STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429185 and IN00429398. Complaint IN00429185 - State deficiencies related to the allegations are cited at R87, R90, R116, R120, and R240. Complaint IN00429398 - State deficiencies related to the allegations are cited at R87, R90, R116, R120, and R240. Survey dates: February 26 and 28, 2024 Facility number: 013825 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/1/24.	R 0000		
R 0087 Bldg. 00	410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees. Based on record review and interview, the administrator failed to ensure adequate provision of medical care was provided to a resident, related to a resident who had an altercation with another	R 0087	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However,	03/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Craig Clemons	Administrator	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	resident, then was assessed by a CNA and not a Licensed Medical Person for psychosocial and emotional status from the altercation, for 2 of 3 residents reviewed for abuse. (Residents D and C) Finding includes: Resident D's record was reviewed on 2/26/24 at 3:12 p.m. The diagnoses included, but were not limited to, dementia. A Service Plan, dated 7/11/23, indicated a long and short term memory impairment and had frequent poor judgement issues. An Indiana Department of Health incident report, dated 2/5/24 at 7:37 p.m., indicated an altercation between Resident C and Resident D was observed by staff. The residents were separated and a head to toe assessment was completed with no unusual findings. The first and only assessment after the altercation in Resident D's record, was dated 2/9/24 at 4:55 p.m. and indicated the resident's psychosocial behavior had been monitored for 72 hours with no change in mood and there had been no emotional ill effect from the incident. The assessment was signed by CNA 1. During an interview on 2/26/24 at 3:18 p.m., the Administrator acknowledged the CNA was not qualified to complete assessments. This citation relates to Complaints IN00429185 and IN00429398.		submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law 1. Residents D and C were affected by the alleged deficient practice 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. CNA 1 been educated that they are not qualified to complete resident assessments. Additional staff in-service conducted that only licensed medical persons are qualified to complete an assessment. 4. The Wellness Director/Designee will audit 5 resident charts weekly for 3 months and then 3 resident charts weekly for 2 months and then 1 resident chart weekly for 1 month to ensure only a licensed medical person is completing resident assessments.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not reporting an allegation of abuse to the Indiana Department of Health (IDOH), not starting an investigation of the allegation of abuse in a timely manner, and not ensuring a staff member reported and included all observations to aid in the investigation, for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 2/26/24 at 9:45 a.m., the Administrator indicated, on 2/23/24, one of the facility's Physicians had informed him there was a potential allegation of abuse and Adult Protective Service (APS) may have been notified by Resident B's family. He indicated there had been no allegation of abuse reported to the facility prior to the Physician's statement. He spoke with one of the resident's family members and they had no concerns, and no allegations had been voiced. He indicated the family member had said there was a lot of bruising around the resident's rib cage and just wanted to make sure nothing else had happened other than the fall on 2/22/24. Resident' B record was reviewed on 2/26/24 at 9:47 a.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, and falls. A Service Plan, dated 7/31/23, indicated there was mild impairment of the resident's orientation and	R 0090	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law /p> 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. Executive Director reviewed Indiana Department of Health Long-Term Care Abuse and Incident Reporting Policy. Executive Director has reviewed facility abuse policy. Additional abuse and reporting in servicing conducted. Employee Relias learning plans audited to ensure that learning plans contains resident rights and abuse education. Executive Director cell phone number has been posted at nursing stations for allegations of abuse to be reported after hours. 4. The Executive Director/Designee will audit	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	short term memory. She required minimal assistance with transfers and had falls. The Nurses' Progress Notes indicated, on 2/22/24 at 8:44 p.m., she was found lying on the floor and complained of pain in her back and bilateral hips. The pain was rated a 10 out of 10. She was transferred to the Emergency Room (ER) by ambulance. On 2/22/24 at 9:07 p.m., she returned from the hospital with no fractures noted. The Nurse's Progress Note, dated 2/23/24 at 2:30 p.m., indicated she was in terrible pain and a family member requested she be transferred back to the ER for a pain evaluation. The resident stated her pain was unbearable. She was transferred to the Emergency Room by ambulance. The IDOH incident report indicated the incident occurred on 2/23/24 at 1:40 p.m. The resident had fallen on 2/22/24 and was transferred to the ER for an evaluation. She returned to the facility on 2/22/24 with no new orders. On 2/23/24, a request was made by a family member to transfer the resident back to the ER due to the increased pain. The ER completed imaging tests and indicated there was a fractured rib. An investigation had been initiated. The Administrator indicated, on 2/26/24 at 9:45 a.m., he was still in the process of investigating the fall and the fractured rib. The investigation included three typed written statements: A signed statement by the Administrator, dated 2/23/24 and included in the investigation, indicated at approximately 1:40 p.m., the Physician stated he had received communication from the Medical Director that the resident's imaging at the hospital revealed a fractured rib. He was informed		incidents for abuse daily 5x week for 3 months and will continue until 100% compliance is achieved for 3 consecutive months. Any incidents that allege abuse will be reported to the Indiana Department of Health.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	by the Physician that the family was concerned that the fractured rib may had been attributed to sexual or physical abuse. The Physician was unable to confirm that the hospital had suspected abuse or had completed any testing that confirmed abuse. The Administrator then contacted one of the family members, who had informed him he received pictures of the extensive bruising around the rib area and they were concerned how the resident would have sustained such bruising from a fall and they wanted to know what exactly happened. They indicated the resident was not a reliable source for information. A statement from the Director of Nursing, dated 2/23/24, indicated a family member had called her on 2/23/24 around 8:15 a.m. - 8:30 a.m., and reported the resident was in excruciating pain and had requested the resident be transferred back to the hospital for a pain evaluation. There had been no other falls since the return from the hospital on 2/22/24, and the family indicated the resident was in terrible pain when she had been discharged from the Emergency Room on 2/22/24. The resident was then transferred by ambulance to the Emergency Room. A statement from CNA 1 indicated, on 2/22/24, the resident had been found on the floor had had complained of back pain. The Nurse assessed the resident and she was transferred to the hospital Emergency Room by ambulance. The resident returned from the hospital in the late afternoon and was transferred to bed. On the morning of 2/23/24, another CNA had informed him the resident was in a lot of pain and had not wanted to get out of bed. She was in a lot more pain than on 2/22/24. The Nurse was notified and assessed the resident and she was transferred back to the hospital by EMS.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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 2/16/24 at 10:40 a.m., CNA 1 indicated the resident had recent increased falls. The resident had complained of extreme pain when she returned from the ER on 2/22/24. When EMS (Emergency Medical System) transferred her back to the facility, she was on a gurney and one of the Paramedics lifted her under the arms from the gurney to her bed. She moaned during the transfer. He had not reported this incident to the Administrator. Another statement received from the Administrator indicated CNA 1 had written another statement about to the incident on 2/22/24. CNA 1 indicated the resident had been found on the floor and had complained of back pain. The Nurse assessed the resident and the Emergency Medical System (EMS) was notified. When the paramedics arrived, one of the Paramedics picked the resident up off the floor by placing their hands under her arms to lift her and placed her on the stretcher. The resident returned back to the facility in the late afternoon and transferred to bed. On 2/23/24 another CNA had indicated the resident was in a lot of pain and had not wanted to get out of bed. She was observed with increased pain. The Nurse was notified and a decision was made to transfer the resident by EMS. There were no other employee statements and no investigation of the allegations of abuse initiated after the allegation was reported to the Administrator on 2/23/24 at approximately 1:40 p.m. The allegation had not been reported to IDOH. An ER Physical Exam, dated 2/22/24, indicated bruising of various ages across the face and a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	posterior scalp hematoma. The ER Case Manager Notes, dated 2/23/24, indicated an allegation of sexual abuse had been voiced by a family member. A Hospital Physician's Note, dated 2/23/24, indicated at 11:01 a.m., the family had made an allegation of possible sexual abuse and the resident had said there had been a man in her bed. APS and the Police had been notified. The CT of the Chest, dated 2/23/24, indicated a fractured left ninth and 10th ribs with some displacement or deformity. A facility abuse policy, dated 2/8/28 and received as current from the Administrator, indicated all allegations, suspicious, and incidents of abuse would be promptly investigate. All initial reports of an alleged or suspected incident would be reported as outlined in the state specific reporting policy. An investigation of the allegation or suspicion will be completed timely. The IDOH abuse and incident reporting policy, dated 12/6/22, and identified by the Administrator as guidelines the facility was to follow, indicated an alleged violation was a situation or occurrence that was observed or reported by staff or other health care providers, but had not been investigated. Immediately means as soon as possible, but no later than two hours after the allegation of abuse is made. This citation relates to Complaints IN00429185 and IN00429398.			
R 0116	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
Bldg. 00	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to properly screen employees hired in the past four months, related to criminal background checks not completed with the Indiana State Police Repository for 4 of 5 employees hired in the past four months reviewed for criminal background checks. (CNA 4, LPN 5, QMA 6, and CNA 7) Finding includes: The employee files were reviewed on 2/26/24 at 3:30 p.m. They indicated CNA 4, LPN 5, QMA 6, and CNA 7 had been hired at the facility within the past four months. The criminal background checks had not included the Indiana State Police Repository or equivalent for the criminal background checks. During an interview on 2/26/24 at 4:11 p.m., the Administrator indicated he notified the Corporate Office and was informed the Indiana State Police Repository/state criminal background checks had not been completed. The facility abuse policy, dated 6/7/23, and received as current from the Administrator, indicated prior to employment, the individual would be screened according to the State Specific Staffing Requirement Policy. This citation relates to Complaints IN00429185	R 0116	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law ="" p=""> ="" p=""> 1. Residents under the care of CNA 4, LPN 5, QMA 6, CNA 7 were affected by the alleged deficient practice. ="" p=""> 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. CNA 4, LPN 5, QMA 6, CNA 7 have received criminal background checks through the Indiana State Police Repository. Employee audit completed with every employee now having a criminal background check completed through the Indiana State Police Repository. 4. The Executive Director/Designee will audit employee background	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	and IN00429398.		checks 2x monthly for 3 months and then 1x monthly for 3 months to ensure employees have a completed background check through the Indiana State Repository. Anyone not in compliance will be removed from the schedule.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure inservice education was completed yearly for an employee who had worked at the facility longer than four months, related to abuse education, for 1 of 5 employees who had worked at the facility longer than four months reviewed for inservice education. (CNA 3) Finding includes: Employee files were reviewed on 2/26/24 at 3:30 p.m. The Administrator indicated the employee start dates of 10/25/23 was the date the facility had changed ownerships and the employees had worked at the facility prior to 10/25/23 start date listed. He was unsure of their actual hire date. CNA 3's education transcript was reviewed and indicated there had not been abuse education since 9/16/2020. During an interview on 2/28/24 at 8:34 a.m., the Administrator was unable to provide abuse education for the past year for CNA 3 and indicated she had been educated on 2/27/24. The facility abuse policy, dated 6/7/23, and received as current from the Administrator, indicated All employees were to received training according to the the State Specific Training Requirements Policy.	R 0120	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law ="" p="">1. Residents under the care of CNA 3 were affected by the alleged deficient practice. ="" p="">="" p="">2. The community realizes that all residents have the potential to be affected by the alleged deficient practice. ="" p="">="" p="">3. C.N.A. 3 has completed yearly abuse education in-service through Relias. All staff members have had their Relias training audited to ensure yearly abuse education has been completed. 4. The Executive Director/Designee will audit employee Relias training 3x monthly for 3 months and then 2x	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	This citation relates to Complaints IN00429185 and IN00429398.		monthly for 2 months and 1x monthly for 1 month to ensure employees are current with yearly abuse training. Anyone not in compliance with the training will be removed from the schedule until such time that they become compliant with the training.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure residents received necessary care and services, related to thorough assessments not completed after falls and transfers to and from the Emergency Room (ER) to determine if the resident had signs and symptoms of injuries and pain. They failed to ensure Physician's Orders were transcribed and followed after a return from the ER, and failed to treat the resident's pain as ordered by the Physician, for 2 of 3 residents reviewed for necessary care and services. (Residents B and D) Findings include: 1) Resident' B record was reviewed on 2/26/24 at 9:47 a.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, and falls. A Service Plan, dated 7/31/23, indicated there was mild impairment of the resident's orientation and short term memory. She required minimal assistance with transfers and had falls. The Physician's Orders, dated 1/5/24, indicated acetaminophen 325 mg (milligrams), one tablet as	R 0240	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law /p> 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. Licensed medical staff in serviced that residents must receive a thorough and complete assessment after a fall or when being transferred to and from the community to the Emergency	03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	needed every six hours for pain and Tramadol (pain medication) 50 mg, one tablet twice a day for pain. A Nurse's Progress Note, dated 2/15/24 at 11:34 p.m., indicated the resident had slid off the bed onto the floor. She denied pain but stated she hit her head. EMS (Emergency Medical System) was notified and she was transferred Emergency Care. A Progress Note, dated 2/16/24 at 5:51 a.m., indicated the resident returned to the facility and all CT scans were negative. There was a hematoma to the right forehead and no complaints of pain or discomfort. There were no assessments of the bruising, pain, or observations for neurological symptoms after the fall with the head injury except for 2/18/24 at 1:02 a.m., which identified facial bruising across the face and there had been no complaints of pain or discomfort. A Progress Note, dated 2/22/24 at 8:44 p.m., indicated the resident was observed lying on the floor. Range of motion was attempted and she complained of pain in the back and bilateral hips, rated at a 10 out of 10. Orders received and she was transferred per EMS to the Emergency Room. The ER Physician's Notes, dated 2/22/24, indicated the resident had a fall and had hit the back of her head. She complained of pain in her neck from the collar and pain in her lower back. She had a fall on 2/15/24 with a negative head and cervical spine CT scan. There were multiple thoracic spine compression fractures. There was bruising of various ages across the face and a posterior scalp hematoma. She has continued thoracic compression fractures and lumbar spine		Room. Licensed medical staff in serviced that Physician orders must be transcribed and followed. 4. The Wellness Director/Designee will audit 5 resident charts weekly for 3 months, then 3 resident charts weekly for 2 months, and 1 resident chart weekly for 1 month for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	fractures, not previously visualized. Outpatient management with bed rest, no nested ambulation, and lidoderm (patch for pain) for the pain. The family was in agreement. The transfer orders from the ER, dated 2/22/24, indicated a lumbar compression fracture and acetaminophen 500 mg, two tablets every six hours as needed for pain and a lidocaine patch, 5% was to be applied every 24 hours for pain. A Progress Note, dated 2/22/24 at 9:07 p.m., indicated she returned from the ER, no new fractures were found, and she was resting in bed. There were no assessments of injury and/or pain upon return from the ER. The Physician's Orders for pain management had not been transcribed and initiated. A Progress Note, dated 2/23/24 at 2:25 a.m., indicated there was no complaints of pain. The next Progress Note was dated 2/23/24 at 2:30 p.m., and indicated at 8:50 a.m. a family member had called the facility and reported the resident was in terrible pain and requested she be transferred to the hospital for a pain evaluation. The resident was assessed and the resident stated her pain was, "unbearable". She was transferred to the ER per EMS. There were no further assessments of the fall injuries, bruising, complaints of pain, and the location of the pain. The facility had only indicated there was facial bruising. There was no documentation of the rib area bruising. The Medication Administration Record, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	2/2024, indicated resident had not been given any pain medication as ordered by the Physician for the pain after the return from the ER on 2/22/24. The ER Physician's Notes, dated 2/23/24, indicated the resident had fallen on 2/22/24 and had been assessed in the ER after the fall. She had fractures observed on the CT scan and was discharged on Tylenol and lidocaine patches. The pain had worsened and she was transferred back to the ER. She complained of back pain. The CT of the chest showed new compression fractures of the T1 (thoracic) and T3. There was a mild compression fracture of the L3 (lumbar). There were closed fractures of multiple ribs of the left side. The CT scan indicated fractures of the left ninth and tenth ribs. During an interview on 2/26/24 at 10:40 a.m., CNA 1 indicated the resident had been complaining of extreme pain after she returned to the facility from ER on 2/22/24. During an interview on 2/28/24 at 9:12 a.m., CNA 2 indicated the resident had bruising on here face on her forehead and some bruising under her eyes from the previous fall. She had been moaning and was in a lot of pain. A Confidential Interview, indicated the resident had not been treated for her pain and she was not monitored frequently. The resident's entire face was black and blue from a fall a few weeks ago, and when she was transferred to the ER on 2/22/24, she had been in a lot of pain. During an interview on 2/26/24 at 2:03 p.m., the Administrator indicated the pain medications were not transcribed, initiated, nor administered as ordered when the resident had pain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	A facility medication policy, dated 5/18/22 and received as current from the Administrator, indicated, all Caregivers were to be alert for changes that can signal a resident was in pain. The as needed pain medication must be given as prescribed for symptoms. 2. Resident D's record was reviewed on 2/26/24 at 3:12 p.m. The diagnoses included, but were not limited to, dementia. A, Service Plan, dated 7/11/23, indicated a moderate impairment of the long term memory and severe impairment of the short term memory, moderate assistance was required for mobility and ambulation, and she required every two hour checks. An Indiana Department of Health incident report, dated 2/5/24 at 7:37 p.m., indicated there was a physical altercation between Resident D and another resident. The resident was assessed and there were no injuries. The report had not indicated who assessed the resident. There was no documentation of the incident in the Progress Notes nor were there assessments or follow up care documented in the Progress Notes. The first documentation in the Progress Notes was 2/9/224 at 12:18 p.m., completed by CNA 1, which indicated an incident had occurred on 2/5/24, the POA had been informed of the incident and measures had been taken to prevent another occurrence. The facility abuse policy, dated 6/7/23 and received as current from the Administrator, indicated, after an occurrence, the documentation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(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
	in the resident's record was to include, but was not limited to, results of the body check, vital signs, notification of the physician and the responsible party, and treatments provided. During an interview on 2/26/24 at 1:45 p.m., the Administrator indicated the assessments had not been completed. This citation relates to Complaints IN00429185 and IN00429398.			