STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/01/2022		
	PROVIDER OR SUPPLIER		6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD BER, 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)	TE	(X5) COMPLETION DATE
	This visit was for a Survey. This visit is Complaints IN0039 IN00381401, and IN Complaint IN00392 residential findings cited. Complaint IN00383 lack of evidence. Complaint IN00382 residential findings cited. Complaint IN00381 residential findings cited. Complaint IN00381 residential findings cited. Complaint IN00377 residential findings cited.	State Residential Licensure included the Investigation of 2801, IN00383405, IN00382475, 100377538. 801 - Substantiated. No state related to the allegations were 405 - Unsubstantiated due to 475 - Substantiated. No state related to the allegations were 401 - Substantiated. No state related to the allegations were 538 - Substantiated. No state related to the allegations were 538 - Substantiated. No state related to the allegations were			urvey of 3, and an any of	
	These State Resider accordance with 410 Quality review com					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Natalie Palmer Wellness Director 11/28/2022

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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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
THE TENT			B. WI			11/01/	
	PROVIDER OR SUPPLIER	2		6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD GER, IN 46530		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
R 0216 Bldg. 00	shall be delineated manual, but at a massessment shall following: (1) The resident 'mental status. (2) The resident 'activities of daily life (3) The resident 'activities of daily life (3) The resident 'admission and see (4) If applicable, the self-administer medication and kept in Based on record reversided to obtain weight (Resident H) review 2 of 8 residents (Resemi-annual weight to have the resident medication orders for and D) Findings include: 1. A clinical record completed on 10/27 included, but were analytically also anxiety disorder. On 11/1/2022 at 10 Resident H's admissing requested from the self-and	ompliance I content of the evaluation d in the facility policy ninimum the needs include an evaluation of the s physical, cognitive, and s independence in the iving. s weight taken on miannually thereafter. he resident 's ability to edications. I shall be documented in In the facility. View and interview, the facility ghts for 1 of 8 residents wed for admission weights, and sidents B and C) reviewed for ss. In addition, the facility failed 's attending physician sign for for 2 of 8 residents reviewed for medications. (Residents B Treview of Resident H was 1/2022 at 10:11 A.M. Diagnoses not limited to: emphysema, to, congestive heart failure and 1:52 A.M., documentation for sion weight from 9/20/2022 was	R 02	216	F216 – Evaluation - Noncompliance It is the practice of this provide obtain weights upon admission and semi-annually. It is the practice of this provide 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 their physician. The residents did not experier any negative outcomes related the deficient concern.	n er to I r ed by nce d to	11/30/2022

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		11/01	/2022
		<u> </u>	1	CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			FIR RD		
STODAD	OINT GRANGER				FIR RD GER, IN 46530		
SIURIP	UNI GRANGER			GRAING	JEN, IN 40000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		reviewed. An admission			potential to be affected by the	ie	
	weight could not be located in Resident H's				same deficient practice will I	oe	
	clinical record by the Wellness Director.				identified and what corrective	e e	
					action(s) will be taken:		
	During an interview on 11/1/2022 at 11:42 A.M.,				All residents have the potentia	al to	
		tor indicated an admission			be affected.		
	weight had not been	n obtained.			Resident B, H, and C had the	ir	
					weights updated.		
		review of Resident B was			Resident B and D had their		
		7/2022 at 8:47 A.M. Diagnoses			self-medication orders review	ed by	
		not limited to: hypertension,			their physician.		
	depression disorder	and exertional dyspnea.			Residents did not experience	-	
					negative outcomes related to	the	
		essment, on 5/28/2021,			deficient concern.		
	indicated Resident	B's weight at 216 pounds.			What measures will be put ir	nto	
					place or what systemic		
		:52 A.M., documentation for			changes will be made to		
		annual weights were requested			ensure that the deficient		
	from the Wellness	Director.			practice does not recur:		
					Nursing has been re-educated		
		:07 A.M., requested			the need to take and docume	nt a	
		reviewed. Semi-annual weight			new resident's weight upon		
		ld not be located in Resident			admission and current resider	nts	
	B's clinical record b	by the Wellness Director.			weight every 6 months by the		
					DNS/designee.		
		review of Resident C was			Nursing has been re-educated		
		7/2022 at 9:06 A.M. Diagnoses			the need of having self-medic		
	· · · · · · · · · · · · · · · · · · ·	not limited to: dementia,			orders reviewed by their phys	ician	
	anemia, and chronic	c kidney disease.			by the DNS/designee.		
		mark 1 of 1 mark 1 m			How the corrective action(s)		
		"Vital Signs and Weight			will be monitored to ensure	the	
	_	ated a weight of 125.5 pounds			deficient practice will not		
	on 7/29/2021. Addi	tional entries were not noted.			recur, i.e., what quality		
	0 11/1/2022 : 10	52 4 34 1			assurance program will be p	ut	
		:52 A.M., documentation for			into place;		
		annual weights were requested			To ensure ongoing complianc		
	from the Wellness	Director.			with this corrective action, the		
	0 11/1/2000	07.136.4			DNS/designee will be respons		
		:07 A.M., the requested			for completion of the audit too	I	
	documentation was	reviewed. Semi-annual weight			titled, "Resident Weight Audit		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COME	E SURVEY PLETED 1/2022	
	PROVIDER OR SUPPLIEI	₹	6330 N	ADDRESS, CITY, STATE, ZI I FIR RD GER, IN 46530	P COD	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	C's clinical record leading an interview the Wellness Directorecords of Resident Resident did not hat completed. She indicated should have a semithe assisted living weighted. On 11/1/2022 at 12 "Resident Weights' indicated, " The policy is to recognite weight related nutricially weight related nutricially will be routinely weight related nutricially will be routinely weight related nutricially will be routinely will be routinely weight related nutricially when returning setting unless other Healthcare provide. 4. A clinical record completed on 10/2' included, but were depression disorder. A Level of Care Extended administration with competency. A Physician's Orderindicated no current physician signed the is this neededno of During an interview.	Id not be located in Resident by the Wellness Director. Iv, on 10/27/2022 at 10:46 A.M., tor reviewed the clinical t's H, B, and C. She indicated we an admission weight icated Resident's B and C annual weight completed, but weights are behind, and the have not had a weight 1:00 P.M., a current policy titled, was received. The policy turpose of the Resident Weight are and respond to resident's ational needsEach resident eighed upon move-in, monthly from an alternative healthcare wise directed by the resident's final review of Resident B was and limited to: hypertension, and exertional dyspnea. In alluation on 3/30/2022, indicated the endent with medication aphysician orders and passes For Report on 4/11/2022, the medications available. The form and indicated, "Why orders, no treatments?" In all not be located in Resident B. The form and indicated, "Why orders, no treatments?"		Tool" and "Physician Self-Medication Ordoweekly for 4 weeks a for six months. If the 100% is not met, an will be developed. For submitted to the Exercite Director for review a submitted to the synchances will be confused to the synchance date: 1	ers Tool" and monthly reshold of action plan Findings will be ecutive and follow up. ystemic mpleted:	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		11/01/	2022
		<u> </u>	<u> </u>	CTREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	₹					
OTODVO	OINT ODANOED				FIR RD		
STURYP	OINT GRANGER			GRANG	SER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Physician's Order R	Report did not have					
	-	for physician signature, and the					
		e something indicating the					
	medications the res						
	physician's signatur	re.					
	5. A clinical record review of Resident D was						
		7/2022 at 9:30 A.M. Diagnoses					
	•	limited to: hypothyroidism,					
		rpe 2, and hypertension.					
	,	1 / 31					
	A Level of Care Ev	valuation on 3/28/2022, indicated					
	Resident D is indep	pendent with medication					
	-	physician orders and passes					
	competency.						
	During an interview	v, on 10/27/2022 at 10:46 A.M.,					
	_	tor reviewed the clinical					
		t D. She indicated Resident D					
		gned physician orders in the					
		e indicated a form with the					
		should be sent to the physician					
	every 6 months for						
		8					
	On 11/1/2022 at 12	2:00 P.M., a policy titled,					
		nistration of" was received.					
		d, "11. Residents can					
		dications when specifically					
		ttending Healthcare provider					
	and in accordance v						
	self-administration	•					
R 0273	410 IAC 16.2-5-5.	.1(f)					
		nal Services - Deficiency					
Bldg. 00		ation and serving areas					
		n residents ' units) are					
	`	ordance with state and					
local sanitation and safe food handling							
	standards, includi	_					
		on and interview the facility	R 02	273	F273 – Food and Nutritional		11/28/2022
	Lasea on observation	en and montries, the montry	IN U2	213			11/20/2022

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		11/01/	/2022
			<u> </u>	CTD PPT	ADDRESS CITY STATE ZIR COP		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
OTODVO	OINT ODANOED				FIR RD		
STURYP	OINT GRANGER			GRANG	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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)		DATE
	failed to properly label and dispose of out dated				Services - Deficiency		
	food in the walk in	cooler for 1 of 1 kitchens			It is the practice of this provide	er to	
	reviewed.				assure all food preparation an	d	
					serving areas (excluding area	s in	
	Finding includes:				residents' units) are maintaine	ed in	
					accordance with state and loc	al	
	An initial observation of the kitchen, including				sanitation and safe food handl	ling	
	food storage areas,	was completed on 10/26/2022			standards.	-	
	at 10:44 A.M. The	walk-in cooler was observed to			What corrective action(s) will	II be	
	have a thawed bag	of uncooked sausage links			accomplished for those		
	with no labeling of	identification, open date or use			residents found to have been	n	
	by date.				affected by the deficient		
					practice:		
	A yellow cheese blo	ock, triangular piece of yellow			Dietary staff was immediately		
	cheese, a white che	ese block, and a triangular			re-educated, by the Dietary		
	piece of white chee	se were wrapped in cellophane.			Manager/designee, regarding		
	There was not a lab	pel for identification, open date			proper labeling and disposal o	of	
	or use by date.				outdated food.		
					The residents did not experier	nce	
	A jar of horseradish	n did not have an open date on			any negative outcomes related	d to	
	the jar, and the mar	nufacturer's use by date was			the deficient concern.		
	8/31/2022.				How other residents having	the	
					potential to be affected by th	ie	
		of sliced black olives had a			same deficient practice will l	be	
	label that indicated	the olives were opened on			identified and what correctiv	re	
	10/17/2022 and use	ed by 10/20/2022.			action(s) will be taken:		
					All residents have the potentia	ıl to	
		observation of the walk-in			be affected.		
	cooler, on 10/31/20	22 at 10:54 A.M., a thawed bag			Dietary staff will be in-serviced	d,	
	of uncooked sausag	ge links with no labeling of			re-educated, by the Dietary		
	identification, open	date or use by date was			Manager/designee, regarding		
	observed.				proper labeling and disposal o	of	
					outdated food.		
		f shredded yellow cheese was			What measures will be put ir	nto	
	observed to not hav	e a label indicating			place or what systemic chan	ges	
	identification, open	date, or use by date.			will be made to ensure that t	he	
					deficient practice does not		
	During an interview	v on 11/1/2022 at 11:28 A.M.,			recur:		
	Cook 1 indicated, a	ll open foods should have a			The Dietary Manager/designe	e will	
	label indicating ide	ntification of the food, open			monitor, the proper labeling ar	nd	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/01/2022	
	ROVIDER OR SUPPLIER OINT GRANGER		6330 N	ADDRESS, CITY, STATE, ZIP COD I FIR RD GER, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	should not be in the On 11/1/2022 at 12: provided by the We Food Storage". The purpose of Proper F cross contamination longerKeep foods and dated with date	00 P.M., a current policy was llness Director titled, "Proper policy indicated, "The ood Storage is to prevent and keeping food fresher properly wrapped or covered opened and date ate mark foods: anytime the		disposal of outdated food. If concerns are noted, the Dieta Manager/Executive Director/Designee will be notific immediately for corrective action (s) be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place To ensure ongoing compliance with this corrective action, the Dietary Manager/designee will responsible for completion of the audit tool titled, "Food and Nutritional Audit Tool" daily for weeks, weekly for 2 weeks and monthly for six months. If threshold of 100% is not met, a 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: 11/28/22	ed on. will ur, e; be ne 2 d an
R 0409	410 IAC 16.2-5-12 Infection Control -				
Bldg. 00	(d) Prior to admiss required to have a including history o infectious disease resident shows no an infectious stage admission and year Based on record reviailed to provide an stating history of or	health assessment, f significant past or present s and a statement that the evidence of tuberculosis in e as verified upon	R 0409	F409 – Infection Control – Non-compliance It is the practice of this provide ensure an annual health	11/28/2022 r to

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED
			B. W	ING		11/01/2022
				·		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD	
					FIR RD	
STORYF	POINT GRANGER			GRANG	GER, IN 46530	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		nts B, C, D, G, and L)			assessment stating history of	
					present infectious disease.	
	Findings include:				What corrective action(s) will	l he
	i mamgs merade.				accomplished for those	
	1 A clinical record	review of Resident B was			residents found to have been	,
		7/2022 at 8:47 A.M. Diagnoses			affected by the deficient	'
	_	not limited to: hypertension,			practice:	
					Residents B, C, D, G and L we	oro
	depression disorder and exertional dyspnea.				provided an annual health	,,,,
	A Physician's Orders Medical Plan of Treatment				assessment stating history of/	or
	1	ited, "Resident shows no			present infectious disease. No	
					harm was incurred to resident	
	signs/symptoms of TB in an infectious state and is free of communicable diseases"					S D,
	is free of communicable diseases"				C, D, G or L related to this	
	There was not any further documentation that				deficient practice.	46-
	1	he medical record since			How other residents having	
		ated a health statement.			potential to be affected by the	
	3/1/2021 that male	ated a nearth statement.			same deficient practice will l	
	2 4 -1::1				identified and what corrective	e
		review of Resident C was			action(s) will be taken:	
	_	7/2022 at 9:06 A.M. Diagnoses			All residents require an annua	
		not limited to: dementia,			health assessment stating his	•
	anemia, and chroni	c kidney disease.			of/or present infectious diseas	
	0 10/07/2022 + 1	102 1 15 1 17 11			No other residents were identi	
		1:02 A.M., the Wellness			related to this deficient practic	
		Resident C's medical record.			What measures will be put in	
		lid not see an Annual Health			place or what systemic chan	_
	Statement in the mo	edical record.			will be made to ensure that t	ne
		1 : CD :1 .D			deficient practice does not	
		d review of Resident D was			recur:	
	_	7/2022 at 9:30 A.M. Diagnoses			Audits will be on-going to ensu	
		limited to: hypothyroidism,			compliance with infection cont	rol
	diabetes mellitus ty	pe 2, and hypertension.			policy and procedure.	
					Audits will be conducted by the	e
		rs Medical Plan of Treatment			nurse management team to	
	· ·	cated, "Resident shows no			monitor compliance.	
		TB in an infectious state and			How the corrective action(s)	will
	is free of communi	cable diseases"			be monitored to ensure the	
					deficient practice will not red	eur,
		further documentation that			i.e., what quality assurance	
	could be found in t	he medical record since			program will be put into place	e;

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/01/2022	
	PROVIDER OR SUPPLIED	₹	633	EET ADDRESS, CITY, STATE, ZIP 30 N FIR RD ANGER, IN 46530	COD	
	SUMMARY (EACH DEFICIEN REGULATORY OF 1/14/2019 that individed on 10/22 included, but were obstructive pulmon and emphysema. Resident G admitted On 10/27/2022 at 1 Director reviewed If She indicated she de Statement in the most of the statement	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION cated a health statement. review of Resident G was 7/2022 at 9:48 A.M. Diagnoses not limited to: chronic ary disease, hypothyroidism, d to the facility on 5/27/2022. 1:24 A.M., the Wellness Resident G's medical record. id not see an Annual Health edical record. review of Resident L was 7/2022 at 1:10 P.M. Diagnoses not limited to: Alzheimer's order, and depressive disorder.		PROVIDERS PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ompliance ction, the eresponsible CQI tool for 4 weeks, as. If not met, an veloped. aitted to the r review and stemic upleted:	(X5) COMPLETION DATE
	on 4/13/2021, indice signs/symptoms of is free of communication. There was not any could be found in the 4/13/2021 that indication. During an interview the Wellness Direction includes the infection be sent to the physis signature. On 11/1/2022 at 11 requested for the arrows.	rs Medical Plan of Treatment rated, "Resident shows no TB in an infectious state and cable diseases" further documentation that me medical record since cated a health statement. It on 10/27/2022 at 10:46 A.M., stor indicated, a form that ous disease statement was to cian every 6 months for 132 A.M., a policy was anual health statement. The indicated a policy was not				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 11/01/2022			
	ROVIDER OR SUPPLIER		6330 N	ADDRESS, CITY, STATE, ZIP COD I FIR RD GER, 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
R 0410 Bldg. 00	completed within t	Noncompliance uberculin skin test shall be hree (3) months prior to			
	forty-eight (48) to result shall be recoinduration with the by whom administ (f) For residents with documented negaresult during the promoths, the basel should employ the first step is negative performed within cafter the first test. testing will depend with tuberculosis. (g) All residents with the tuberculin shave a chest x-ray	a admission and read at seventy-two (72) hours. The orded in millimeters of a date given, date read, and ered and read. The have not had a tive tuberculin skin test receding twelve (12) ine tuberculin skin testing a two-step method. If the two-step method. If the two-step method is should be one (1) to three (3) weeks. The frequency of repeat is on the risk of infection the have a positive reaction kin test shall be required to a and other physical and ations in order to complete			
	Based on record rev failed to provide tw newly admitted resi reviewed for infecti H) Findings include: 1. A clinical record completed on 10/27 admitted to the facil included, but were redepression disorder	riew and interview, the facility o-step Mantoux testing for dents for 2 of 8 residents on control. (Residents B and review of Resident B was /2022 at 8:47 A.M. Resident B lity on 5/28/2021. Diagnoses not limited to: hypertension, and exertional dyspnea.	R 0410	F410 – Infection Control – Non-compliance It is the practice of this providensure a two-step Mantoux te for newly admitted residents is complete. What corrective action(s) with accomplished for those residents found to have been affected by the deficient practice: Residents B and H were provident atwo-step Mantoux test. No harm was incurred to resident or H related to this deficient	esting s III be n
	Record indicated an	initial Mantoux test was		practice.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		11/01/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8					
CTODVD	OINT CDANCED				FIR RD		
STURTE	OINT 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	completed on 11/10	/2021. The Mantoux test was			How other residents having	the	
	negative. A second step Mantoux test was not				potential to be affected by th	е	
	documented.				same deficient practice will b	oe .	
					identified and what correctiv	е	
	During an interview	on 10/27/2022 at 10:46 A.M.,			action(s) will be taken:		
	the Wellness Direct	or indicated, she thought a			All new residents require a		
	Mantoux test had be	een completed at the			two-step Mantoux testing. No		
	physician's office, b	out could not find the			other residents were identified		
	documentation. She	e indicated a second step			related to this deficient practic	e.	
	Mantoux should har	ve been completed.			What measures will be put in	ito	
					place or what systemic chan	ges	
	2. A clinical record	review of Resident H was			will be made to ensure that t	he	
	completed on 10/27/2022 at 10:11 A.M. Resident H				deficient practice does not		
	admitted to the facility on 9/20/2022. Diagnoses				recur:		
	included, but were	not limited to: Alzheimer's			Audits will be on-going to ensu	ıre	
	disease, congestive	heart failure and anxiety			compliance with infection cont	rol	
	disorder.				policy and procedure.		
					Audits will be conducted by the	е	
	_	ond step Mantoux could not			nurse management team to		
	be located in the me	edical record.			monitor compliance.		
					How the corrective action(s)	will	
		:52 A.M., requested			be monitored to ensure the		
		ne Mantoux tests were			deficient practice will not red	eur,	
	requested. Docume	ntation was not provided.			i.e., what quality assurance		
					program will be put into place		
	_	on 10/27/2021 at 10:46 A.M.,			To ensure ongoing compliance	Э	
		or indicated the first and			with this corrective action, the		
	_	ix test should have been			DNS/designee will be respons	ible	
	completed.				for completion of the CQI tool		
					titled, "TB Testing" weekly for		
		:00 P.M., the Wellness Director			weeks, monthly for six months		
	1 ^	policy titled, "TB Infection			threshold of 100% is not met,	an	
		na". The policy indicated, "e.			action plan will be developed.		
	·	culin skin test shall be			Findings will be submitted to the		
		nree (3) months prior to			Executive Director for review a	and	
		admission and read forty-eight			follow up.		
		ty-two (72) hoursf. For			By what date the systemic		
		not had a documented			chances will be completed:		
		skin test result during the			Compliance date: 11/28/22		
	preceding twelve (1	2) months, the baseline					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WING			11/01/2022	
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER CLAMARY STATEMENT OF DEFICIENCIE				6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD 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)		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"							

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