STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		00	COMPLETED		
		B. WI	B. WING			02/18/2025	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			FIR RD		
STORYPOINT GRANGER					GER, IN 46530		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	Sida 00						
	This visit was for the	he Investigation of Complaint	R 00	000	3/6/24 – To Whom It May		
	IN00452241.				Concern: On February 17th and		
					18th, 2025, a complaint survey		
	Complaint IN00452241 - State deficiencies related				was conducted at StoryPoint	<u> </u>	
	to the allegations are cited at R0090.				Granger. Attached is the plan	of	
	to the uneganical are cited in Mooyer				correction for tag R090. The		
	Survey date: Febru	ary 17 & 18, 2025			creation and submission of thi	S	
					plan of correction does not		
Facility number: 01222		12229			constitute an admission by this	3	
					provider of any conclusion set	forth	
Residential Census: 126		s: 126			in the statement of deficiencie	s, or	
					of any violation of regulation.		
	These State Residential Findings are cited in				Due to the relatively low scope	÷	
accordance with 410 IAC 16.2-5.		10 IAC 16.2-5.			and severity of this survey, the	,	
					community respectfully reques	sts a	
	Quality Review completed on 2/20/2025				desk review in lieu of a post-si	urvey	
					revisit.		
					Thank you for your time and		
					consideration,		
					Martin Lebbin		
					Executive Director		
					StoryPoint Granger	ļ	
						ļ	
R 0090	410 IAC 16.2-5-1						
	Administration an	d Management - Deficiency					
Bldg. 00							
		on interview and record review, the facility)90	R090 – Administration and		03/06/2025
	_	t their policy related to the			Management - Deficiency		
		eporting allegations of abuse			It is the practice of this provide		
	for 1 of 3 residents	review for abuse, (Resident B)			immediately report any unusua		
	Finding includes:				occurrence and allegations of		
					abuse that directly threaten the		
		2/17/2025 - 2.00	1		welfare, safety, or health of any resident, per policy. What corrective action(s) will be accomplished for those		
		e interview on 2/17/2025 at 2:00	1				
		rse Aide (CNA) 2, indicated on					
		evening and night shifts,					
	CNA 3 came into F	Resident B's room to help him			residents found to have been		
			1		l .		

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

TITLE

(X6) DATE

Martin Lebbin Executive Director 03/06/2025

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.

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 1 of 6

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

PRINTED: 03/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
			B. WING			02/18/2025		
				CTD FET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER								
CTODYDOINT CDANCED				6330 N FIR RD				
STORYPOINT GRANGER				GRANGER, IN 46530				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	place a wedge unde	er the residents mattress while			affected by the deficient			
	the resident was in	the bed. CNA 2 indicated CNA			practice:			
	3 yanked the mattre	ess up causing Resident B to			The policy on "Resident			
	fall back and hit his	s head against the wall. CNA 2			Incident/Accident Reporting" w	/as		
	indicated CNA 3 wa	as yelling at the resident for			reviewed with staff regarding t	he		
	"shitting all over him	mself " the previous night.			immediate reporting of any			
		NA 3 indicated the resident's			unusual occurrence and			
		but that he (the resident)			allegations of abuse that direc	-		
	-	last night," and that the			threaten the welfare, safety, or	-		
		all over himself and she had			health of any resident, per poli	су.		
	to clean him up and	that "pissed her off." CNA 2			(Appendix A.) Staff were			
	-	ed the incident to the Assistant			re-educated, by the			
	Director of Nursing (ADON), two days after the event had occurred. CNA 2 indicated he did not				ED/DNS/Designee, regarding	the		
					need to report any unusual			
	intend to report abuse, because the resident was				occurrence and allegations of			
	not injured and the action was not intentional, but				abuse that directly threaten the	Э		
	he did not feel CNA 3 should have spoken to the				welfare, safety, or health of a			
	resident or about the resident, the way she had				resident, "immediately" to the			
	-	licated CNA 3 was not			ED/DNS. (Appendix B.)			
		an investigation and no			The resident did not experience			
	follow-up was done	-			any unexpected outcome relat	ed		
		had made a referral to Adult			to the deficient concern.			
	Protective Services	on 1/13/2025.			How other residents having t			
					potential to be affected by th			
	-	v on 2/18/25 at 10:05 A.M., an			same deficient practice will b			
		rvices Representative (APS),			identified and what correctiv	е		
		ad filed a report with the APS			action(s) will be taken:			
		lleging abuse in the form of			All residents have the potentia	l to		
	-	3 toward Resident B. The APS			be affected.			
	-	ated she had visited the			The policy on "Resident			
	facility on 1/14/25 and had spoken with the			Incident/Accident Reporting" was				
	Director of Nursing, who indicated a report had			reviewed with staff regarding the		he		
	been made, the resident was assessed with no			immediate reporting of any				
	findings and investigation had been completed				unusual occurrence and			
	without findings. The APS representative			allegations of abuse that directly				
	indicated their office had not substantiated the allegation, but was concerned the facility had				threaten the welfare, safety, or			
					health of any resident, per poli	су.		
	•	allegation to the State			(Appendix A.) Staff were			
		PS representative indicated she			re-educated, by the			
	had filed a report to the State Agency following				ED/DNS/Designee, regarding	the		

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 2 of 6

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING OO COMPLETED O2/18/2025 STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 were working together on the evening of 1/1/24 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530 (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG Regulatory ID PROVIDER'S PLAN OF CORRECTION COMPLETION COMPLETION COMPLETION DEFICIENCY DEFICIENCY DATE OCMPLETION COMPLETION COMPLETED COMPLETION COMPL		
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. her 1/14/25 facility visit. During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OCCURRENCE need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a		
STORYPOINT GRANGER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. her 1/14/25 facility visit. During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 6330 N FIR RD GRANGER, IN 46530 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	02/18/2025	
STORYPOINT GRANGER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. her 1/14/25 facility visit. During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 6330 N FIR RD GRANGER, IN 46530 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NAME OF PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		
STORYPOINT GRANGER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION DUring an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 GRANGER, IN 46530 (X5) PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (A5) COMPLETION DEFICIENCY DATE		
(X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION THAT DEFICIENCY DATE COMPLETION DATE COMPLETION THAT DEFICIENCY DATE COMPLETION THAT DATE DATE COMPLETION THAT DATE DATE COMPLETION THAT DATE DATE COMPLETION THAT DATE DATE DATE DATE COMPLETION THAT DATE DATE DATE DATE DATE DATE DATE DA		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION her 1/14/25 facility visit. her 1/14/25 facility visit. During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 Deficiency TAG PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX CROSS-REFERENCE OT O THE APPROPRIATE DEFICIENCY) her 1/14/25 facility visit. need to report any unusual occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a		
her 1/14/25 facility visit. her 1/14/25 facility visit. need to report any unusual occurrence and allegations of abuse that directly threaten the Welfare, safety, or health of a	ON	
During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 Occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a		
During an interview on 2/18/24 at 10:30 A.M., the Director of Nursing indicated CNA 2 and CNA 3 Occurrence and allegations of abuse that directly threaten the welfare, safety, or health of a		
Director of Nursing indicated CNA 2 and CNA 3 welfare, safety, or health of a		
Director of Nursing indicated CNA 2 and CNA 3 welfare, safety, or health of a		
when CNA 2 asked CNA 3 to help with Resident ED/DNS. (Appendix B.)		
B. The Director of Nursing indicated CNA 2 Residents did not experience any		
indicated CNA 3 was putting a bolster mattress negative outcomes related to the		
under Resident B's mattress when the resident hit deficient concern.		
his head against the wall. CNA 2 indicated he did What measures will be put into		
not like the way CNA 3 had spoken to the resident place or what systemic changes		
afterwards. He indicated CNA 3 had stated the will be made to ensure that the		
resident had "shit" himself and made a mess and deficient practice does not		
that the statement was made in the presence of recur :		
the resident. The Director of Nursing indicated The policy on "Resident		
CNA 3 had denied saying anything in the Incident/Accident Reporting" was		
presence of Resident B. The Director of Nursing reviewed with staff regarding the		
indicated both Qualified Medication immediate reporting of any		
Administration Aide,(QMA) 4 and QMA 7 were unusual occurrence and		
present at the time of the incident and both allegations of abuse that directly		
employees denied hearing CNA 3 speak that way threaten the welfare, safety, or		
in the presence of the resident and they also health of any resident, per policy.		
denied the resident had hit his head on the wall. (Appendix A.) Staff were		
The Director of Nursing indicated she was off re-educated, by the		
work during the time of the allegation and did not DNS/ED/Designee, regarding the		
return to work until 1/6/25, when the allegation of need to report any unusual		
abuse was first reported to her. The Director of occurrence and allegations of		
Nursing indicated the allegation of abuse should abuse that directly threaten the		
have been immediately reported to her and to the welfare, safety, or health of a		
Administrator and a State Report should have resident, "immediately" to the		
been submitted, CNA 3 should have been ED/DNS. (Appendix B.)		
suspended pending an investigation at the time If concerns are noted, the		
the allegation of abuse was reported the the ED/DNS/Designee will be notified		
ADON. The Director of Nursing indicated CNA 2 immediately for corrective action.		
should have reported the allegation of abuse To ensure timely reporting, the		
immediately to the Supervisor, Director of Nursing ED/DNS/Designee will be notified		
and Administrator immediately, but had not. "immediately", per policy, of any		
resident incidents. Any staff not		
reporting any unusual occurrence		
During an interview on 2/18/25 at 11:01 A.M., the or allegations of abuse that		

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			02/18/2025	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
CTORVIDOINT ORANGER			6330 N FIR RD				
STORYPOINT GRANGER				GRANG	SER, IN 46530		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	. –	DATE
	Assistant Director of Nursing indicated on 1/3/25				directly threatens the welfare,		
	at the beginning of second shift, CNA 2 reported				safety, or health of any resider	nt,	
	to her that on 1/1/2:	5, CNA 3's actions were			will be reprimanded per policy up		
	abusive to Resident	B. The Assistant Director of			to and including termination.		
	Nursing indicated s	he had not documented the			How the corrective action(s) will		
	conversation with C	CNA 2 so she could not say			be monitored to ensure the		
		orted, but she had suspended		deficient practice will not recur,			
		investigation and had started			i.e., what quality assurance		
		garding the resident hitting his			program will be put into plac	e:	
		Director of Nursing indicated			The policy on "Resident		
	1	d the allegation to the			Incident/Accident Reporting" w	/as	
	Director of Nursing nor the Administrator until				reviewed with staff regarding t	he	
	1/6/25. The Assistant Director of Nursing				immediate reporting of any		
	indicated she should have reported the allegation			unusual occurrence and			
	to the Director of Nursing and the Administrator			allegations of abuse that directly			
	immediately.				threaten the welfare, safety, or		
					health of any resident, per poli	су.	
	During an interview on 2/18/25 at 11:14 A.M., the				(Appendix A.) Staff were		
	Administrator indicated he was on vacation				re-educated, by the		
	_	he alleged abuse and was not			DNS/ED/Designee, regarding	the	
		gation of abuse had occurred			need to report any unusual		
		work on 1/6/25 and at that			occurrence and allegations of		
		leted an internal incident report			abuse that directly threaten the	9	
		trator indicated he had not			welfare, safety, or health of a		
		tion of abuse to the State			resident, "immediately" to the		
		e allegation had been			ED/DNS. (Appendix B.)		
	unsubstantiated and	I there was nothing to report.			In order to ensure timely repor	ting,	
					the ED/DNS/Designee will		
		s's timesheets indicated the			question staff daily for 2 weeks		
		ediately suspended pending an			weekly for 2 weeks, and month	-	
	investigation and continued to work, on 1/3/2025			for 2 months to ens			
	and on 1/3/2025, following the allegation of abuse				they need to report any unusua	aı	
	reported to the Assistant Director of Nursing.			occurrence and allegations of		_	
	O., 2/17/24 -4 1:05 D.M. 4b. C. T. 1				abuse that directly threaten the		
	On 2/17/24 at 1:05 P.M., the facility's abuse		welfare, safety, or health of any				
	investigation documentation was reviewed and included the following: An undated written statement by CNA 2, who indicated on 1/1/25 he went into Resident B's				resident, immediately per police	-	
					(Appendix C.) Any staff not be	ırıg	
					aware of the policy will be		
	_				identified and retrained and/or		
	room with CNA 3 because he could not place a				reprimanded, per policy up to	and	

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 4 of 6

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WI	B. WING		02/18/2025		
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8					
OTODYDOINT ODANIOED					FIR RD		
STORYPOINT GRANGER				GRANG	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 OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	wedge under the res	sident's mattress by myself			including termination. All new		
	and CNA 3 said she	e could. CNA 3 then grabbed			employees will be trained befo	ore	
	the resident's mattr	ess and lifted it, causing the			they start work.		
	resident to roll over	and hit his head on the wall.			If a threshold of 100% is not n	net,	
	CNA 3 said "and th	at's how you do it." CNA 2			an action plan for the employe	ee	
	indicated he asked t	the resident if he was alright			will be implemented. Starting	with	
	and placed a pillow	between him and the wall.			retraining and proceeding to b	eing	
	CNA 2 indicated Cl	NA 3 said to the resident, "Oh			reprimanded per policy up to a	-	
	he's alright but you	pissed me off last night didn't			including termination. Findings		
	you. He shit all ove	r the bed and I had to clean it			be submitted to the Executive		
	up God D *** Was	I pissed." CNA 2 told CNA 3			Director for review and follow-	up.	
	that the resident had not done it on purpose and				By what date the systemic		
	CNA 3 stated, "I don't care it was a lot of shit and				changes will be completed:		
	I had to clean it up!	"			Compliance date: 3/6/25		
	Resident B's clinical record was reviewed on 2/17/25 at 3:04 P.M. Diagnoses included Dementia, Parkinson's Disease, encephalopathy, and anxiety.						
		vice Plan dated 8/2/24,					
		B required full staff assistance					
	1	incontinence, dressing and					
	0	and transfers. The resident					
		tive impairment and required					
	assistance with com	nmunication, and reasoning.					
		Progress Note dated 1/3/25 at					
		Assistant Director of Nursing					
		at staff had reported a possible					
	, · · ·	y due to the resident hitting his					
	head during care in the previous 48 hours. The residents' skin was assessed for injury, with no abnormal findings, and Resident B's wife and the physician had been present at the time of the						
	assessment.						
	TE1 C 11: 11 .	24 1 HA1 - NT 1 -					
		titled, "Abuse, Neglect, or					
	_	1 6/7/23 indicated, "Initial					
		ould report all incidents					
	immediately to the supervisor on dutyIf a staff						

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 5 of 6

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

PRINTED: 03/06/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED			
			B. WING 02/18/2025					
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER			STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION					DATE	
		or suspected of abuse, neglect						
	or exploitation, the staff member will be							
	immediately removed from the community and work schedule pending the outcome of the investigation'immediately' means as soon as possible, but will not exceed twenty-four (24) hours after the incidentThe investigation should be documentedResults of the investigation will be reported to the appropriate licensing							
	agencies"							
	This Citation is related to Complaint IN00452241.							

State Form Event ID: CF6Y11 Facility ID: 012229 If continuation sheet Page 6 of 6