STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	A. BUILDING <u>00</u>		COMPLETED	
			B. WING				2024
				TDEET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R		330 N F			
STORYP	OINT GRANGER				ER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY		DATE
R 0000							
Bldg. 00							
Blug. 00	This visit was for a	State Residential Licensure	R 0000	n	1/28/24 – To Whom It May		
		included the Investigation of	I K 0000		Concern: On January 3rd and 4th,		
	Complaint IN0042				2024, a health survey was	141,	
	1				conducted at StoryPoint Grang	ger.	
	Complaint IN0042	3080 - State deficiency related to			Attached is the plan of correct	-	
	the allegations is ci				for tags R064, R092, R121, R		
	-				R217, R246, R302, R306, R34		
	Survey dates: 1/3/2	2024 to 1/4/2024			R356, R409, R410, and R414	the	
					creation and submission of this	S	
	Facility number: 0	12229			plan of correction does not		
					constitute an admission by this	8	
	Residential Census	s: 113			provider of any conclusion set		
					in the statement of deficiencie	s, or	
		ential Findings are cited in			of any violation of regulation.		
	accordance with 41	10 IAC 16.2-5.			Due to the relative low scope a	and	
	0.15	1 . 1 . 1/10/04			severity of this survey, the		
	Quality review con	mpleted on 1/12/24.			community respectfully reques		
					desk review in lieu of a post-si	ırvey	
					revisit.		
					Thank you for your time and consideration,		
					Martin Lebbin		
					Executive Director		
					StoryPoint Granger		
					2.51,1 On Change		
R 0064	410 IAC 16.2-5-1	.2(hh)					
	Residents' Rights	• •					
Bldg. 00	_	hall exercise reasonable					
	care for the prote	ction of residents ' property					
	from loss and the	ft. The administrator or his					
	or her designee is	s responsible for					
		orts of lost or stolen resident					
	property and that						
	•	reported to the resident.					
		view and interview, the facility	R 0064	4	R064 – Residents' Rights -		01/31/2024
	failed to ensure a re				Noncompliance		
	misappropriation o	of property for 1 of 1 residents			It is the practice of this provide	er to	

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

TITLE

(X6) DATE

Martin Lebbin Executive Director 01/27/2024

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

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED	
			B. W	ING	.	01/04/2	2024	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			FIR RD			
STODVE	POINT GRANGER				GER, IN 46530			
STORTE	OINT GRANGER			GRANC	3ER, IN 40000			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	reviewed for misap	propriation of property.			exercise reasonable care for t	he		
	(Resident B)				protection of residents' proper	ty		
					from loss and theft.			
	Finding includes:				What corrective action(s) will	II		
					be accomplished for those			
	_	Form indicated on 11/18/2023,			residents found to have been	n		
		y had reported a check had been			affected by the deficient			
		00 from Resident B's account			practice:			
		d not write. The check was			Resident B's missing property	'		
		13. CNA 13 was immediately			was reported per policy. State	÷,		
		investigation. The Wellness			police, and family were all not	ified.		
	Director and Execu	itive Director were notified.			The residents did not experier	nce		
					any negative outcomes relate	d to		
	_	ed on 11/30/2023, which			the deficient concern.			
		2023, the Executive Director			How other residents having	the		
		picture of the check was			potential to be affected by the	ie		
		B's son indicated a picture		same deficient practice will be				
		11/27/2023, a picture of the			identified and what corrective	e e		
		ed check was received. On			action(s) will be taken:			
	_	are of the back of the check was			All residents have the potentia	al to		
		/2023 CNA 13 provided a			be affected.			
		hat she did not have any			Resident B's missing property			
	_	check. On 11/30/2023, CNA 13			was reported per policy. State			
		r prior attempts, regarding			police, and family were all not			
		ation. CNA 13 was provided a			The residents did not experier			
	1	per her request to follow up.			any negative outcomes relate	d to		
		nated on 11/30/2023 as a result			the deficient concern.			
	_	esident B's bank identified the			What measures will be put in	nto		
		eimbursed the resident the			place or what systemic			
	\$3,500.00. The Pol	ice department was notified.			changes will be made to			
	l				ensure that the deficient			
	_	w on 1/4/2023 at 1:35 P.M., the			practice does not recur:			
		indicated the employee had			New employees will continue			
		r misappropriation of resident			screened prior to hiring, include	ding		
	property.				background checks for any			
					concerns or issues. Staff will be			
		0 P.M., the Wellness Director			re-educated on resident abuse	e and		
		titled, " Abuse, Neglect or			neglect policy.			
		a revision date of 6/7/2023, and			How the corrective action(s)			
indicated the policy was the one currently used				will be monitored to ensure	the			

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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 01/04/2024	
	PROVIDER OR SUPPLIER		6330 N	ADDRESS, CITY, STATE, ZIP COD I FIR RD GER, IN 46530	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	by the facility. The 3. Definitions: Expl fundsby another p	oitation - Misuse of an adults	TAG	deficient practice will not recur, i.e., what quality assurance program will be pinto place: To ensure ongoing compliant with this corrective action, the ED/DNS/designee will be responsible for completion of reviewing the new employee orientation packet to make suemployees have been oriented resident's rights and abuse an neglect. The completed pape will be reviewed by the busing office prior to creating the employee file. If a threshold of 100% is not met, an action ple will be developed. Findings was submitted to the Executive Director for review and follow By what date the systemic chances will be completed: Compliance date: 1/31/24	and are ed to nd rwork ess of an vill be
R 0092 Bldg. 00	disaster prepared continuity of care of emergency as follows: (1) Fire exit drills in transmission of a simulation of emergency that the more residents to safe at the building is not conducted quarter familiarize all facility.	It maintain a written fire and mess plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, overment of nonambulatory areas or to the exterior of required. Drills shall be			

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 3 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMP			TED
			B. W	ING		01/04/2	2024
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R			FIR RD		
STODVI	POINT GRANGER				GER, IN 46530		
STORT	-OINT GRANGER			GRANC	3EK, IN 40550		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions. At least	st twelve (12) drills shall be					
	held every year. V	When drills are conducted					
	between 9 p.m. a	nd 6 a.m., a coded					
	announcement m	ay be used instead of					
	audible alarms.						
	(2) At least every	six (6) months, a facility					
	shall attempt to he	old the fire and disaster drill					
	in conjunction with	h the local fire department.					
		ining and drills shall be					
		the names and signatures					
	of the personnel p						
		review and interview, the	R 0	092	R092 – Administration and	I .	01/31/2024
	facility failed to ensure quarterly fire drills were				Management - Noncomplian		
	_	nonths of January of 2023			It is the practice of this provide		
		23. This had the potential to			conduct quarterly fire drills on		
	affect all residents	residing in the facility.			each shift.		
					What corrective action(s) will	ll be	
	Finding includes:				accomplished for those		
					residents found to have been	n	
		e drill binder on 1/3/2024 at 2:15			affected by the deficient		
		t no fire drills were completed			practice:		
	-	23 through May of 2023, and no			The Maintenance Director was	S	
	documentation was	s located for these months.			re-educated regarding the		
	D	1/4/2024 + 10.05 A.M. (1			requirement to conduct fire dri	IIIS	
	_	w on 1/4/2024 at 10:05 A.M., the			quarterly on each shift to		
		tor indicated that no my fire drills from January 2023			familiarize all facility staff with	I .	
		23 could be provided.			signals and emergency action required under varied condition		
	unough way of 202	23 could be provided.			1		
	On 1/3/2023 at 2:29	8 P.M., the Wellness Director			The residents did not experier any negative outcomes related	I .	
		titled "Fire Drill Standard			the deficient concern.	u 10	
		re", dated 9/22/2017 and			How other residents having	the	
		and indicated the policy was			potential to be affected by the	I .	
		sed by the facility. The policy			same deficient practice will i		
	_	ills are required quarterly on			identified and what corrective		
		arize employees with signals			action(s) will be taken:		
		d. Because the communities			All residents have the potentia	al to	
	_	total of 12 drills a year with			be affected.		
	_	are required. The drills will need			The Maintenance Director was	s	
		onthly throughout the year to			re-educated regarding the	·	
		J J	1			I .	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530	
<u> </u>	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	(X5) COMPLETION DATE

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 5 of 31

PRINTED: 02/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/04/2024		
	ROVIDER OR SUPPLIER		6330	ADDRESS, CITY, STATE, ZIP COD N FIR RD IGER, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E COMPLETIC	ON
	ALGOLIN GA			Executive Director for review follow-up. By what date the systemic changes will be completed Compliance date: 1/31/24	v and	
R 0121	410 IAC 16.2-5-1.					l
Bldg. 00	employee of a fact contact. The screen skin test, using the PPD), unless a procan be documented recorded in millimed date given, date readministered. The following: (1) At the time of equal (1) month prior to annually thereafted personnel of facility tuberculosis. The must be read prior work. For health of had a documented test result during the months, the basel should employ the first step is negative performed one (1) first step. The free depend on the risk tuberculosis. (2) All employees reaction to the skill have a chest x-ray laboratory examinal diagnosis.	a shall be required for each sility prior to resident en shall include a tuberculin en shall be enters of induration with the ead, and by whom facility must assure the employment, or within one employment, and at least rr, employees and nonpaid ries shall be screened for first tuberculin skin test ro the employee starting are workers who have not donegative tuberculin skin the preceding twelve (12) intertuberculin skin testing en two-step method. If the ver, a second test should be to three (3) weeks after the luency of repeat testing will				

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 6 of 31

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> COMPLET			ETED	
			B. W	ING		01/04	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			FIR RD		
CTODVD	OINT CDANCED				SER, IN 46530		
SIUNTE	STORYPOINT GRANGER			GRANG	3ER, IN 40330		
(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
	of each employee	that includes reports of all					
	employment-relate	ed health screenings.					
	(4) An employee v	with symptoms or signs of					
	, ,	ymptoms suggestive of					
		s, including, but not limited					
		night sweats, and weight					
	_	permitted to work until					
	tuberculosis is rule	•					
	Based on record review and interview, the facility		R 0	121	R121 – Personnel -		03/01/2024
	failed to ensure new employees had a health				Noncompliance		
	screen prior to resident contact for 4 of 5				It is the practice of this provide	er to	
	employee files reviewed for health screens (LPN				assure all staff have a health		
	10, Housekeeper (HK) 11, Dietary Aide (DA) 12, &				screen prior to resident contac	et.	
	CNA 14).				What corrective action(s) will		
	,				accomplished for those		
	Findings include:				residents found to have been	1	
					affected by the deficient	•	
	1. A record review	of LPN 10's employee file was			practice:		
		024 at 1:30 P.M. LPN 10 had a			The orientation process was		
	•	21. LPN 10's employee file			immediately updated, to make		
		ntation to indicate she had a			sure all employees have a hea		
	health screen prior				screening.		
	•				The residents did not experien	ice	
	2. A record review	of HK 11's employee file was			any negative outcomes related		
		024 at 1:35 P.M. HK 11 had a			the deficient concern.		
	_	3. HK 11's employee file lacked			How other residents having	the	
		to indicate she had a health			potential to be affected by th		
	screen prior to resid				same deficient practice will k		
	•				identified and what correctiv		
	3. A record review	of DA 12's employee file was			action(s) will be taken:		
		024 at 1:40 P.M. DA 12 had a			All residents have the potentia	l to	
	_	23. DA 12's employee file			be affected.		
		ntation to indicate he had a			The orientation process was		
	health screen prior				immediately updated, to make		
	•				sure all employees have a hea		
	4. A record review	of CNA 14's employee file was			screening.		
		024 at 1:45 P.M. CNA 14 had a			What measures will be put in	ito	
	_	223. CNA 14's employee file			place or what systemic chan		
		ntation to indicate she had a			will be made to ensure that to	_	
	health screen prior				deficient practice does not	·- -	
	Insulan sereen prior	to 1551acm commen			achording practice aces flot		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		SURVEY LETED /2024		
	PROVIDER OR SUPPLIE	R	6	STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION During an interview on 1/4/2023 at 3:30 P.M., the Wellness Director indicated the facility doesn't require employees to have a health screening upon hire or before resident contact. A policy for pre-employment health screening and a policy for maintaining employee records was requested, but neither were provided prior to the survey exit.		PR	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) recur: The Wellness Team Supervisor/designee will the completion of new er health screenings. The Wellness Team Supervisor/designee will the ADON to ensure heat screenings are complete hire. If concerns are noted, the will be notified immediate corrective action. How the corrective action deficient practice will nie., what quality assure	monitor nployee work with lth d upon e ED/DNS ely for on(s) will the ot recur, unce	(X5) COMPLETION DATE			
				program will be put into The Wellness Team Supervisor/designee will the completion of new er health screenings. The fo "Communicable Disease Agreement" will be utilize health screening. The W Team Supervisor/design work with the ADNS to e annual health screenings completed. All employee will be reviewed for a hea screening and updated a If a threshold of 100% is an action plan will be dev Findings will be submitte Executive Director for rev follow-up. By what date the syster changes will be comple Compliance date: 3/1/24	monitor inployee form titled Reporting and for the sellness see will insure see are records soluth seeded. inot met, iveloped. de to the view and ic ted:			

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 8 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPL			ETED
			B. W	B. WING 01/04/			/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			6330 N			
STORYP	OINT GRANGER				SER, IN 46530		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
R 0216	410 IAC 16.2-5-2(, , , ,					
Dida 00	Evaluation - Nonc						
Bldg. 00		content of the evaluation					
		d in the facility policy					
		ninimum the needs					
		include an evaluation of the					
	following:	s physical, cognitive, and					
	mental status.	s priysical, cognitive, and					
		s independence in the					
	activities of daily li						
		_					
	(3) The resident 's weight taken on admission and semiannually thereafter.						
		ne resident 's ability to					
	self-administer me	-					
		shall be documented in					
	writing and kept in						
	Based on record rev		R 0	216	R216 – Evaluation -		03/01/2024
	observation, the fac	ility failed to ensure a			Noncompliance		
	Self-Medication Ad	ministration Evaluation was			It is the practice of this provide	er to	
	completed for a resi	dent who self-administers			assess a resident's ability to		
	-	s, and failed to ensure			self-administer medications.		
	~	s were completed for 1 of 1			It is the practice of this provide	r to	
	residents reviewed	for self-administration of			obtain a resident's weight upor	n	
		of 7 residents reviewed for			admission, per policy, and whe	en	
	weights. (Residents	2 and 6)			returning from an alternative		
					healthcare setting.		
	Findings includes:				What corrective action(s) will		
					be accomplished for those		
		was or Resident 2 was			residents found to have beer	1	
	completed on 1/3/20	024 at 11:20 A.M.			affected by the deficient		
	C AND C	N 1			practice:		
	-	Orders included a nebulizer			Resident 2 had their	. "	
	treatment four times				"Self-Administration Evaluation	I	
	clinician.	rol to be administered per			updated.		
	ciiiiciaii.				Resident 6 had their weight		
	A Wellness Evoluet	ion, dated 7/28/2023, indicated			updated. The residents did not experien	00	
		on Service Plan section that			The residents did not experien		
					any negative outcomes related the deficient concern.	ı lU	
staff managed the medications for Resident 2 and				ule delicient concern.			

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 9 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
			B. WI	NG		01/04/2024	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF I	PROVIDER OR SUPPLIE	R			FIR RD		
STORYF	POINT GRANGER			l	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	daily supervision of	of medications was required.			How other residents having		
					potential to be affected by the		
	_	ce Evaluation, completed by the			same deficient practice will		
	facility and dated 10/31/2023, indicated Resident 2				identified and what corrective	ve	
	_	or standby assistance for the			action(s) will be taken:		
	assistance with me	oulizer treatment and required			All residents have the potentia	ai to	
	assistance with me	dications.			be affected.		
	Duning on internal	ry on 1/2/2024 at 11.40 A M			Resident 2 had their	"	
	During an interview on 1/3/2024 at 11:40 A.M., Resident 2 indicated staff will fill up his nebulizer				"Self-Administration Evaluation	on	
		-			updated.		
	and leave it for him to administer himself. He indicated that he takes 2-3 nebulizer treatments				Resident 6 had their weight		
	per day.	ikes 2-3 heoditzer treatments			updated. Residents did not experience	any.	
	per day.				negative outcomes related to		
	A Medication Adn	ninistration Record, dated			deficient concern.	uie	
		cated Resident 2 had performed			What measures will be put in	nto	
		treatment at 3:01 P.M. on			place or what systemic		
	1/3/2024.				changes will be made to		
					ensure that the deficient		
	During an interview	w on 1/4/2024 at 9:40 A.M.,			practice does not recur:		
	_	ed he thought he had a couple			Nursing has been re-educate	d on	
	of nebulizer treatm	nents the day before.			the requirement to have		
					self-medication orders review	red	
	During an interview	w on 1/4/2024 at 9:45 A.M.,			and updated upon admission	and	
	QMA 7 indicated s	staff sets up the nebulizer			as a resident's need change l	by	
	machine and reside	ent will administer the nebulizer			the DNS/designee.		
	treatment when he	wants to.			Nursing has been re-educate	d on	
					the requirement to take and		
		tion on 1/4/2024 at 9:48 A.M.,			document a resident's weight		
		esident 2's nebulizer machine in			upon admission and current		
		lizer medication was in the			resident's weight per standard	d	
	nebulizer cup.				operating procedure by the		
					DNS/designee.		
	_	ew on 1/4/2024 at 9:42 A.M.,			How the corrective action(s)		
	1	Resident 2 would administer his			will be monitored to ensure	the	
	nebulizer when he	returned to his room.			deficient practice will not		
		1/4/2024 - 12 12 22 2			recur, i.e., what quality		
	_	w on 1/4/2024 at 12:12 P.M., the			assurance program will be p	out	
		indicated a Self-Administration			into place:		
of Medication Evaluation should be done upon				To ensure ongoing compliand	ce		

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PRINTED: 02/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 01/04/2024	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
STORYF	POINT GRANGER			GER, IN 46530	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	admission if a resid own medications. Completed, an order Physician indicating administer their own Director indicated Fevaluation complete nebulizer treatments. Director indicated to Resident 2's medical indicated a cliniciar nebulizer treatment. On 1/4/2024 at 1:45 provided a policy to Administration", da 6/10/2022, and indipolicy used by the formulate administer and store Review shall be per begins to self-administration with administration and significant change in evaluationIn additional self Administration order from the health resident may self-admedications must be 2. A record review 11:42 A.M. Residen 12/29/2022. A weig admission on 12/30.	ent wanted to administer their once that evaluation was would be obtained from the gethat the resident could in medications. The Wellness desident 2 should have had an ed in order to administer is himself. The Wellness the facility administered attions and that the order in would administer the in would administer the in would administer the in the Wellness Director and the Welln		with this corrective action, the DNS/designee will be respon for completing the "Medicatio Self- Audit" and "Weight Entry reports out of the Point Click computer system monthly. If threshold of 100% is not met, action plan will be developed Findings will be submitted to Executive Director for review follow-up. By what date the systemic chances will be completed: Compliance date: 3/1/24	e sible n y" Care a , an . the

State Form Event ID: RE4911 Facility ID: 012229 If continuation sheet Page 11 of 31

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
			B. WI	NG		01/04/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER			6330 N				
STORYP	OINT GRANGER		GRANGER, IN 46530					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO		RECTION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	Wellness Director in weights for Residen	ndicated there were no current t 6.						
	provided the policy with a reviewed dat the policy was the of facility. The policy will be routinely we	15 P.M., the Wellness Director titled," Resident Weights", e of 10/17/2022, and indicated me currently used by the indicated"2. Each resident eighted upon move-in, returning from an alternate						
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency							
Bldg. 00	(e) Following comfacility, using appropriate members, shall ideservices to be profollows: (1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facility change. Either the request a service (3) The agreed upsigned and dated of the service planterident upon request (4) No identification services provided subsequent to the no need for a chair	pletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as ffered to the individual appropriate to the: ffered shall be reviewed and riate and discussed by the y as needs or desires a facility or the resident may plan review. on service plan shall be by the resident, and a copy a shall be given to the uest. n and documentation of is needed if evaluations initial evaluation indicate						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		
			B. W	ING		01/04	/2024
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					FIR RD		
STORYP	OINT GRANGER			GRANC	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	I -	ential nursing services, or					
	both, is needed, a licensed nurse shall be involved in identification and documentation of						
	the services to be	e provided.			R217 – Evaluation – Deficiency		
			R 0	217			03/01/2024
		v and record review, the facility			It is the practice of this provid		
		e resident's signature, date, and			assure all residents have iden		
		the service plan for 1 of 6			needed services in the service	_	
		cords were reviewed. (Resident			plan and they are signed and		
	5)				dated.	91 L -	
	E' 1' ' 1 1				What corrective action(s) w	III be	
	Findings include:				accomplished for those		
	A managed marriages very	as conducted on 1/3/2024 at			residents found to have bee	en	
		ent 5's diagnoses included, but			affected by the deficient		
		o, type 2 diabetes mellitus and			practice:	-1	
	chronic kidney dise				Resident 5 had their service p		
	cinonic kidney disc	ease.			reviewed, updated, signed, and dated.	IIu	
	An unsigned Service	ce Plan, dated 9/11/2023, did			The residents did not experie	nco	
	_	ident received kidney dialysis,			any negative outcomes relate		
		for dialysis, transportation			the deficient concern.	u io	
	I	dialysis done. The record also			How other residents having	the	
	1 -	order for kidney dialysis.			potential to be affected by t		
	lucked a physician	order for maney diarysis.			same deficient practice will		
	During an interview	w on 1/4/2024 at 1:28 P.M.,			identified and what correcti		
	_	ed she had been receiving			action(s) will be taken:	-	
		Fresenius Kidney Care since her			All residents have the potenti	al to	
	admission on 5/12/	_			be affected.		
					Resident 5 had their service	olan	
	During an interview	w on 1/4/2024 at 11:46 A.M., the			reviewed, updated, signed, a		
	_	current service plan was not			dated.		
	signed by the resid	ent and should be. The current			What measures will be put i	into	
	service plan also does not address her dialysis,				place or what systemic chair	nges	
	days scheduled, or transportation and should.				will be made to ensure that	the	
	1				deficient practice does not		
	A current policy, provided by the Wellness				recur:		
	Director on 1/4/2024 at 12:07 P.M., titled "Service				The DNS/designee will review	w and	
	Conference" and updated on 3/23/2023, included,				update all service plans for co		
		l to, "The purpose of the			residents. Nursing staff will be	е	
	Service Conference Policy is to keep all parties				re-educated on the procedure	e for	

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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 01/04/2024	
	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
	informed of the nee	ds and condition of residents in our communities"		updating service plans. If concerns are noted, the Executive Director will be noti immediately for corrective act How the corrective action(s) be monitored to ensure the deficient practice will not rei i.e., what quality assurance program will be put into place To ensure ongoing compliance with this corrective action, the DNS/ADNS/designee will be responsible for running the "Service Plan" reports out of the Point Click Care computer systemethy. If a threshold of 100c not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow- By what date the systemic changes will be completed: Compliance date: 3/1/24	fied ion. i will cur, ce; ee the stem % is
R 0246 Bldg. 00	` '	Deficiency ons may be administered by			
	authorization by a physician. The QN authorization for e PRN medication. A physician not on the authorization to ac documented in the the time and date	MA must receive appropriate ach administration of a All contacts with a nurse or ne premises for Iminister PRNs shall be a nursing notes indicating	R 0246	R246 – Health Services –	02/00/2024
	failed to ensure a Pl administered by a Q	RN (as needed) medication MA was approved by a of 7 residents reviewed for	K U246	Deficiency It is the practice of this provide assure all medications are	02/09/2024 er to

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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	ILDING	00	COMPL	ETED
			B. WI	NG		01/04/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t		6330 N			
STORYP	OINT GRANGER				GER, IN 46530		
	C C.V.IIOLIK			Ц			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medications. (Resid	lent 2)			administered by a qualified		
					medication aide (QMA) only up		
	Finding includes:				authorization by a licensed nu	rse	
		1.4.11/2/2024			or physician.		
		s completed, on 1/3/2024 at			What corrective action(s) wil	ı be	
		nt 2's diagnoses included, but			accomplished for those	_	
		Chronic Obstructive			residents found to have been	7	
	Skin Cancer.	, Hypertension, and Basal Cell			affected by the deficient		
	Skill Calleet.				practice:	'n	
	The MAR (Medica)	tion Administration Record),			Resident 2 had their medication administration reviewed by the		
		23, indicated a PRN (as			ADNS for proper medication	•	
		(anti-anxiety medication) had			administration.		
		on 12/5/2023 at 12:26 P.M.,			Nursing staff was immediately		
		A.M. by QMA without			re-educated, by the DNS/ADN		
		licensed nurse approving the			regarding the appropriate	Ü	
	administration of th				authorization for each		
					administration of a PRN		
	During an interview	on 1/4/2023 at 11:11 A.M., the			medication by a QMA.		
	-	ndicated there should have			The resident did not experience	e	
	been documentation	n that the QMA had			any negative outcomes related		
		a nurse to administer the			the deficient concern.		
	Lorazepam.				How other residents having	the	
					potential to be affected by th		
		95 P.M., the Wellness Director			same deficient practice will k	oe .	
	provided the policy				identified and what correctiv	е	
		d indicated that the policy was			action(s) will be taken:		
	_	sed by the facility. The policy			All residents have the potentia	l to	
		ocumentation: 5. When PRN			be affected.		
		ministered the following			Resident 2 had their medication		
	-	ovided: D. Signature or initials			administration reviewed by the	•	
		administration and signature			ADNS for proper medication		
	_	recording effects if different			administration.		
	tnan person admini	stering medication"			Nursing staff was immediately		
					re-educated, by the DNS/ADN	১	
					regarding the appropriate		
					authorization for each		
					administration of a PRN		
					medication by a QMA.	100	
					The residents did not experien	ice	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PPLIER/CLIA (X2) MUL		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED			
			B. WI	NG		01/04/2024			
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	t .			FIR RD				
STORYP	OINT GRANGER				SER, IN 46530				
	T		ı						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X:			
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	Έ		
					any negative outcomes related	to			
					the deficient concern.	_			
					What measures will be put in				
					place or what systemic chan				
					will be made to ensure that t	1e			
					deficient practice does not				
					recur: The DNS/ADNS/designee will				
					educate staff on the utilization	of			
					the triage nurse line. QMA's a				
					call the triage prior to				
					administering a PRN medication	on			
					to receive authorization to				
					administer when a nurse is no	:			
					available in the community.				
					If concerns are noted, the				
					Executive Director will be notif	ed			
					immediately for corrective acti	on.			
					How the corrective action(s)	will			
					be monitored to ensure the				
					deficient practice will not red	ur,			
					i.e., what quality assurance				
					program will be put into plac				
					To ensure ongoing compliance	•			
					with this corrective action, the				
					DNS/ADNS/designee are				
					responsible for reviewing the a				
					tool titled, "PRN Medication A				
					Report" located in the Point Cl				
					Care system. The report will be	E			
					viewed daily for 2 weeks and weekly thereafter. If a threshol	d of			
					100% is not met, an action pla				
					will be developed. Findings to				
					submitted to the Executive				
					Director to review/follow-up.				
					By what date the systemic				
					changes will be completed:				
					Compliance date: 2/9/24				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W.	B. WING 01/04			2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	2			FIR RD		
STORVE	OINT GRANGER				GER, IN 46530		
3101(11	- OINT GIVANGLIX			GIVAIN	JEN, IN 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	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0302	410 IAC 16.2-5-6(
D		ervices - Deficiency					
Bldg. 00	l ` '	ter medications must be					
	identified with the	<u> </u>					
	(A) Resident name						
	(B) Physician nam						
	(C) Expiration date						
	(D) Name of drug.						
	(E) Strength.		D 0	202			02/02/2024
		on, interview, and record	R 0	302	R302 – Pharmaceutical		02/09/2024
		failed to ensure over the s were labeled in 3 of 6			Services - Deficiency		
		served. (AL 1 & 2 and North			It is the practice of this provide	er to	
	Memory Care medi	•			ensure all, over the counted, medications are labeled.		
	Wiemory Care medi	cation carts)			What corrective action(s) will	II bo	
	Findings include:				accomplished for those	,, De	
	i maniga metade.				residents found to have been	n	
	1. During an observ	vation of medication cart 1 on			affected by the deficient	"	
	_	A.M. with QMA 8, the following			practice:		
		ned bottles of Centrum			Nursing staff were immediatel	v	
	_	rvision with no labels.			re-educated by the DNS/ADN	-	
					regarding the appropriate		
	During an interview	v on 1/4/2023 at 10:10 A.M.,			identification and labeling of		
	QMA 8 indicated th	ne medications should have			over-the-counter medications.		
	been labeled.				The resident did not experience	се	
					any negative outcomes related	d to	
	1	vation of medication cart 2 on			the deficient concern.		
	1/4/2024 at 10:25 A	A.M. with QMA 7, the following			How other residents having	the	
		pened bottle of preservision			potential to be affected by th	те	
	with no label.				same deficient practice will l	be	
					identified and what corrective	⁄e	
	_	v on 1/4/2024 at 10:30 A.M.,			action(s) will be taken:		
	1	ne preservision medication			All residents have the potentia	al to	
	should have been la	beled.			be affected.		
	1				Nursing staff were immediatel	-	
	_	vation of the medication cart on			re-educated by the DNS/ADN	S	
		Care,\ on 1/4/2024 at 10:50			regarding the appropriate		
		5, the following was observed:			identification and labeling of		
	_	mega 3 and Tylenol with no			over-the-counter medications.		
	labels.				What measures will be put in	าto	

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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		01/04	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			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	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
		1/4/2024 - 11 00 4 3 5			place or what systemic chan	_	
	-	v on 1/4/2024 at 11:00 A.M.,			will be made to ensure that t	he	
		the medications Omega 3 and			deficient practice does not		
	Tylenol should hav	e labels.			recur:		
	0 1/4/2022 1 11	7.11			The DNS/ADNS/designee will		
		Vellness Director provided the			perform a medication cart aud	lit to	
		ication Storage", dated			ensure the appropriate		
		icated the policy was the one			identification and labeling of		
		ne facility. The policy indicated			over-the-counter medications.		
		rage: 2. Medication labels			If concerns are noted, the	e ,	
		ent name, medication name, n/dose, frequency, route, and			Executive Director will be notif		
	_	Over the counter medications			immediately for corrective acti		
	-	th pharmacy printed label and			How the corrective action(s)	WIII	
		allowed for multi resident			be monitored to ensure the	011F	
	use"	anowed for mutti resident			deficient practice will not red i.e., what quality assurance	Jur,	
	usc				program will be put into place	201	
					To ensure ongoing compliance		
					with this corrective action, the		
					DNS/ADNS/designee will be		
					responsible for completion of the	the	
					audit tool titled, "Cart Audit Fo		
					on a weekly basis. If a thresh		
					of 100% is not met, an action		
					will be developed. Findings w		
					submitted to the Executive		
					Director for review and follow-	up.	
					By what date the systemic		
					changes will be completed:		
					Compliance date: 2/9/24		
R 0306	410 IAC 16.2-5-6(,					
		ervices - Noncompliance					
Bldg. 00	, - ,	dministered by the facility					
		in compliance with					
		al, state, and local laws, and					
		released, returned, or					
		tion shall be documented in					
		nical record and shall					
	include the followi	ing information:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
			B. W	ING		01/04/2	2024
		.		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			FIR RD		
STODVD	OINT GRANGER				GER, IN 46530		
STURTE	OINT GRANGER			GRANC	3EK, 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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1) The name of the						
	' '	l strength of the drug.					
	(3) The prescription						
	(4) The reason for						
	(5) The amount di						
	(6) The method of						
	(7) The date of the						
	, ,	of the person conducting					
	the disposal of the	_					
	· ,	of a witness, if any, to the					
	disposal of the dru	•	D 0	206			00/00/0004
		on, interview, and record	R 0	306	R306 – Pharmaceutical		02/09/2024
		failed to ensure expired			Services – Noncompliance		
		emoved from the medication			It is the practice of this provide	er to	
	-	in 3 of 3 medication carts			assure all medications are	_	
	· ·	2 and North Memory Care			disposed of in compliance with		
	medication cart 1)				appropriate, federal, state, and local laws.	a	
	Findings include:						
	Findings include.				What corrective action(s) will accomplished for those	ii be	
	1 During an observ	vation of AL medication cart 1			residents found to have been	n	
	_	0 A.M. with QMA 8, the			affected by the deficient	"	
		rved: an opened tube of			practice:		
		hat had expired on 8/21/2023.			Nursing staff were immediatel	, l	
	1 Typiain omanen i	nat had expired on 6/21/2025.			re-educated by the DNS/ADN	-	
	During an interview	v on 1/4/2023 at 10:10 A.M.,			regarding the appropriate revi	I .	
	_	ne expired medication should			and disposal of expired or		
	not be in the medical	•			discontinued medications.		
					The resident did not experience	ce	
	2. During an observ	vation of AL medication cart 2			any negative outcomes related	I .	
	_	5 A.M. with QMA 7, the			the deficient concern.		
		rved: an opened bottle of Milk			How other residents having	the	
	_	had expired on 11/10/2023, and			potential to be affected by the		
	a Ventolin inhaler that had expired on 9/3/2023.				same deficient practice will i		
		-			identified and what corrective		
	During an interview	v on 1/4/2024 at 10:30 A.M.,			action(s) will be taken:		
	QMA 7 indicated the expired medications should not be in the cart.				All residents have the potentia	al to	
					be affected.		
					Nursing staff were immediatel	y I	
	3. During an observ	vation of the medication cart on			re-educated by the DNS/ADN	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
			B. W	ING		01/04/	2024
		<u> </u>		CTDEET	ADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
OTODVO	OINT ODANOED		6330 N FIR RD GRANGER, IN 46530				
STORYP	OINT GRANGER			GRANG	5ER, IN 40530		
(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
	the North Memory	Care on 1/4/2024 at 10:50 A.M.			regarding the appropriate revi	ew	
	with QMA 15, the f	following was observed: lomotil			and disposal of expired or		
	(anti diarrheal) pills	that had expired on 9/23/2023.			discontinued medications.		
					What measures will be put in	ito	
	During an interview	on 1/4/2024 at 11:00 A.M.,			place or what systemic chan	ges	
	QMA 15 indicated	the lomotil medication should			will be made to ensure that t	he	
	have been removed	from the medication cart.			deficient practice does not		
					recur:		
	On 1/4/2023 at 12:	05 P.M., the Wellness Director			The DNS/ADNS/designee will		
	provided the policy	titled, "Medication			perform a medication cart aud	it to	
	Destruction/Disposa	al", with a revision date of			ensure the appropriate review	and	
	6/10/2022, and indi	cated the policy was the one			disposal of expired or disconti	nued	
	currently used by th	e facility. The policy			medications.		
	indicated"Expired	1. Expired medications are			If concerns are noted, the		
		2. The designated staff			Executive Director will be notif	ied	
		containers for expired dates on			immediately for corrective acti		
		en appropriate, replacement			How the corrective action(s)	will	
		ordered. 3. To properly dispose			be monitored to ensure the		
	_	ons the designated staff			deficient practice will not red	:ur,	
	_	rn the medication to the			i.e., what quality assurance		
		ey for disposal; or b. Destroy			program will be put into place		
		owing medication disposal			To ensure ongoing compliance		
	policy"				with this corrective action, the		
					DNS/ADNS/designee will be		
					responsible for completion of t		
					audit tool titled, "Cart Audit Fo		
					on a weekly basis. If a thresho		
					100% is not met, an action pla		
					will be developed. Findings w	ill be	
					submitted to the Executive		
					Director for review and follow-	up.	
					By what date the systemic		
					changes will be completed:		
					Compliance date: 2/9/24		
R 0349	/10 IAC 16 2 5 9	1(2)(1.4)					
11 00 1 0	410 IAC 16.2-5-8. Clinical Records -						
Bldg. 00		st maintain clinical records					
Diag. 00	, ,	These records must be					
		the supervision of an					
	mamameu under	me supervision of all					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLETED	
			B. W	B. WING			/2024
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			FIR RD		
STORVE	OINT GRANGER				GER, IN 46530		
3101(11	- CINT GIVANGEIX			GIVAIN			
(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		TAG	DEFICIENCY)		DATE
	1	acility designated with that					
	1	e records must be as					
	follows:						
	(1) Complete.						
	(2) Accurately dod						
	(3) Readily access						
	(4) Systematically	view and interview, the facility	D 0	2.40	R349 – Clinical Records –		02/01/2024
		ician's Orders signed timely by	K U	349			03/01/2024
	1	f 8 residents whose Physician's			Noncompliance It is the practice of this provide	ar to	
	1 -	ved. (Residents 7, 8 and 6).			assure all orders are signed ti		
	Orders were review	red. (residents 7, 6 and 6).			by a resident's attending	ПСТУ	
	Findings include:				physician.		
	i maniga matawa.				What corrective action(s) with	II be	
	1. Resident 7's reco	ord review was reviewed on			accomplished for those	., 20	
	1/4/2024 at 10:15 A	A.M. Resident 7's record had the			residents found to have been	n	
	following unsigned				affected by the deficient		
		•			practice:		
	a. A Physician's Or	der, dated 9/22/2023, for senna			Residents 6, 7, and 8's physic	ian	
	8.6 mg (milligram)	tablet.			was contacted and had their		
					orders signed.		
	b. A Physician's Or	der, dated 10/2/2023, for Norco			The residents did not experier	nce	
	5/325 mg tablet.				any negative outcomes relate	d to	
					the deficient concern.		
	1	der, dated 12/3/2023, for			How other residents having		
	lorazepam 2 mg/mi	Illiliter (mL).			potential to be affected by the		
	1 4 751	1 1 1 1 1 1 2 2 2 2 2 2 2			same deficient practice will		
	1	der, dated 12/3/2023, for			identified and what corrective	⁄e	
	morphine concentra	ate 100 mg/3 mL.			action(s) will be taken:	.1.4	
	2 Davids + Ol	ord review was completed on			All residents have the potentia	ai to	
		A.M. Resident 8's record had the			be affected.	ion	
	following unsigned				Residents 6, 7, and 8's physic was contacted and had their	an	
	Tollowing unsigned	physician's orders.			orders signed.		
	a A Physician's Or	der, dated 9/22/2023, for			What measures will be put in	nto	
	I -				place or what systemic char		
	furosemide 20 mg tablet.				will be made to ensure that t	-	
	b. A Physician's Order, dated 9/22/2023, for				deficient practice does not		
	allopurinol 100 mg				recur:		
	1				Nursing staff have been		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	TED
			B. WI	NG		01/04/2	2024
				CTD FFT A	ADDRESS OF A STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
CTODVE	STORYPOINT GRANGER				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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	c. A Physician's Or	der, dated 9/22/2023, for			re-educated on the process of	.	
	rosuvastatin 2.5 mg	tablet.			preparing orders for a physicia	an's	
					signature weekly and filing the	m in	
	d. A Physician's Or	der, dated 9/22/2023, for			a resident's chart after being		
	levothyroxine 125 i	nicrograms (mcg) tablet.			signed by a physician.		
					How the corrective action(s)	will	
	e. A Physician's Or	der, dated 9/22/2023, for			be monitored to ensure the		
	carvedilol 25 mg ta	blet.			deficient practice will not red	cur,	
					i.e., what quality assurance		
	f. A Physician's Ord	der, dated 9/22/2023, for Eliquis			program will be put into place	:e:	
	5 mg tablet.				To ensure ongoing compliance	e	
					with this corrective action, the		
	During an interview	v on 12/4/2024 at 11:50 A.M.,			DNS/ADNS/designee are		
		tor indicated Resident 7's and			responsible for reviewing a ca	rbon	
	1	ian's Orders were not signed,			copy of the telephone orders t	o	
		ld have been signed.			confirm the original copies are		
		was completed on 1/3/2024 at			signed and placed in the		
		6's clinical record lacked the			resident's chart weekly for 4		
		re for the following orders:			weeks and monthly for four		
		ray to left tibia and left fibula,.			months. If a threshold of 1009	% is	
		er change to Puree diet, Nectar			not met, an action plan will be		
	thick, crush medica				developed. Findings will be		
	- 8/18/2023 dc (dise	continue) BP (blood pressure)			submitted to the Executive		
	parameters.				Director for review and follow-	up.	
		f Magnesium changed to daily.			By what date the systemic		
	- 9/24/2023 Gabape				changes will be completed:		
	- 10/3/2023 DC Pro				Compliance date: 3/1/22		
		calutamide (hormone), and					
		pratropium/Albuterol					
		on. Start Metalozone (diuretic),					
	Guifenesin (cough						
	_	ange diet to mechanical soft.					
	- 12/18/2023 Tamu						
	•	ol with Codeine and DC					
	Robitussin when Tylenol/codeine is started 12/19/2023 DC Flomax due to allergy.						
	-12/20/2023 UA/C&S (urinalysis and culture and						
	sensitivity) due to urinary retention.						
	-12/21/2023 Pyridi						
	-12/21/2023 Finste	ride for BPH (Benign prostatic					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUIL B. WING	DING	00	COMPL 01/04/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530					
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
R 0356 Bldg. 00	hyperplasia) During an interview Wellness Director in have been signed by During an interview Director indicated sl Physician orders. 410 IAC 16.2-5-8. Clinical Records - (i) A current emerge be immediately act in case of emerger following: (1) The resident 's apartment number date of birth. (2) The resident 's (3) The name and legally authorized (4) The name and resident 's physici (5) The name and family members or contacted in the extending the property of the proper	r on 1/3/2024 at 3:15 P.M., the indicated the orders should the physician. If on 1/4/2024 the Wellness he did not have a policy on the did not have a policy on	R 035		R356 – Clinical Records – Noncompliance It is the practice of this provide		DATE 02/02/2024	
	emergency informat 2, 3, 4, and 6).	for 4 of 7 residents whose tion was reviewed. (Residents			ensure accurate and current emergency information is locat in the resident emergency bind	ler.		
	Findings include:				What corrective action(s) will	pe		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		01/04/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t.			FIR RD		
STORYP	OINT GRANGER		GRANGER, 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
	0 1/2/2024 + 2.4				accomplished for those		
		0 P.M., the Wellness Director			residents found to have been	1	
	provided the Emerg	gency Binder.			affected by the deficient		
	1 Desident 2's amo	ranay information about			practice:	hoir	
		rgency information sheet eference and the current			Resident's 2, 3, 4, and 6 had t		
	attending Physician				emergency information update and added to the resident	;u	
		ergency information sheet			emergency binder.		
		ne resident, and allergies.			The residents did not experier	ice	
					any negative outcomes related		
	3. Resident 4's eme	rgency information sheet			the deficient concern.	- 	
		e resident, the hospital			How other residents having	the	
	*	attending physician.			potential to be affected by th		
					same deficient practice will l		
	4. The emergency b	vinder lacked Resident 6's			identified and what correctiv		
	emergency informa	tion sheet.			action(s) will be taken:		
					All residents have the potentia	l to	
	-	on 1/3/2023 at 2:45 P.M., the			be affected.		
	· ·	Director of Nursing) indicated			Resident's 2, 3, 4, and 6 had t		
		ets should have a photo, the			emergency information update	ed	
		allergies and the current			and added to the resident		
	attending physician				emergency binder.		
	0 1/4/2022 **	. 16 5			What measures will be put in		
	-	ey was requested for Emergency			place or what systemic chan	_	
		, but one was not provided			will be made to ensure that t	ne	
	prior to the survey	exit.			deficient practice does not		
					Nursing has been re-educated	lon	
					Nursing has been re-educated the need to have undated res		
					the need to have updated, res emergency information in the	iu c iil	
					emergency binder.		
					How the corrective action(s)	will	
					be monitored to ensure the		
					deficient practice will not red	eur,	
					i.e., what quality assurance		
					program will be put into place	e:	
					To ensure ongoing compliance		
					with this corrective action, Nur		
					will provide the business office	;	
					with any new residents or any		
			1				l

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING 0			01/04/	01/04/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S DI AN OF CORRECTION (X			
PREFIX	(EACH DEFICIENCY 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 OR	LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE	
R 0409	410 IAC 16.2-5-12 Infection Control	Noncompliance			current resident updates on the face sheet to be included in the emergency binder. All new resident admissions or readmissions will be reviewed the DNS/ADNS/designee weef or 4 weeks and monthly for simonths. If a threshold of 100% not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-By what date the systemic changes will be completed: Compliance date: 2/2/24	e , by kly x 6 is		
Bldg. 00	required to have a including history or infectious disease resident shows not an infectious stage admission and years admission and years and the physician was on 7 residents whose residents 3 & 6) Findings include: 1. A record review 2:39 P.M. Resident on 7/24/2023. The clinical record	arly thereafter. view and interview, the facility annual health statement from btained on admission for 2 of ecords were reviewed. was completed on 1/3/2024 at 3 was admitted to the facility lacked the physician's health g the resident was free from	R 040	9	R409 – Infection Control – Noncompliance It is the practice of this provide ensure an annual health assessment showing any histor of significant past or present infectious disease. What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice: Residents 3 and 6 were provide with an annual health assessmit identifying any significant past	ory I be I I I I I I I I I I I I I	02/09/2024	

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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	COMP	ESURVEY LETED 1/2024				
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER			6330 N	STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE					
	2:57 P.M. Resident on 12/22/2022. The clinical record statement indicating communicable dise. During an interview Wellness Director a of Nursing) indicate computer system nowere not being pull to provide the docustatements for the run on 1/4/2024 at 12:0 provided the policy Services and Health Care Division Progulate of 8/11/2021. Assessment and Te Residents." The letter resident must have admissionThe meassessment and a st	or on 1/4/2023 at 11:19 P.M., the and ADON (Assistant Director ed they have a different ow and the ancillary orders ed over, so they were unable mentation of the annual health esidents. D5 P.M., the Wellness Director a copy of the IDOH Consumer a Care Regulations Long-term ram Letter, with an updated Titled,"Tuberculosis sting of Long term Care ter indicated" 1. Each a health assessment upon dical record should include the atement that the resident of TB in an infectious stage		present infectious dis No harm was incurre 3 or 6 related to this of practice. How other residents potential to be affect same deficient practice identified and what action(s) will be take All residents have the be affected. All residents require a health assessment sl history of significant present infectious dis No other residents we related to this deficient What measures will place or what system will be made to enside deficient practice do recur: Audits will be on-goin compliance with infect policy and procedure Audits will be conduct nurse management to monitor compliance. How the corrective at be monitored to ensideficient practice with i.e., what quality ass program will be put To ensure ongoing co with this corrective at DNS/designee will be for completion of the "Order Summary Reg in the Point Click Car Audits will be conduct	d to residents deficient s having the ted by the tice will be corrective en: e potential to an annual howing a past or sease. Here identified into practice. The put into mic changes we that the pes not eam to eat on control ted by the eam to eat on the put into mic changes we that the pes not eat on the eam to eat on the eam to eat on the eam to eat on the ear opposite the ill not recur, surance into place: compliance cotion, the eresponsible tool titled, port" located re system.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 01/04/2024				
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER			STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530					
(X4) ID PREFIX TAG	(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			
				for 4 weeks then monthly for s months. If a threshold of 100% not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow- By what date the systemic chances will be completed: Compliance date: 2/9/24	b is			
R 0410 Bldg. 00	completed within the admission or upon forty-eight (48) to a result shall be reconsidered induration with the by whom administ (f) For residents who documented negalaresult during the part months, the baselist should employ the first step is negative performed within cafter the first test. It testing will depend with tuberculosis. (g) All residents with the tuberculin shave a chest x-ray	Noncompliance uberculin skin test shall be hree (3) months prior to admission and read at seventy-two (72) hours. The orded in millimeters of date given, date read, and ered and read.						
	Based on record rev failed to ensure a re- or had a risk assessr failed to read an adr	iew and interview, the facility sident was tested for TB and ment completed for 2023 and mission TB timely for 1 of 6 for TB testing. (Resident 2)	R 0410	R410 – Infection Control – Noncompliance It is the practice of this provide ensure a two-step Mantoux terfor newly admitted residents is complete.	st			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WING 01/04/2024					
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			FIR RD		
STORYPOINT GRANGER					GER, IN 46530		
			1		, I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	Finding includes:				What corrective action(s) will	n be	
	During a record ray	riew on 1/3/2024 at 11:20 A.M.,			accomplished for those residents found to have been	_	
	-	skin testing or an annual TB			affected by the deficient		
	· · · · · · · · · · · · · · · · · · ·	2023 was located in Resident			practice:		
	2's chart.	2023 was located in Resident			Resident 2 and any residents		
	25 Chart.				identified as not receiving a		
	During an interview	v, on 1/4/2024 at 2:45 P.M., the			two-step Mantoux test will be		
	_	indicated that she could not			re-tested. No harm was incur	red	
	· ·	d annual TB risk assessment			to resident 2 related to this		
		nd this should have been			deficient practice.		
	completed.				How other residents having	the	
	•				potential to be affected by th		
					same deficient practice will l		
					identified and what corrective		
					action(s) will be taken:		
					All residents have the potentia	al to	
					be affected.		
					All new residents require a		
					two-step Mantoux test. Reside	ent 2	
					and any residents identified as		
					receiving a two-step Mantoux	test	
					will be re-tested.		
					What measures will be put in		
					place or what systemic chan	-	
					will be made to ensure that t	ne	
					deficient practice does not		
					recur:	aura	
					Audits will be conducted to en		
					compliance with infection cont	101	
					policy and procedure.		
					Audits will be conducted by th	<u> </u>	
					nurse management team to monitor compliance.		
					How the corrective action(s)	will	
					be monitored to ensure the	*****	
					deficient practice will not rec	cur.	
					i.e., what quality assurance	,,,	
					program will be put into place	e.	
					To ensure ongoing compliance		
	1		1			1	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			01/04/2024	
NAME OF I	DDOVIDED OD CLIDDLIED		1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				6330 N	FIR RD		
STORYP	OINT GRANGER			GRANG	GER, IN 46530		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
R 0414 Bldg. 00	410 IAC 16.2-5-12 Infection Control - (k) The facility must hands after each of which hand washide professional pract Based on observation staff failed to follow obtaining a blood ginsulin injection for administration obsection of the control of the resident's finger with an alcohold the resident's finger obtained the blood siglowers and then were pulled out Resident	Deficiency set require staff to wash their direct resident contact for ang is indicated by accepted ice. In and interview, the facility of standards of care while ducose level and during an and an expectation and interview, the facility of standards of care while ducose level and during an and an expectation and an expectation arvations. (QMA 2 & QMA 7) 1:30 A.M., QMA 2 was desident 6's blood sugar. All and a lancet is and pad. QMA 2 then pricked ausing a lancet. The QMA asample. She removed the and to the medication cart and and a service is an expectation of the medication and gave them appleted no hand washing after	R 04	TAG	with this corrective action, the DNS/ADON/designee are responsible for reviewing the atool titled, "TB Screen" located the Point Click Care system. report will be viewed monthly. threshold of 100% is not met, action plan will be developed. Findings will be submitted to the Executive Director for review a follow-up. By what date the systemic chances will be completed: Compliance date: 2/9/24 R414 – Infection Control – Noncompliance It is the practice of this provide ensure staff follow standards of care while providing resident of What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice: Nursing staff were immediately re-educated by the DNS/ADO regarding infection control and appropriate hand washing whi providing resident care. The resident did not experience any negative outcomes related the deficient concern. How other residents having it	In The The If a an he and he and he are to of care. If be the care is a continuous cont	02/09/2024

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>0</u>		00	COMPLETED		
			B. W	B. WING 01/04/20				
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD FIR RD			
OTODYDOINT ODANOED								
STURTE	OINT GRANGER			GRANGER, IN 46530				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	During an interview	v at 11:30 A.M., QMA 2			potential to be affected by th	ne		
	indicated she should	d have washed her hands.			same deficient practice will l	be		
					identified and what corrective	re		
	-	administration on 1/4/2023 at			action(s) will be taken:			
	8:02 A.M., QMA 7	applied gloves, obtained the			All residents have the potentia	al to		
	_	cose level through her device.			be affected.			
		d she had forgotten the			Nursing staff were immediatel	-		
	-	nsulin injection, and left the			re-educated by the DNS/ADO	•		
		pad. QMA 7 indicated the			regarding infection control and			
	-	units. She used an alcohol pad			appropriate hand washing whi	ile		
	-	ent's abdomen. The QMA			providing resident care.			
		he injection. QMA 7, with			What measures will be put in			
	-	t into the bathroom looking for			place or what systemic chan	_		
	-	She then went to the kitchen			will be made to ensure that t	the		
	-	loved hand, opened up			deficient practice does not			
		ng for a sharps container.			recur:			
		the room with her hands			Audits will be on-going to ensu			
	gloved.				compliance with infection cont	trol		
		1/4/2024			policy and procedure.			
	-	v on 1/4/2024 at 8:04 A.M., the			Audits will be conducted by th	e		
		injection pen had the cap over			nurse management team to			
		had looked for the sharps			monitor compliance.			
		ld have removed her gloves			How the corrective action(s)	WIII		
		ids prior to exiting the			be monitored to ensure the			
	resident's room.				deficient practice will not red	sur,		
	Policies for glove u	se and hand washing and			i.e., what quality assurance program will be put into place	···		
		on were requested on 1/4/2024.			To ensure ongoing compliance			
	msum aummstatt	on were requested on 1/4/2024.			with this corrective action, the			
	On 1/4/2024 at 12.0)3 P.M. the Wellness Director			DNS/ADON/designee are			
	On 1/4/2024 at 12:03 P.M., the Wellness Director indicated she had no policy for obtaining blood glucose levels and indicated they follow the state regulations for hand glove use and hand washing.				responsible for the completion	n of		
					the tool titled, "Hand Hygiene			
					Monthly Monitoring" weekly fo	r 4		
	Samuello for hunc	- 0 Z use una mana musimb.			weeks and then monthly for fo			
					months. If a threshold of 100%			
					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	~r·		
					,	•		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
			B. WING			01/04/2024	
NAME OF PROVIDER OR SUPPLIER STORYPOINT GRANGER			STREET ADDRESS, CITY, STATE, ZIP COD 6330 N FIR RD GRANGER, IN 46530				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	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 APPROPRIATE		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					chances will be completed: Compliance date: 2/9/24		

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