STATEMEN	T 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		10/04/	/2024
			Ь,	CTREET	ADDRESS SITY STATE ZIR COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD FIR RD		
STORVE							
STURTE	OINT GRANGER			GRAIN	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
		he Investigation of Complaints	R 00	000	11/5/24 – To Whom It May		
	IN00444050, IN00	435195, IN00435202 and			Concern: On October 1st to		
	IN00435204.				October 4th, 2024, a complain	t	
					survey was conducted at		
	_	4050 - State deficiency related			StoryPoint Granger. Attached		
	to the allegations is	s cited at R0051			the revised plan of correction t		
					tags R051, R052, R090 and R		
	_	5195- State deficiencies related			the creation and submission o		
	to the allegations a	re cited at R0052 and R0090			this plan of correction does no		
					constitute an admission by this		
	Complaint IN00435202 - State deficiency related to the allegations is cited at R0240. provider of any conclusion set forth in the statement of deficiencies, or						
					of any violation of regulation.		
	_	5204 - State deficiency related to			Due to the relative low scope a	and	
	the allegations is ci	ited at R0240.			severity of this survey, the		
	g 1. G.				community respectfully reques		
	Survey dates: Octo	ber 1, 2, 3 and 4, 2024			desk review in lieu of a post-si	ırvey	
	E 11'4 1 0'	12220			revisit.		
	Facility number: 0	12229			Thank you for your time and		
	D: 4 4: -1 C	110			consideration,		
	Residential Census	: 118			Martin Lebbin		
	Thosa Stata Dasida	ntial Findings are cited in			Executive Director		
	accordance with 41				StoryPoint Granger		
	accordance with 41	10 IAC 10.2-3.					
	Quality Daview co	mpleted on 10/10/2024					
	Quality Review co.	impleted on 10/10/2024					
R 0051	410 IAC 16.2-5-1	2(u)					
	Residents' Rights	• •					
Bldg. 00							
	Based on interview	and record review, the facility	R 00)51	R051 – Residents' Rights -		11/01/2024
		idents were free from chemical			Offense	ļ	11,01,202
	restraints related to	the use of antipsychotic			It is the practice of this provide	er to	
		sident B without a supporting			assure residents have the righ		
		ysicina's order, for its use, for 1			be free from any physical or		
		ewed for antipsychotic			chemical restraints imposed for	or	
	medication usage.				the purposes of discipline or		
		•			' ' ' ' '		

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

TITLE

(X6) DATE

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 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.

State Form Event ID: NKIK11 Facility ID: 012229 If continuation sheet Page 1 of 17

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		10/04/	2024
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD FIR RD		
ST\D\D	OINT GRANGER				SER, IN 46530		
SIUNIF	OINT GRANGER			GRAING	3ER, 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 APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					convenience and not required	to	
	Finding includes:				treat the resident's medical		
					symptoms.		
	On 10/3/24 at 11:22 A.M., a review of the clinical				What corrective action(s) will	I	
	record for Resident B was conducted. The record				be accomplished for those		
	indicated the resident was admitted on 6/27/24.				residents found to have bee	n	
	_	noses included, but were not			affected by the deficient		
	limited to: "unspecified dementia, unspecified				practice:		
	severity, without behavior disturbance, psychotic				Resident B was missing a		
	disturbance, mood disturbance and anxiety and				supporting diagnosis and		
	osteoarthritis of hip	·"			physician's order.		
					The residents did not experier		
	A Nursing Progress Note, dated 7/9/24 at 6:13				any negative outcomes relate	d to	
	P.M., indicated there was a new order to start				the deficient concern.		
	ABH (Ativan 1mg/Benadryl 25 mg/Haldol 1 mg)				How other residents having		
		nt every evening ,between 7:00			potential to be affected by the		
	& 8:00 P.M., for an	ixiety.		same deficient practice will be			
					identified and what corrective	е	
	_	sion Note, dated 9/11/24 at 3:20			action(s) will be taken:		
		sident B had been continuously			All residents have the potentia	al to	
		sured, had been yelling out			be affected.		
		agitated by any distractions			Resident B was missing a		
		th staff. Staff had attempted to			supporting diagnosis and		
		cks but the interventions had			physician's order.		
	been unsuccessful.				Residents did not experience	-	
	A D1 '' 1	1 . 10/11/24 : 1: . 1.			negative outcomes related to	tne	
		dated 9/11/24, indicated to of ABH gel and apply the gel,			deficient concern.	4.	
		the resident's inner wrist twice a			What measures will be put in	ito	
	day and once a day				place or what systemic		
	day and once a day	rkiv (as needed).			changes will be made to ensure that the deficient		
	A Rehavior Everes	sion Note, dated 9/12/24 at 3:01			practice does not recur:		
	_	sident B was yelling out and			Nursing will review charts and		
		to hydrate the resident to help			meet with medical providers to		
	•	the intervention was			assure supporting diagnosis a		
	-	PRN anxiety medication used			physician's orders are up to d		
	had been approved	-			for all in-house residents. The		
	a ocen approved	202 Wallimbuwion			DNS/Designee will re-educate		
	A Medication Adm	inistration Note, dated 9/13/24			(Appendix A) the nursing staff		
		atted the resident was			the need to have supporting	J11	
		and replacify was			l and field to flave supporting		

State Form Event ID: NKIK11 Facility ID: 012229 If continuation sheet Page 2 of 17

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	NG		10/04/	2024
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
OTODVO	OINT ODANOED				FIR RD		
STORYP	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	administered a PRN	I dose of the ABH gel due to			diagnosis and physician order	s	
	yelling out. The medication was ineffective.				upon admission.		
					The physician/psych provider	will	
	A Medication Adm	inistration Note, dated 9/14/24			see the residents on antipsych		
		ted the resident was again			medications monthly and revie		
		I dose of the ABH gel, for			their effectiveness. Any new		
		medication was ineffective.			residents prescribed antipsych	notic	
	, ,				medications will be monitored		
	A Communication 1	Note from the facility to the			7-14 days with supporting		
		6/24 at 12:42 P.M., indicated			documentation for any advers	е	
	*	Lesident B had increased			reactions including notifying th		
	agitation and aggression towards staff during				provider if needed. The		
	dinner the previous evening. A new order was				physician/psych provider will		
	received for Ativan (an anti-anxiety medication)				reevaluate the resident in two		
	0.5 mg (milligrams)	•			weeks and then monthly. This	will	
		•			be ongoing. The DNS/Designe		
	A Behavior Express	sion Note, dated 9/17/24 at 3:20			will retrieve weekly reports for		
	-	ident B was yelling out and			resident receiving antipsychot	-	
		to distract the resident, but he			medications to ensure		
	continued to yell ou				documentation is complete. T	his	
					will be ongoing.		
	A new Physician's (Order was received, on 9/17/24,			How the corrective action(s)		
	-	i-psychotic medication) 5 mg			will be monitored to ensure t	:he	
		for "antipsychotic".			deficient practice will not		
	•				recur, i.e., what quality		
	A Communication 1	Note from the facility to the			assurance program will be p	ut	
		20/24 at 1:17 P.M., indicated			into place:		
	the resident had exp	perienced increased weakness,			The physician/psych provider	will	
	was dropping food	from his mouth and his tongue			see the residents on antipsych		
	had become deviate	ed to the right side. The			medications monthly and revie		
		contacted but refused to allow			their effectiveness. Any new		
	the resident to be se	ent to a local ER. Staff were			residents prescribed antipsych	notic	
	advised to have the	resident lie down and			medications will be monitored		
	continue to monitor	the resident. However, when			7-14 days with supporting		
	the staff transferred	the resident, to bed, he			documentation for any advers	e	
		ve. The note indicated the			reactions including notifying th		
	_	with his eyes closed and the			provider if needed. The		
		ed for the resident to be			physician/psych provider will		
	transferred to a loca				reevaluate the resident in two		
					weeks and then monthly. This	will	
	i		1		i		

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PRINTED: 11/12/2024 FORM APPROVED OMB NO. 0938-039

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 10/04/2024	
	ROVIDER OR SUPPLIER		6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD GER, IN 46530	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION partment Note, dated 9/20/24 at	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	1:15 P.M., indicated ER with decreased reported to the ER became more agitat on Ativan, as well a received a CT (Conblood work and a cl normal. The Note in spoke to the resident would take the resident procession, dated 9 the resident had bee effect of drug" and to the facility. The Medication Ad resident was adminited P.M. on 9/20/2024. A Communication of the resident had return the ER physic but to discontinue the A Communication of physician, dated 9/2 the resident had a mantipsychotic of 12.5 and anxiety because resident had been can be a communication of the Communication of the R Communication of the	partment Note, dated 9/20/24 at d Resident B presented to the mental status. It had been that the resident had recently ed at nighttime and was started as Zyprexa. The resident inputed Tomography) scan, nest x-ray which were all indicated the ER physician it's internist and he agreed he dent off of the sedating in & Zyprexa) and "ramp" them he resident became more indicated the resident was facility. The ER Clinical /20/24 at 6:48 P.M., indicated in diangosed with: "Adverse resident was discharged back in diangosed with: at the fistered Zyprexa 5 mg at 8:00. Note from the facility to the form the ER, with orders ian to administer the ABH gel in Ezyprexa and Ativan. Note from the facility to the staff had reported the alling out since 2:00 P.M. Note from the facility to the 24/24 at 12:50 P.M., indicated		be ongoing. The DNS/Designee will be responsible for the review and completion of resident record Reviewing to make sure they contain updated supporting diagnosis and physician orde This is ongoing. If a threshold 100% is not met, an action plie will be developed. Findings we submitted to the Executive Director for review and follow By what date the systemic chances will be completed: Compliance date: 11/15/24	s. rs. l of an vill be
	the resident appeare	ed to be adjusting to the			

State Form Event ID: NKIK11 Facility ID: 012229 If continuation sheet Page 4 of 17

PRINTED: 11/12/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUI		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF PROVIDER OR SUP-		6330 N	ADDRESS, CITY, STATE, ZIP CO FIR RD GER, IN 46530	DD .	
STORYPOINT GRANGE (X4) ID SUMM PREFIX (EACH DEFIX TAG REGULATOR Seroquel with a resident had not support to the resident support to the resi	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION To adverse side effects noted. The It yelled out. Order/Medication Note, dated P.M., indicated a new physician ved. The resident's current dose of iscontinued and a new order for mg at bedtime was received for E:19 P.M., an Admit/Discharge Note esident had moved from the facility. View, on 10/3/24 at 3:03 P.M., the eter of Nursing (ADON) confirmed build not have received another oreza medication after his return al as it had been discontinued. E:15 P.M., the ADON provided a Psychotropic Medication Review", and indicated the policy was the sed by the facility. The policy are purpose of the Psychotropic view policy is to ensure medications are used to prescriber's the lowest effective dose for the dent safetyPsychotropic any be used in the treatment of a	6330 N	FIR RD	ECTION DULD BE	(X5) COMPLETION DATE
older adult, not preferred. Whe prescribed, a P form should be	hotic and anxiety disorders. In the n-pharmacological alternatives are n a psychotropic medication is sychotropic Medication Review completedThe review is to be the Wellness Director"				

State Form Event ID: NKIK11 Facility ID: 012229 If continuation sheet Page 5 of 17

STATEMEN	NT 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	LETED
			B. WI	NG		10/04	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	3			FIR RD		
STORYP	OINT GRANGER			GRANGER, IN 46530			
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		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)	TE	DATE
		ial finding relates to Complaint					
	IN00444050.						
R 0052	410 IAC 16.2-5-1.	2(v)(1-6)					
	Residents' Rights	- Offense					
Bldg. 00							
		and record review, the facility	R 0	052	R052 – Residents' Rights -		10/31/2024
		e nursing assessments, after			Offense		
		" for 1 of 4 residents reviewed			It is the practice of this provide		
		eient practice the resident			assure residents have the righ	it to	
		onsive prior to being sent to			be free from sexual abuse,		
		n with diagnoses of a brain bleeding), a massive brain			physical abuse, mental abuse		
	• •	C, .		corporal punishment, neglect, a involuntary seclusion.		and	
	from his injuries. (F	blood). The resident did expire			-	II bo	
	nom ms mjunes. (r	Conceil D _j			What corrective action(s) will accomplished for those	ıı De	
	Finding includes:				residents found to have been	n	
	1 manig merades.				affected by the deficient	•	
	On 10/1/24 at 1:05	P.M., a review of the clinical			practice:		
		D was conducted. The record			The Wellness staff were		
		nt was admitted on 4/18/24			re-educated by the DNS/Design	gnee	
		noses included, but were not			regarding the protocol (Appen	-	
		(inability to speak well),			B) for assessing a resident wit		
	_	delusions, history of brain			unwitnessed fall after normal		
	hemorrhage and sei	zures.			business hours.		
					It is unclear if the resident		
		ssment for Resident D,			experienced any negative		
		24, indicated the resident			outcomes related to the deficie	ent	
		all Assessment indicated a			concern.		
		er indicated the resident was at			How other residents having		
	high risk for a falls.				potential to be affected by th		
	4.31 . 5	N 1 . 1 4/10/04 1 40 P.35			same deficient practice will l		
		s Note, dated 4/18/24 1:42 P.M.,			identified and what corrective	re	
		D was alert and oriented to			action(s) will be taken:	.1.4	
		me. The resident was verbal			All residents have the potentia	ii to	
	_	delayed speech response			be affected.		
		ulatory with a steady and slow			The Wellness staff were	nnoo	
	gait and used a wall	nci ai tillics			re-educated by the DNS/Desig		
	There were no othe	r Progress Notes until the date			regarding the protocol (Appen B) for assessing a resident wit		
	I THELE WELL HO OTHE	i i rogress riones unun une uane	1		וטו עם ן ויט מססכססוווע מ ועסועלוון Wil	uı all	I

State Form Event ID: NKIK11 Facility ID: 012229 If continuation sheet Page 6 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE:		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		10/04/	2024
			<u> </u>	CTDEET A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	₹		6330 N	ADDRESS, CITY, STATE, ZIP COD		
ST\D\D	OINT GRANGER				GER, IN 46530		
STURTE	OINT GRANGER			GRANG	SER, IN 40550		
(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	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of his fall on 5/2/20	024.			unwitnessed fall after normal		
					business hours.		
	A Nursing Progress Note, dated 5/2/24 at 4:35				Residents did not experience a	any	
	A.M., created on 5/2/24 by Triage Agency Nurse				negative outcomes related to t	he	
		owing "QMA 2 stated resident			deficient concern.		
	_	ounds lying on his right side			What measures will be put in	to	
		m near the bathroom doorway.			place or what systemic chan	ges	
		state what he was doing or			will be made to ensure that the	he	
		nt does not use a walker or			deficient practice does not		
	-	ries noted to head or body.			recur:		
		y pain. Resident was assisted			StoryPoint utilizes an in-house		
	-	was able to ambulate back to			on-call nurse who is available	for	
	bed without difficul	lty. Vital signs obtained"			visual triage after hours. Any		
					after-hour triage calls are hand	lled	
		, dated 5/2/24 at 4:35 A.M.,			by the on-call nurse and the		
		ving "QMA 2stated resident			DNS/Designee is notified to make		
	_	ounds lying on his right side			sure all assessments are		
		m near the bathroom doorway.		completed appropriately. If			
		state what he was doing or			concerns are noted, the		
		nt does not use a walker or			DNS/Designee follow-up to ma	ake	
	-	ries noted to head or body.			sure the assessment was		
		y pain. Resident was assisted			completed. This will be on-goin	-	
	_	was able to ambulate back to			The DNS/Designee will review		
		lty" The resident's			"Pertinent Q Shift Charting" rep		
		7.7, Pulse 75, Respirations 17,			(Appendix C) each weekday.		
	_	/87 and oxygen saturation was			report will be reviewed for any		
		was alert and oriented to			after-hour falls and documenta		
		The form indicated Resident D			will be reviewed. Any wellness		
		e hospital and the daughter D (Medical Doctor) was faxed			staff not following the protocol	WIII	
	· ·	*			be identified.		
	the fall.	Nursing was emailed regarding			How the corrective estimates	will	
	uic 1411.				How the corrective action(s)	WIII	
	There were no other	r documented assessments, on			be monitored to ensure the		
		5 A.M. and 8:33 A.M.			deficient practice will not rec i.e., what quality assurance	ui,	
	5,2,2+ octween 4.5.	5 71.1v1. and 6.55 71.1v1.			program will be put into plac	٠.	
	A Nursing Progress	s Note, dated 5/2/24 at 8:34			StoryPoint utilizes an in-house		
		3 Note, dated 3/2/24 at 8.54 3 had documented Resident			on-call nurse who is available		
		to a local Emergency Room			visual triage after hours. Any	101	
	-	injury with a change in the			after-hour triage calls are hand	lled	
	(LIC) due to a nead	injury with a change in the			alter-libul triage calls are flatfe	ai c u	

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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. B	UILDING	00	COMPL	ETED
			B. W	ING		10/04/	/2024
				OTREET	ADDRESS CITY STATE TIP COP		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
0.7.00\/0	OINT ODANOES				FIR RD		
I STORYP	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident's condition	and a decline in his mobility.			by the on-call nurse and the		
					DNS/Designee is notified to m	ake	
	An Emergency Roo	om (ER) Note, dated 5/2/24 at			sure all assessments are		
	8:47 A.M., indicate	d the following: "Resident D			completed appropriately. If		
	arrived to the ER u	nresponsive. According to the			concerns are noted, the		
		tient had been found on the			DNS/Designee follow-up to ma	ake	
		is bed, at approximately 4:00			sure the assessment was		
	A.M. and placed ba	ck in his bed. Later, facility			completed. This will be on-goi	ng.	
	staff found the patie	ent to be minimally responsive,			To ensure ongoing compliance	•	
	nursing concerned	with possible right facial droop			with this corrective action, nur	sing	
	and had not appeare	ed to be moving his			will review the "Pertinent Q Sh	nift	
	extremities. He was	taken directly to CT			Charting" report (Appendix C)	each	
	(Computerized Tomography) by EMS (Emergency				weekday. The report will be		
	Medical Services) where he was evaluated. CT				reviewed for any after-hour fal	ls	
	demonstrated a cata	strophic large left intracranial			and documentation will be		
	hemorrhage. "				reviewed. Any wellness staff r	ot	
					following the protocol will be		
	A CT report, dated	5/2/24 at 8:59 A.M., indicated			identified. If a threshold of 100)% is	
	"New massive lef	t hemispheric parenchymal			not met, an action plan for the		
	_	the brain] hematoma			employee will be developed.	This	
	measuring at least 9	cm [centimeters]"			will be ongoing. Findings will be submitted to the Executive	е	
	A Nursing Progress	Note, dated 5/2/24 at 1:04			Director for review and follow-	un	
		sident D " is admitted to			By what date the systemic	up.	
		for massive brain bleed per ER			changes will be completed:		
		is planning to take resident			Compliance date: 11/5/24		
	homeon hospice				Compilarioe date. 11/6/24		
	l and the second						
	A review of Times	ard Report indicated there was					
		es (RN) or Licensed Practical					
		ring at the facility during the					
	night shift on 5/2/2						
	A Nursing Progress	Note dated 5/7/24 at 12:43					
		resident's daughter "notified					
	l '	t passed away on Saturday,					
	May 4th"	• • • • • • • • • • • • • • • • • • • •					
	A hand written state	ement by LPN 3, dated 5/17/24					
		night shift reported a fall with					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	COM	E SURVEY PLETED 4/2024
	PROVIDER OR SUPPLIER		6330	EET ADDRESS, CITY, STATE 0 N FIR RD ANGER, IN 46530	E, ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ent D's room. LPN had directed	ID PREFIX TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T	TO THE APPROPRIATE	(X5) COMPLETION DATE
	staff, on 1st shift (6 start time), to check noted a laceration whead. Resident was room]" A hand written state 5/21/24, indicated, A.M., CNA 4 had QMA 2 to report to fallen. When QMA observed the reside lying on his right si QMA 2 called a Tristatement indicated he was in pain "h" QMA 2 explain QMA 2 to the Triage the Triage nurse ask injuries, which QM were none. QMA 2 nurse, to "get him ocomplete her report indicated as she wa LPN 3 (day shift nut that had happened, unit to get CNA 5 to D up off of the flood During an interview Director of Nursing and CNAs worked to RN or LPN in the instructed to contact a need for a nurse a service The Triage required incident/fa	ent D's room. LPN had directed :00 A.M. was the day shift on the resident . "It was as present to back of his then sent to ER [emergency] ement by QMA 2, dated on 5/2/24 at approximately 4:00 called on a walkie talkie to Resident D's room as he had 2 arrived to the room, she on the floor of his bedroom, de. CNA 4 obtained vitals as age Agency. QMA 2's I she had asked the resident if the emumbled but no clear answer and everything CNA 4 had told the Agency nurse and the entire the entire the entire the was instructed, by the Triage off the floor and she would ". QMA 2's statement as coming downstairs she saw arse) and explained everything then proceeded to the North to assist CNA 4 to lift Resident or. To on 10/1/24 at 2:24 P.M., the (DON) indicated when QMAs the night shift and there was the facility, the QMA's had been to a Triage Service if there was and RN 6 worked for the Triage as Service was contacted for II reports and as needed for II. The DON indicated a QMA				
	can not assess a res	ident after a fall. The DON				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 10/04/2024	
	ROVIDER OR SUPPLIER		6330 N	ADDRESS, CITY, STATE, ZIP COD FIR RD GER, IN 46530	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR indicated LPN 3 and the facility and were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION d QMA 2 no longer worked for e unable to be contacted for an	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	falsifying document During a telephone	interview, on 10/1/24 at 3:13			
	Service located in M had been contacted regarding Resident to her notes during	d she worked for a Triage Mississippi. She indicated she by QMA 2, on 5/2/24, D's fall and would be referring the conversation. RN 6			
	,who indicated she l floor during her rou bathroom. RN 6 ind	ceived a call from a QMA 2 nad found the resident on the nds, lying on his side, near the icated she heard the n machine working in the			
	background and the signs to her. RN 6 in resident had no inju	QMA had relayed the vitals andicated she was told the ries. She could not see the ected them to place the			
	directions to QMA note with the inform	had not provided any further 2 and had written the Progress nation provided by QMA 2.			
	CNA 4 indicated sh his room, on the flo did not find him. Cl "walkie" stating Res	r, on 10/2/24 at 10:00 A.M., e had found the Resident D, in or. CNA 4 indicated QMA 2 NA 4 had called for help on a sident D was on the floor and assistance. CNA 4 indicated			
	the resident was inc answered her call fo minutes, so she told get help and left him	oherent and moaning. No one or help for approximately 10 the resident she needed to go on to go to the first floor and			
	temperature, and pu D's room and called taking the resident's instructed her to lift	chine (takes the resident's b/p, lse). QMA 2 came in Resident the Triage Nurse as she was vital signs . QMA 2 the resident to his bed but IA 4, as QMA 2 said she had			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET		(X3) DATE SURVEY COMPLETED 10/04/2024
STORYP	ROVIDER OR SUPPLIER		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 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
	and obtained another then lifted the reside minutes after CNA CNA 4 indicated the the transfer and was indicated this was note had walked independent ould bear his own had checked on the and he had been was earching for somet. On 10/1/24 at 3:12 policy titled, "Residenticated the policy by the facility. The purpose of the Residential Caregivers provide resident checks. And to the Wellness Leastaff, with the Healt follow up on any face resident is stable and as late fracture or suruled out of [sic] resident State Residential IN00435195.	P.M., the DON provided a dent Falls", dated 3/22/23, and was the one currently used policy indicated "The dents Falls policy is to provide ating a resident after a falla. appropriate care and frequent y change in status is reported der [Director of Nursing]. The hcare provider's guidance, will ll with associated injury until d delayed complications such abdural hematoma have been solved"			
R 0090 Bldg. 00		Management - Deficiency			
	failed to inform the (IDOH) of a incider	and record review, the facility Indiana Department of Health at, in which a resident had an hich resulted in hospitalization t D)	R 0090	R090 – Administration and Management - Deficiency It is the practice of this provide immediately report any unusu occurrence that directly threat the welfare, safety, or health of	al ens

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
			B. W	ING		10/04/2	2024
				CTREET /	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD FIR RD		
CTODVD	OINT GRANGER						
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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Finding includes:				resident.		
					What corrective action(s) will	ll be	
	On 10/1/24 at 1:05 P.M., a review of the clinical				accomplished for those		
	record for Resident D was conducted. The record				residents found to have been	n	
	indicated the resident was admitted on 4/18/24				affected by the deficient		
	The resident's diagr	noses included, but were not			practice:		
	limited to: aphasia ((inability to speak well),			The policy on "Resident		
	cerebral infarction,	delusions, history of brain			Incident/Accident Reporting" v	vas	
	hemorrhage and sei	zures.			reviewed regarding the reporti	ng of	
					any unusual occurrence that		
	A Nursing Progress	Note, dated 5/2/24 at 4:35			directly threatens the welfare,		
	A.M., created on 5	/2/24 by Triage Agency Nurse			safety, or health of a resident.		
	6 indicated the follo	owing: "QMA 2stated			(Appendix D) Staff were		
	resident was found	during rounds lying on his			re-educated, by the DNS/ED,		
	right side outside hi	s bathroom near the bathroom			regarding the need to report a	ny	
	doorway. Resident	could not state what he was			unusual occurrence (Appendix	(E)	
	doing or how he fel	l. Resident does not use a			that directly threatens the welf	are,	
	walker or wheelcha	ir. No injuries noted to head or			safety, or health of a resident		
	body. Resident den	ied any pain. Resident was			within 24 hours to the state.		
	assisted off the grou	and and was able to ambulate			The resident did not experience	e	
	back to bed without	difficulty. Vital signs			any unexpected outcome relat	ted	
	obtained"				to the deficient concern.		
					How other residents having	the	
		, dated 5/2/24 at 4:35 A.M.,			potential to be affected by th	e	
		ving: "QMA 2stated resident			same deficient practice will l		
	_	ounds lying on his right side			identified and what correctiv	re	
		n near the bathroom doorway.			action(s) will be taken:		
	Resident could not	state what he was doing or			All residents have the potentia	ıl to	
		nt does not use a walker or			be affected.		
	1	ries noted to head or body.			The policy on "Resident		
		y pain. Resident was assisted			Incident/Accident Reporting"		
	_	was able to ambulate back to			(Appendix D) was reviewed		
		ty" The resident's vital			regarding the reporting of any		
	1 -	nted as follows: temperature			unusual occurrence that direct	-	
		, Respirations 17, blood			threatens the welfare, safety,		
	1 ^	d oxygen saturation was 91%.			health of a resident. Staff wer	-	
		to be alert and oriented to			re-educated (Appendix E), by		
	_	he form indicated Resident D			DNS/ED, regarding the need t		
		hospital, the resident's			report any unusual occurrence		
	daughter was notific	ed, the MD (Medical Doctor)			that directly threatens the welf	are,	

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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			10/04/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				6330 N			
STORYPOINT GRANGER					FIR RD BER, IN 46530		
310111	ONT GIVANGER			GIVAING	JEIX, IIV 40000		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Director of Nursing was emailed			safety, or health of a resident		
	regarding the fall.				within 24 hours to the state.		
					Residents did not experience	did not experience any	
		Note, dated 5/2/24 at 8:34			negative outcomes related to t	he	
	· ·	N 3 had documented Resident			deficient concern.		
	_	o a local Emergency Room			What measures will be put into		
	1 ' '	injury with a change in the			place or what systemic chan	_	
	resident's condition	, with a decline in his mobility.			will be made to ensure that t	he	
					deficient practice does not		
	1	om (ER) Note, dated 5/2/24 at			recur:		
		d the following: "Resident D			The policy on "Resident		
		nresponsive. According to the			Incident/Accident Reporting"		
		tient had been found on the			(Appendix D) was reviewed		
	_	is bed, at approximately 4:00			regarding the reporting of any		
	A.M. and placed back in his bed. Later, facility				unusual occurrence that direct	-	
		ent to be minimally responsive,			threatens the welfare, safety, o		
	nursing concerned with possible right facial droop				health of a resident. Staff wer		
	and had not appeare				re-educated (Appendix E), by		
		s taken directly to CT			DNS/ED, regarding the need t		
		nography) by EMS (Emergency			report any unusual occurrence		
	· · · · · · · · · · · · · · · · · · ·	where he was evaluated. CT			that directly threatens the welf	are,	
		strophic large left intracranial			safety, or health of a resident		
	hemorrhage. "				within 24 hours to the state. If		
		N 1 . 15/0/04			concerns are noted, the		
		Note, dated 5/2/24 at 1:04			ED/DNS/Designee will be notif		
		ident D " is admitted to			immediately for corrective action		
		for massive brain bleed per ER			To ensure timely reporting, the)	
] is planning to take resident			DNS/ED/Designee will		
	homeon hospice	 "			immediately be notified of any	_	
					resident incidents. The DNS/E	ט	
	A Nurse Progress Note dated 5/7/24 at 12:43 P.M.,		will follow up and submit any				
	indicated the following "notified facility that				reportables to the state. The	41	
	resident passed away on Saturday, May 4th"				DNS/ED/Designee will review	ше	
	Resident D's daughter had notified the facility of the resident's passing.				24-hour report and or incident	ont	
					reports to ensure that all residents		
					incidents have been complete		
		on 10/2/24 at 12:25 P.M., the			and reported. Per the policy or	1	
		ated there was no self-reported			"Resident Incident/Accident		
	incident reported to IDOH regarding the fall with injury for Resident D.				Reporting" (Appendix D). This	WIII	
					be ongoing.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED			
			B. WING		10/04/2024		
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530 ID PROVIDERS PLAN OF CORRECTION (X5)				
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
R 0240	policy titled, "Resiner Reporting", dated by policy was the one The policy indicate Administrator is remanagement of the the administrator slow, the following: (twenty-four (24) how unusual occurrence welfare, safety, or unusual occurrence followed by a writt only that is faxed of division within the period. Unusual occurrence (A) epidemic outbrown (B) poisonings; (C) fires; or (D) major accident Types of incidents Death of a resident suspicious, or resultance and the policy of the polic	s reportable under state rules2. that is unusual, violent, ted from an accident" tial finding relates to Complaint		How the corrective action(s) be monitored to ensure the deficient practice will not review, what quality assurance program will be put into place. The policy on "Resident Incident/Accident Reporting" (Appendix D) was reviewed regarding the reporting of any unusual occurrence that direct threatens the welfare, safety, health of a resident. The ED monitor the reporting of any allegations of abuse and report the state within 24 hours. If concerns are noted, the ED/DNS/Designee will be not immediately for corrective action order to ensure timely report the DNS/ED/Designee will immediately be notified of any resident incidents. The DNS/E will follow up and submit any reportables to the state. The DNS/ED/Designee will review 24-hour report and or incident reports to ensure that all resid incidents have been complete and reported. Per the policy of "Resident Incident/Accident Reporting" (Appendix D). This be ongoing. By what date the systemic changes will be completed: Compliance date: 11/5/24	tly or will rt to fied ion. rting, the ident id		
Bldg. 00	Health Services -	• •					

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED			
			B. WING 10			10/04/2024	10/04/2024	
				GTDFFT	ADDRESS CITY STATE ZIR SOD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
					I FIR RD			
STORYP	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CON	MPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)]	DATE	
	Based on observation	on, interview and record	R 0	240	R240 - Health Services -	10/	/31/2024	
	review, the facility	failed to provide, physician			Noncompliance			
	ordered, colostomy	//ileostomy care and			It is the practice of this provide	er to		
	-	residents reviewed who had			provide personal care, and			
	an iloeostomy (an o	ppening in the abdominal wall			assistance with activities of da	ıily		
		es out of the body). (Resident			living, based upon the individu	•		
	C)	• , ,			needs and preferences.			
	Í				What corrective action(s) wil	ı l		
	Finding includes:				be accomplished for those			
	J				residents found to have been	ո		
	On 10/1/24 at 2:22	P.M., the Director of Nursing			affected by the deficient			
		d Medication Aide (QMA)			practice:			
		which indicated a QMA could			Nursing staff followed up with			
	empty and change a colostomy bag.				resident 1's physician to upda	te		
	empty and enange a corostomy oug.				colostomy/ileostomy care orde			
	On 10/2/24 at 12:54 P.M., a review of the clinical				The residents did not experier			
	record for Resident C was conducted. The				any negative outcomes related			
	resident's diagnoses included, but were not				the deficient concern.			
	limited to: intestinal obstruction with ileostomy				How other residents having	the		
	and edema				potential to be affected by th			
	und Calmu				same deficient practice will be			
	A Physician Order,	dated 1/27/24 indicated "			identified and what correctiv			
		replacement of ostomy			action(s) will be taken:			
		wafer and paste, cleanse with			All residents have the potentia	ıl to		
	-	dry with blow dryer on low			be affected.			
	*	p, apply clear protectant film,			Nursing staff followed up with			
	apply stoma powder to stoma, apply paste to				resident 1's physician to upda	te		
	wafer system, apply to stoma and secure with				colostomy/ileostomy care orde			
		lry area on low heat for 1 min			Any new residents admitted w			
	and press firmly to secure, apply ostomy belt one				colostomy/ileostomy care orde			
	time a day every 3 day(s) for ileostomy" There			will be reviewed by the				
	was also an order to provide ostomy assistance as				DNS/Designee to make sure the			
	needed.				proper care is being administe			
					Residents did not experience			
	A Wellness Evaluation/Service Plan dated				negative outcomes related to	-		
		Resident C required atypical			deficient concern.			
		ical limitations including, but			What measures will be put in	ıto		
		tance with ostomy care and			place or what systemic			
	toileting manageme				changes will be made to			
		· 			ensure that the deficient			
					Silvaro mat me denomin			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING			10/04/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					FIR RD		
STORYPOINT GRANGER					SER, IN 46530		
			_		· ,	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	_	v, on 10/2/24 2:11 P.M.,			practice does not recur:	Ller	
		ed she had an ostomy and er abdomen. She indicated			Nursing has been re-educated	тру	
		t had refused to mess with it			the DNS/Designee on the requirements for		
		l insecure. She indicated if			colostomy/ileostomy care		
		want to mess with it were					
		hing went wrong, they might			residents admitted with	ppendix F & G). Any new	
	_	e resident indicated she was			colostomy/ileostomy care orders		
		ra on her rent due to needing			will be reviewed by the		
		th her ostomy, due to her			DNS/Designee to make sure t	he	
		indicated her ostomy care			proper care is being administe		
		eted on her shower days			All existing and new nursing s		
	(Monday and Thursday) but she might have to				will be in-serviced using		
	wait until there was someone at the facility who				colostomy/ileostomy care che	ck	
	was willing to help her.		off with return demonstration to				
					make sure they are comfortab	le	
	A Review of the MAR (Medication				with providing		
	Administration Record) for September indicated				colostomy/ileostomy care.		
	there was no documentation indicating the				How the corrective action(s)		
	•	was provided on the following			will be monitored to ensure t	:he	
	days: 9/2, 9/8, 9/17	, 9/20, 9/23, 9/26 and 9/29/24.			deficient practice will not		
					recur, i.e., what quality		
	_	v, on 10/2/24 at 2:57 P.M., the			assurance program will be p	ut	
		of Nursing (ADON) indicated			into place:		
	• •	ess was being provided and			To ensure ongoing compliance	е	
	-	id just failed to document its			with this corrective action, all	20	
		ome indicated some QMAs ion Aide) had refused to assist			existing and new nursing staff	WIII	
	* *				be in serviced using	ok	
	the resident with her ostomy care and the resident				colostomy/ileostomy care che		
	had to wait until another staff member provided		off with return demonstration to make sure they are comfortable				
	the assistance.				with providing	ie	
	On 10/2/24 at 2:59 P.M., the ADON provided a				colostomy/ileostomy care. Th	Δ	
	policy titled, "Medication Administration", dated				DNS/ADNS will meet with any		
	4/11/24, and indicated the policy was the one currently used by the facility. The policy indicated				resident needing		
					colostomy/ileostomy care wee	klv	
		administers medication and/or			for 4 weeks. Monthly for 4 mo	-	
	treatments on the resident's MAR "records the				and then quarterly. Nursing st		
	administration"				will be in-serviced yearly.		
					The DNS/Designee will be		
			1		l ~		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/04/2024		
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER			STREET ADDRESS, CITY, STATE, ZIP COD 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	
	During an interview, on 10/4/24 at 12:18 P.M., the Administrator indicated there was no facility policy regarding ostomy care or procedure. This State Residential finding relates to Complaints IN00435202 and IN00435204.			responsible for reviewing the orders of any new residents admitted or with a new diagnor requiring colostomy/ileostomy care. The DNS/Designee to me sure the proper care is being administered by reviewing the "Pertinent Q Shift Charting" respectively (Appendix C) regarding any concerns regarding colostomy/ileostomy care. If a threshold of 100% is not met, action plan will be developed. Findings will be submitted to the ED for review and follow-up. By what date the systemic chances will be completed: Compliance date: 11/15/24	nake e eport an		

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