the interpretation of the place program vill be put into place in the program vill village in the program village program villa	re al to hs of not a. lete k' ing nds . any to nto nges the hs of not a. lete k'' ing inds . e e e diffy ew  will cur,
			1	The DNS/Designee will comp	lete

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED  11/14/2024			
	PROVIDER OR SUPPLIER		6330 N	STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				the "Infection Control Logbook (Appendix D) monthly identifyi any trends. If there are no trer identified this will be reflected. To ensure timely reporting, the DNS/Designee will run the "Medication Classification Aud Report" (Appendix E) to identify any residents that received ne antibiotic orders. Information of the audit report will be logged to the surveillance line list to identify any trends. This will be done weekly for 4 weeks, mor for 4 months, and then ongoin of a threshold of 100% is not man action plan will be developed Findings will be submitted to the Executive Director for review a follow-up.  By what date the systemic changes will be completed: Compliance date: 12/13/24	ng nds e lit fy w rom on e nthly g. net, ed. he			
R 0410 Bldg. 00	410 IAC 16.2-5-12 Infection Control -							
2.43. 00	failed to complete a skin test after admis whose records were Finding includes: A record review wa 11:12 A.M. for Res documentation whe	riew and interview, the facility second step tuberculosis (TB) sion for 1 of 7 residents reviewed. (Resident 7)  s completed on 11/13/2024 at ident 7. The record lacked in the first step had been second step had not been	R 0410	R410 – Infection Control It is the practice of this provide make sure new residents rece tuberculin skin test within 3 months prior to admission or u admission and read at least forty-eight (48) to seventy-two hours. The result shall be rece in millimeters of induration with date given, date read, and by whom administered and read. What corrective action(s) will be accomplished for those	ive a ipon (72) orded in the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPLE	ETED	
			B. WING 11/14/2024			2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
OTODVO	OINT ODANOED				FIR RD		
STORYP	OINT GRANGER			GRANG	BER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	I	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	y on 11/14/2024 at 9:26 A.M.,			residents found to have beer	1	
	the DON indicated	a 2nd step TB skin test should			affected by the deficient		
		the test was not administered.			practice:		
					The DNS/Designee will review	,	
	On 11/14/2024 at 1	0:44 A.M., the DON provided a			resident records for complianc		
		d 8/23/2024 and titled,			with tuberculin skin testing. Ar		
		tion Control Plan." The policy			resident(s), having been ident	-	
	indicated, "Testin				as noncompliant will receive a		
	· ·	est), BAMT (blood assay for			tuberculin skin test with follow		
	· ·	erculosis), or other as			The residents did not experier		
	accepted by public				any negative outcomes related		
					the deficient concern.		
					How other residents having t	the	
					potential to be affected by th		
					same deficient practice will b		
					identified and what correctiv		
					action(s) will be taken:		
					All residents have the potentia	l to	
					be affected.		
					The DNS/Designee will review	,	
					resident records for complianc		
					with tuberculin skin testing. Ar		
					resident(s), having been ident	-	
					as noncompliant will receive a		
					tuberculin skin test with follow		
					The residents did not experier		
					any negative outcomes related		
					the deficient concern.		
					What measures will be put in	to	
					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 compliand	e	
					with tuberculin skin testing. Ar		
					resident(s), having been ident	ified	
					as noncompliant will receive a		
					tuberculin skin test with follow		
					To ensure timely reporting, the	•	

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CE.TERD I OF	THE TOTAL CONTESTS					•	2110102000
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI		<del></del>	11/14/	
			D. WII			1 1/ 14/	<u> </u>
NAMEOUR	DROWIDED OF CURPY ISS			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF			6330 N	FIR RD		
STORYP	OINT GRANGER				GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					DNS/Designee will run the		
					"Evaluation Scheduled Audit		
					Report" (Appendix F) to identi	fv	
					any residents requiring tuberc	-	
					skin testing.	runi i	
					_		
					How the corrective action(s)		
					will be monitored to ensure t	uie	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					The DNS/Designee will review		
					resident records for compliand	ce	
					with tuberculin skin testing. Ar	าy	
					resident(s), having been ident	ified	
					as noncompliant will receive a	1	
					tuberculin skin test with follow		
					To ensure timely reporting, the	•	
					DNS/Designee will run the		
					"Evaluation Scheduled Audit		
					Report" (Appendix F) to identi	fv	
						-	
					any residents requiring tubero		
					skin testing. This will be done		
					weekly for 4 weeks, monthly for	or 4	
					months, and then ongoing.		
					If a threshold of 100% is not n	•	
					an action plan will be develop		
					Findings will be submitted to t		
					Executive Director for review a	and	
					follow-up.		
					By what date the systemic		
					chances will be completed:		
					Compliance date: 12/13/24		

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