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	11/01/2022

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 Complaints IN00392801, IN00383405, IN00382475, IN00381401, and IN00377538. Complaint IN00392801 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00383405 - Unsubstantiated due to lack of evidence. Complaint IN00382475 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00381401 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00377538 - Substantiated. No state residential findings related to the allegations were cited. Survey dates: October 26, 27, 28, and 31, 2022 and November 1, 2022. Facility number: 012229 Residential Census: 127 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 11/7/22.	R 0000	11/28/22 – To Whom It May Concern: On October 24 to November 1, 2022, a health survey was conducted at StoryPoint Granger. Attached is the plan of correction for tags F216, F273, F409 and F410, 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, Natalie Palmer Director of Nursing Services StoryPoint Granger	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Palmer	Wellness Director	11/28/2022

Any defiencystatement 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 disclo days 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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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain weights for 1 of 8 residents (Resident H) reviewed for admission weights, and 2 of 8 residents (Residents B and C) reviewed for semi-annual weights. In addition, the facility failed to have the resident's attending physician sign for medication orders for 2 of 8 residents reviewed for physician orders for medications. (Residents B and D) Findings include: 1. A clinical record review of Resident H was completed on 10/27/2022 at 10:11 A.M. Diagnoses included, but were not limited to: emphysema, Alzheimer's disease, congestive heart failure and anxiety disorder. On 11/1/2022 at 10:52 A.M., documentation for Resident H's admission weight from 9/20/2022 was requested from the Wellness Director. On 11/1/2022 at 11:07 A.M., requested	R 0216	**F216 – Evaluation - Noncompliance** It is the practice of this provider to obtain weights upon admission and semi-annually. It is the practice of this provider to have a resident's attending physician review and sign self-medication orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B, H, and C had their weights updated. Resident B and D had their self-medication orders reviewed by their physician. The residents did not experience any negative outcomes related to the deficient concern. **How other residents having the**	11/30/2022

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	documentation was reviewed. An admission weight could not be located in Resident H's clinical record by the Wellness Director. During an interview on 11/1/2022 at 11:42 A.M., the Wellness Director indicated an admission weight had not been obtained. 2. A clinical record review of Resident B was completed on 10/27/2022 at 8:47 A.M. Diagnoses included, but were not limited to: hypertension, depression disorder and exertional dyspnea. An Admission Assessment, on 5/28/2021, indicated Resident B's weight at 216 pounds. On 11/1/2022 at 10:52 A.M., documentation for Resident B's semi-annual weights were requested from the Wellness Director. On 11/1/2022 at 11:07 A.M., requested documentation was reviewed. Semi-annual weight documentation could not be located in Resident B's clinical record by the Wellness Director. 3. A clinical record review of Resident C was completed on 10/27/2022 at 9:06 A.M. Diagnoses included, but were not limited to: dementia, anemia, and chronic kidney disease. A document, titled, "Vital Signs and Weight Monitoring", indicated a weight of 125.5 pounds on 7/29/2021. Additional entries were not noted. On 11/1/2022 at 10:52 A.M., documentation for Resident C 's semi-annual weights were requested from the Wellness Director. On 11/1/2022 at 11:07 A.M., the requested documentation was reviewed. Semi-annual weight		**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 B, H, and C had their weights updated. Resident B and D had their self-medication orders reviewed by their physician. 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 has been re-educated on the need to take and document a new resident's weight upon admission and current residents weight every 6 months by the DNS/designee. Nursing has been re-educated on the need of having self-medication orders reviewed by their physician by the DNS/designee. **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;** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the audit tool titled, "Resident Weight Audit	

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	documentation could not be located in Resident C's clinical record by the Wellness Director. During an interview, on 10/27/2022 at 10:46 A.M., the Wellness Director reviewed the clinical records of Resident's H, B, and C. She indicated Resident did not have an admission weight completed. She indicated Resident's B and C should have a semi-annual weight completed, but the assisted living weights are behind, and the residents probably have not had a weight completed. On 11/1/2022 at 12:00 P.M., a current policy titled, "Resident Weights" was received. The policy indicated, "...The purpose of the Resident Weight policy is to recognize and respond to resident's weight related nutritional needs...Each resident will be routinely weighed upon move-in, monthly and when returning from an alternative healthcare setting unless otherwise directed by the resident's Healthcare provider...." 4. A clinical record review of Resident B was completed on 10/27/2022 at 8:47 A.M. Diagnoses included, but were not limited to: hypertension, depression disorder and exertional dyspnea. A Level of Care Evaluation on 3/30/2022, indicated Resident B is independent with medication administration with physician orders and passes competency. A Physician's Order Report on 4/11/2022, indicated no current medications available. The physician signed the form and indicated, "...Why is this needed...no orders, no treatments?..." During an interview on 10/27/2022 at 10:46 A.M., the Wellness Director indicated the the		Tool" and "Physician Self-Medication Orders Tool" weekly for 4 weeks and monthly for six months. If 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: 11/30/22	

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	Physician's Order Report did not have medications listed for physician signature, and the facility should have something indicating the medications the resident takes with the physician's signature. 5. A clinical record review of Resident D was completed on 10/27/2022 at 9:30 A.M. Diagnoses included, but were limited to: hypothyroidism, diabetes mellitus type 2, and hypertension. A Level of Care Evaluation on 3/28/2022, indicated Resident D is independent with medication administration with physician orders and passes competency. During an interview, on 10/27/2022 at 10:46 A.M., the Wellness Director reviewed the clinical records of Resident D. She indicated Resident D did not have any signed physician orders in the medical record. She indicated a form with the medication orders should be sent to the physician every 6 months for signature. On 11/1/2022 at 12:00 P.M., a policy titled, "Medication Administration of" was received. The policy indicated, "...11. Residents can self-administer medications when specifically authorized by the attending Healthcare provider and in accordance with procedures for self-administration of medications...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) 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, including 410 IAC 7-24. Based on observation and interview the facility	R 0273	**F273 – Food and Nutritional**	11/28/2022

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	failed to properly label and dispose of out dated food in the walk in cooler for 1 of 1 kitchens reviewed. Finding includes: An initial observation of the kitchen, including food storage areas, was completed on 10/26/2022 at 10:44 A.M. The walk-in cooler was observed to have a thawed bag of uncooked sausage links with no labeling of identification, open date or use by date. A yellow cheese block, triangular piece of yellow cheese, a white cheese block, and a triangular piece of white cheese were wrapped in cellophane. There was not a label for identification, open date or use by date. A jar of horseradish did not have an open date on the jar, and the manufacturer's use by date was 8/31/2022. A plastic container of sliced black olives had a label that indicated the olives were opened on 10/17/2022 and used by 10/20/2022. During a follow-up observation of the walk-in cooler, on 10/31/2022 at 10:54 A.M., a thawed bag of uncooked sausage links with no labeling of identification, open date or use by date was observed. A clear container of shredded yellow cheese was observed to not have a label indicating identification, open date, or use by date. During an interview on 11/1/2022 at 11:28 A.M., Cook 1 indicated, all open foods should have a label indicating identification of the food, open		**Services – Deficiency** 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:*** Dietary staff was immediately re-educated, by the Dietary Manager/designee, regarding proper labeling and disposal of outdated food. 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. Dietary staff will be in-serviced, re-educated, by the Dietary Manager/designee, regarding proper labeling and disposal of outdated food. ***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 Manager/designee will monitor, the proper labeling and	

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	date and use by date. She indicated expired foods should not be in the walk-in cooler. On 11/1/2022 at 12:00 P.M., a current policy was provided by the Wellness Director titled, "Proper Food Storage". The policy indicated, "...The purpose of Proper Food Storage is to prevent cross contamination and keeping food fresher longer...Keep foods properly wrapped or covered and dated with date opened and date expires...When to date mark foods: anytime the packaging is opened...."		disposal of outdated food. If concerns are noted, the Dietary Manager/Executive Director/Designee will be notified immediately for corrective action. ***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;*** To ensure ongoing compliance with this corrective action, the Dietary Manager/designee will be responsible for completion of the audit tool titled, “Food and Nutritional Audit Tool” daily for 2 weeks, weekly for 2 weeks and monthly for six months. If 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: 11/28/22	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to provide an annual health assessment stating history of or present infectious disease for 5 of 8 residents reviewed for annual health	R 0409	**F409 – Infection Control – Non-compliance** It is the practice of this provider to ensure an annual health	11/28/2022

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	statements. Residents B, C, D, G, and L) Findings include: 1. A clinical record review of Resident B was completed on 10/27/2022 at 8:47 A.M. Diagnoses included, but were not limited to: hypertension, depression disorder and exertional dyspnea. A Physician's Orders Medical Plan of Treatment on 5/7/2021, indicated, "...Resident shows no signs/symptoms of TB in an infectious state and is free of communicable diseases...." There was not any further documentation that could be found in the medical record since 5/7/2021 that indicated a health statement. 2. A clinical record review of Resident C was completed on 10/27/2022 at 9:06 A.M. Diagnoses included, but were not limited to: dementia, anemia, and chronic kidney disease. On 10/27/2022 at 11:02 A.M., the Wellness Director reviewed Resident C's medical record. She indicated she did not see an Annual Health Statement in the medical record. 3. A clinical record review of Resident D was completed on 10/27/2022 at 9:30 A.M. Diagnoses included, but were limited to: hypothyroidism, diabetes mellitus type 2, and hypertension. A Physician's Orders Medical Plan of Treatment on 1/14/2019, indicated, "...Resident shows no signs/symptoms of TB in an infectious state and is free of communicable diseases...." There was not any further documentation that could be found in the medical record since		assessment stating history of or present infectious disease. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents B, C, D, G and L were provided an annual health assessment stating history of/or present infectious disease. No harm was incurred to residents B, C, D, G or L related to this deficient practice. ***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 require an annual health assessment stating history of/or present infectious disease. No other residents were identified related to this deficient practice. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Audits will be on-going to ensure compliance with infection control policy and procedure. Audits will be conducted by the nurse management team to monitor compliance. ***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;***	

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	1/14/2019 that indicated a health statement. 4. A clinical record review of Resident G was completed on 10?27/2022 at 9:48 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, hypothyroidism, and emphysema. Resident G admitted to the facility on 5/27/2022. On 10/27/2022 at 11:24 A.M., the Wellness Director reviewed Resident G's medical record. She indicated she did not see an Annual Health Statement in the medical record. 5. A clinical record review of Resident L was completed on 10/27/2022 at 1:10 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, anxiety disorder, and depressive disorder. A Physician's Orders Medical Plan of Treatment on 4/13/2021, indicated, "...Resident shows no signs/symptoms of TB in an infectious state and is free of communicable diseases...." There was not any further documentation that could be found in the medical record since 4/13/2021 that indicated a health statement. During an interview on 10/27/2022 at 10:46 A.M., the Wellness Director indicated, a form that includes the infectious disease statement was to be sent to the physician every 6 months for signature. On 11/1/2022 at 11:32 A.M., a policy was requested for the annual health statement. The Wellness Director indicated a policy was not available.		To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI tool titled, “Annual Health Assessment” weekly for 4 weeks, monthly for six months. If 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: 11/28/22	

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at 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. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to provide two-step Mantoux testing for newly admitted residents for 2 of 8 residents reviewed for infection control. (Residents B and H) Findings include: 1. A clinical record review of Resident B was completed on 10/27/2022 at 8:47 A.M. Resident B admitted to the facility on 5/28/2021. Diagnoses included, but were not limited to: hypertension, depression disorder and exertional dyspnea. A Resident TB (tuberculosis)/Immunization Record indicated an initial Mantoux test was	R 0410	**F410 – Infection Control – Non-compliance** It is the practice of this provider to ensure a two-step Mantoux testing for newly admitted residents is complete. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** Residents B and H were provided a two-step Mantoux test. No harm was incurred to residents B or H related to this deficient practice.	11/28/2022

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	completed on 11/10/2021. The Mantoux test was negative. A second step Mantoux test was not documented. During an interview on 10/27/2022 at 10:46 A.M., the Wellness Director indicated, she thought a Mantoux test had been completed at the physician's office, but could not find the documentation. She indicated a second step Mantoux should have been completed. 2. A clinical record review of Resident H was completed on 10/27/2022 at 10:11 A.M. Resident H admitted to the facility on 9/20/2022. Diagnoses included, but were not limited to: Alzheimer's disease, congestive heart failure and anxiety disorder. A first step and second step Mantoux could not be located in the medical record. On 11/1/2022 at 10:52 A.M., requested documentation of the Mantoux tests were requested. Documentation was not provided. During an interview on 10/27/2021 at 10:46 A.M., the Wellness Director indicated the first and second step Mantoux test should have been completed. On 11/1/2022 at 12:00 P.M., the Wellness Director provided a current policy titled, "TB Infection Control Plan--Indiana". The policy indicated, "...e. in addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read forty-eight (48) hours to seventy-two (72) hours...f. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline		***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 new residents require a two-step Mantoux testing. No other residents were identified related to this deficient practice. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** Audits will be on-going to ensure compliance with infection control policy and procedure. Audits will be conducted by the nurse management team to monitor compliance. ***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;*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI tool titled, “TB Testing” weekly for 4 weeks, monthly for six months. If 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: 11/28/22	

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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
	tuberculin skin test should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test...."			