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	03/27/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00449511. Complaint IN00449511 - No deficiencies related to the allegations are cited. Survey dates: March 26 and 27, 2025 Facility number: 013825 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/31/25.	R 0000	No deficiency related to the allegations were cited.	
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency Based on record review and interview, the facility failed to ensure transfer/discharge papers were completed when residents were transferred out of the facility for 2 of 7 records reviewed. (Residents 2 and 4) Findings include: 1. Resident 2's record was reviewed on 3/26/25 at 12:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure and hypertension. A Progress Note, dated 3/14/25, indicated the resident had been found on the floor in his room. The resident was complaining of pain to his	R 0045	**R045** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit.	04/13/2025

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

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	03/27/2025

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	bilateral lower extremities. Emergency transport was notified and the resident was taken to the hospital for evaluation. The were no State Transfer/ Discharge papers available for review. During an interview on 3/27/25 at 10:44 a.m., the Health and Wellness Director (HWD) indicated the facility sent a face sheet, advance directives and orders when a resident was sent to the hospital. She was not aware the State Transfer/ Discharge papers were required.2. Resident 4's record was reviewed on 3/26/25 at 2:10 p.m. Diagnoses included, but were not limited to, dementia. The Service Plan, dated 8/26/24, indicated the resident was on hospice care and required assistance from staff for activities of daily living. A Nurses' Note, dated 12/17/24 at 3:10 p.m., indicated a CNA reported the resident had loose stools, dark in color. The resident was assessed and was unable to follow commands, weak, pale in color, and wheezing and congested. New orders were received to send the resident to the hospital for evaluation and treatment. The family was notified. The resident was transferred to the hospital and sent with paperwork. Report was called to the receiving hospital. There was a lack of documentation related to transfer/discharge paperwork in the record. During an interview on 3/27/25 at 10:48 a.m., the HWD indicated any time a resident was transferred out of the facility, they were sent with the face sheet, current Physician's Orders, and a copy of the advance directives. They did not use		**What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** Resident 4 was affected by this deficient practice. The resident did not experience any adverse outcomes related to the deficient concern. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community realizes that all residents have the potential to be affected by the deficient practice. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** The Wellness Director/Designee will reeducate staff through in-service on necessary documentation related to transfer/discharge paperwork for residents. The Wellness Director/Designee will educate staff, through in-service, on proper documentation and charting of discharge from the community. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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STORYPOINT SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

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	a state transfer form.		The Wellness Director/Designee will audit any resident transferring/discharging from the community for proper documentation for three (3) months. Once 100% compliance is achieved, audits will be completed for an additional two (2) months. **By what date will the systemic changes be completed:** April 13, 2025 ***Request for IDR for this deficiency** The community is requesting clarification and additional support on the form required for residents transferring to the hospital indefinitely. State Transfer/Discharge form 49669 (see attachment A) does not provide hospital as an option in *Reason for Transfer or Discharge*. Requesting clarification on expectations if a resident is sent to hospital indefinitely. Currently residents are sent with Face Sheet, current physician orders, and copy of advance directives. See attachment B and C	

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			Attachment A Attachment B Attachment C	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to invite the fire department to participate in fire drills every six months as required. This had the potential to affect all 88 residents residing in the facility. Finding includes: The annual fire drill documents were reviewed on 3/27/25 at 2:50 p.m. The fire drill records lacked documentation the fire department had been invited to participate in any of the drills. During an interview on 3/27/25 at 3:02 p.m., the Maintenance Director indicated he started working at the facility in July of 2024 and he had	R 0092	**R0092** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those**	04/11/2025

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	not invited the fire department to any drills.		**residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** The Community realizes that other residents, staff, and families/visitors could have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** The Executive Director reviewed with the Maintenance Director the Fire Drill Protocol that delineates that at least every (6) months, a facility shall attempt to hold fire and disaster drills in conjunction with the local fire department. The local fire department has been requested to assist in fire and disaster drills every six months (see attachments A&B). We are awaiting their response. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Maintenance Director will	

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			review all drills to ensure the schedule is maintained. The community is required to input the drills into a safety smart sheet monthly which is monitored by the home office. **By what date the systemic changes will be completed:** April 11, 2025 Attachment A R092 The Executive Director reviewed with the Maintenance Director the Fire Drill Protocol that clearly delineates that at least every (6) months, a facility shall attempt to hold fire and disaster drills in conjunction with the local fire department. The local fire department has been requested to assist in fire and disaster drills every six months (see attachments A&B). We are awaiting their response. **2025 Fire Drill Schedule** **Month** **Shift** **Time** April 2nd Shift 4PM-5PM May 3rd Shift 11PM-12AM	

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			June 1st Shift 11AM-12PM July 2nd Shift 3PM-4PM August 3rd Shift 6AM-7AM September 1st Shift 2PM-3PM October 2nd Shift 4PM-5PM November 3rd Shift 11PM-12Am December 1st Shift 10AM-11AM **2026 Fire Drill Schedule** **Month** **Shift** **Time** January 2nd Shift 4PM-5PM February 3rd	

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			Shift 11PM-12AM March 1st Shift 9AM-10AM April 2nd Shift 3PM-4PM Attachment B April 11, 2025 Dear Chief Patterson, My name is Stephanie Peterson, and I am the Executive Director of StoryPoint Schererville located at 7770 Burr Street, Schererville, Indiana. As part of our state regulations, a community must attempt to coordinate a fire and disaster drill with the local fire department every (6) months. Would you be willing to assist us in fulfilling this obligation? Please let me know your availability so we can coordinate the date. Thank you. Respectfully, Stephanie Peterson Executive Director	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility	R 0117		04/30/2025

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	failed to ensure there was one staff member with a current first aid certificate scheduled for 21 of 21 shifts reviewed. This had the potential to affect all 88 residents residing in the facility. Finding includes: Facility staffing schedules for 3/17/25 through 3/23/25 were reviewed on 3/27/25 at 2:30 p.m. The schedules indicated there were no staff members who were first aid certified during 1st, 2nd, and 3rd shifts on 3/17, 3/18, 3/19, 3/20, 3/21, 3/22, and 3/23/25. During an interview on 3/27/25 at 3:40 p.m., the Health and Wellness Director indicated she thought there were some staff members who had completed the first aid training with the facility's online training program, but she was unable to provide documentation at the time.		**R117** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** No residents were affected by the deficient practice **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Community realizes that all residents have the potential to be affected by the deficient practice. First aid training will be completed on or before 04/30/2025 for all employed nurses, the Wellness Director, the Assistant Wellness Director, the Executive Director, and additional community directors. Certifications will be documented and kept in employee	

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			files. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** First Aid training will be required and/or provided for any new nurse or director hired. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Wellness Director/designee will be responsible for daily audits for one month and bi-weekly audits for the following two (2) months. Once 100% compliance is achieved, one week-a-month audits will be completed for the next two (2) months. See Attachment A **By what date the systemic changes will be completed:** April 30, 2025 Attachment A R117 Wellness Director/Designee will indicate, by employee initial, first-aid certified employee on duty for scheduled shifts. Daily for one (1) month, bi-weekly for the next two (2) months, and one week per month for the following two (2) months.	

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			Day 1st Shift 2nd Shift 3rd Shift 1 2 3 4 5 6 7 8 9 10	

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			11 12 13 14 15 16 17 18 19 20	

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			21 22 23 24 25 26 27 28 29 30	

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			31 Day 1st Shift 2nd Shift 3rd Shift 1 2 3 4 5 6 7	

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			15 16 17 18	

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			19 20 21 29 30	

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			31 Day 1st Shift 2nd Shift 3rd Shift	

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			8 9 10 11 12 13 14	

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			22 23 24 25 26 27	

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			28 Day 1st Shift 2nd Shift 3rd Shift 1 2 3 4 5	

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			6 7 Day 1st Shift 2nd Shift 3rd Shift 1 2 3 4 5 6	

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	03/27/2025

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
			7	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure health screenings were completed for employees for 2 of 5 employee records reviewed. (Server 1 and CNA 3) Findings include: The Employee Records were reviewed on 3/27/25 at 10:31 a.m. a. Server 1 was hired on 2/12/25 and did not have a health screen available for review. b. CNA 3 was hired on 2/26/25 and did not have a health screen available for review. During an interview on 3/27/25 at 3:38 p.m., the Executive Director indicated the employees did not have a health screen in their employee files.	R 0121	**R0121** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice **How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** The Community realizes that all residents have the potential to be affected by the deficient practice.	04/13/2025

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			All employee files have been audited for compliance. An employee checklist will be implemented for new hires that will include a health screening/ Tuberculin skin test. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** The Community will ensure that health screenings/tuberculin skin tests are completed prior to the start of employment. Any employees identified as non-compliant will receive a health screening/Tuberculin test. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Property Administrator/designee will review employee files monthly for three (3) months. Once 100% compliance is achieved in monthly audits, quarterly audits will be completed for one year. See Attachment A **By what date the systemic changes will be completed:** April 13, 2025 Attachment A	

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			R121 The Property Administrator/designee will review employee files monthly for three (3) months. Once 100% compliance is achieved in monthly audits, quarterly audits will be completed for one year. Employee Name Health Screening TB	

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			***Request for IDR for this deficiency** The community is requesting	

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			clarification and additional support on differentiating between a health screen and a required tuberculin skin test. If an employee completes a tuberculin skin test (section G), what additional health screening (section F) form is needed? (See attachment A) 410 1AC 16.2-5-1.4(f)(1-4) States that a tuberculin skin test is necessary before employment with no additional requirements. (See attachment B). The community is asking for clarification on pre-employment screening requirements and necessary forms for employee files. Attachment A	

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			Attachment B	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were updated to reflect hospice services and ensure a service plan was signed by the resident's power of attorney (POA) for 2 of 7 service plans reviewed. (Residents 8 and 7) Findings include: 1. The closed record for Resident 8 was reviewed on 3/27/25 at 9:50 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, macular degeneration and hypothyroidism. A Physician's Order, dated 10/26/24, indicated the resident was admitted for hospice services. The Service Plan, revised on 1/8/25, did not indicate the resident was receiving hospice services. During an interview on 3/27/25 at 2:20 p.m., the Health and Wellness Director (HWD) indicated the service plan should have been updated for hospice. 2. Record review for Resident 7 was	R 0217	**R217** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice:** Residents 7 and 8 were affected by this deficient practice. The residents did not experience any negative consequences related to	04/20/2025

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	completed on 3/27/25 at 10:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, dementia, hypothyroidism, and hypertension. A Service Plan, dated 7/16/24, indicated the resident was cognitively impaired and resided on the memory care unit. There was no documentation to indicate the resident's POA had signed the Service Plan. During an interview on 3/27/25 at 2:30 p.m., the HWD indicated she was unable to provide any documentation the resident's POA had signed the Service Plan. A facility policy, titled "Evaluation and Care Conference" and received as current from the facility indicated, "...Standard Operating Procedure 1. The purpose of the Evaluation and Care Conference policy is to establish the process to evaluate the resident/client care needs and maintain a form of communication to keep all parties informed of current and ongoing care needs..."		the deficient concerns. **How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** All facility residents had the potential to be affected by this deficient practice. Residents did not experience any negative outcomes related to the deficient concerns. **What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur:** Wellness will review service plans and meet with the resident or resident's representative to ensure service plans are signed. Service plans for identified residents have been corrected. If the signature is missing, the Wellness Director/Designee will follow up with the resident or resident's representative for signature by 4/20/2025. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Service plans will be audited once (1) monthly to ensure compliance by the Executive Director. This practice will remain ongoing until 100% compliance is maintained	

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			for three (3) consecutive months. See Attachment A. **By what date the systemic changes will be completed:** April 20, 2025 Attachment A **R217** Service plans will be audited once (1) monthly by ED. Audits will be on-going until 100% compliance is maintained for three (3) months. **Resident Name** **Service plan signed by resident/family** **Updated in resident chart/binder** **Comments**	

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure QMAs (Qualified Medication Aides) received authorization from a licensed nurse prior to giving a PRN (as needed) medication for 2 of 7 records reviewed. (Residents 2 and 8) Findings include: 1. Resident 2's record was reviewed on 3/26/24 at 12:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure and hypertension. A Physician's Order, dated 3/3/25, indicated to give loperamide (an antidiarrheal) 2 milligrams (mg) every four hours as needed. The March 2025 Medication Administration Record (MAR) indicated the medication had been administered by QMA 1 on 3/7/25 and QMA 2 on 3/8, 3/9, 3/10 and 3/13/25. There was no documentation prior authorization had been given by a licensed nurse. 2. Resident 8's closed record was reviewed on 3/27/25 at 9:50 a.m. Diagnoses included, but were not limited to Alzheimer's disease, macular degeneration and hypothyroidism. A Physician's Order, dated 11/27/24, indicated to	R 0246	**R0246** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.¿ Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit.¿¿ **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Staff re-educated on the scope of practice including proper protocol for PRN medications administration requiring nurse assessment and approval prior to administration.	04/13/2025

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	give morphine sulfate 100 mg/5 milliliters (ml) take 0.25 ml by mouth every four hours as needed for pain or shortness of breath. A Physician's Order, dated 11/27/24, indicated to give lorazepam (anti-anxiety medication) 2 mg/ml take 0.5 ml every six hours as needed for anxiety or restlessness. The December 2024 MAR indicated morphine sulfate was administered on 12/25/24 and lorazepam was administered on 12/17, 12/19 and 12/25/24 by QMA 1. There was no documentation prior authorization had been given by a licensed nurse. During an interview on 3/27/25 at 4:02 p.m., the Health and Wellness Director indicated there was no documentation found that the QMAs had received prior authorization, and she was going to inservice staff today.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who receive PRN medications have the potential to be affected. Staff were educated on PRN protocols and scope of practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Wellness Director/Designee will provide ongoing education to all current and newly hired QMA's on scope of practice, with emphasis on PRN medication protocols. A copy of the scope of practice guidelines will be reviewed and signed by all QMAs and filed in their personnel records. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Wellness Director or designee will audit PRN medication administration records for proper	

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			nurse authorization and documentation daily for 4weeks, the weekly for 4 weeks, then monthly for 3 months. Any discrepancies will be addressed immediately and reviewed during monthly QA meetings to ensure ongoing compliance. See attachment A **By what date the systemic changes will be completed:** **Compliance date:** April 13, 2025 Attachment A R0246 The Wellness Director or designee will audit PRN medication administration records for proper nurse authorization and documentation daily for 4weeks, the weekly for 4 weeks, then monthly for 3 months **Date** **Resident Name** **PRN Medication Given** **Reason** **Nurse Notified/ Permission Given** **Documentation completed**	

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R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure medications were given as ordered for 2 of 5 residents	R 0247	**R0247** Preparation and/or execution of this plan of correction does not	04/13/2025

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	observed for medication administration. (Residents 9 and 10) Findings include: 1. On 3/26/25 at 11:34 a.m., LPN 1 was observed administering medications to Resident 9. He performed hand hygiene and then prepared a Tylenol 650 milligram (mg) tablet, carbidopa-levodopa (Parkinson's disease treatment) 25 mg/100 mg tablet, and sucralfate (an antacid medication) 1 gram tablet into a medication cup. The sucralfate medication card indicated the medication was to be administered at least 1 hour before meals or 2-3 hours after meals. The LPN proceeded to give the medication cup to the resident with an Ensure (dietary supplement) drink and water. The resident was observed eating her lunch at the time. At 11:45 a.m., LPN 1 indicated he was aware of the special instructions on the medication card, but the medication was due at 12:00 p.m. and the resident preferred to take her medications at that time. 2. On 3/26/25 at 12:35 p.m., QMA 1 was observed administering eye drops to Resident 10. She washed her hands, donned gloves, and administered 1 drop of dorzolamide 2% solution (treats high pressure in the eye) to each eye. She proceeded to wait 5 minutes, washed her hands, and donned clean gloves. She administered 1 drop of brimonidine 0.2% solution (glaucoma treatment) to the left eye. Resident 10's record was reviewed on 3/26/25 at 12:40 p.m. The current March 2025 Physician's Order Summary indicated dorzolamide 2%		constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Residents 9 and 10 were assessed with no adverse effects, staff will be re-educated on medication-administered policy and procedures on an ongoing basis via quarterly in-services **How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action(s) will be taken:** All residents receiving medications have the potential to be affected. All charts will be reviewed to ensure medication orders are correct. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	solution, 1 milliliter three times a day to affected eye(s). During an interview on 3/26/25 at 12:42 p.m., LPN 1 indicated she was not aware the order for dorzolamide 2% solution indicated the resident was supposed to get 1 milliliter to each eye. The resident was supposed to get the dorzolamide solution to each eye and the order would need to be clarified. During an interview on 3/26/25 at 9:20 a.m., the Health and Wellness Director indicated she would have the orders clarified with the physician. An applicable policy was requested and was not received.		**practice does not recur:** The Wellness Director/Designee will conduct five (5) chart audits weekly until compliance at 100%. See attachment A **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Once 100% compliance is met Wellness Director/Designee will audit four (4) charts monthly for three (3) months. See Attachment A **By what date the systemic changes will be completed:** **Compliance date:** April 13, 2025 Attachment A /p> /p> **Resident Name** **Physicians Orders followed** **Orders correct in PCC** **Corrections Needed**	

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			Auditors Name:_____ _____ Date:_____	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review and interview, the facility failed to maintain a safe and sanitary kitchen related to improper thawing of frozen meat and staff not wearing hairnets while food was being prepared for 2 of 4 kitchens observed. This had the potential to affect all 88 residents who received meals prepared in the kitchens. (Main kitchen and Crabtree kitchenette)	R 0273	**R0273** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the	04/11/2025

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	Findings include: 1. The initial Main Kitchen tour was completed on 3/26/25 at 9:00 a.m. with the Dining Manager (DM) and Sous Chef. a. Neither the DM or Sous Chef were wearing hairnets. There were two servers present and a dish washer who also did not have hairnets on. There was a sign posted on the kitchen entrance that indicated hairnets must be worn when in the kitchen. During an interview at that time, the DM indicated that was just to discourage other staff from entering the kitchen. Only the cooks were required to use hair protection. b. There were two trays of frozen meatballs on the counter thawing. The Sous Chef indicated that was how they normally thawed meat, or placed it in the sink to thaw. He indicated they did not thaw meat in the refrigerator usually, except frozen breakfast food would be placed in refrigerator the night before. c. During a follow up visit to the kitchen on 3/27/25 at 10:30 a.m., staff were not wearing hairnets. There were two plastic containers filled with water that had frozen chicken in them. The Culinary Manager (CM) indicated the chicken was thawing. A policy related to thawing of frozen meat was requested, the CM indicated he was looking for one. The document titled, "Four Proper Ways to Thaw", indicated, " 1. Under refrigeration 2. Cold running water within 2 hours 3. Continuous cooking method 4. Microwave (must finish cooking immediately)."		facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** No residents were affected by the deficient practice. The residents did not experience any negative consequences related to the deficient concerns. **How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** The Community realizes that all residents have the potential to be affected by the deficient practice. The dietary staff were reeducated by the Executive Chef/ Designee regarding the proper thawing of frozen meat. The Executive Chef/Designee re-educated staff on proper wearing of hair net in the kitchen. See attachments A & B **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** Executive Chef/Designee will monitor thawing procedures daily	

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		A. BUILDING 00 B. WING	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(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. On 3/26/25 at 11:45 a.m., the Crabtree Kitchenette was observed. There were two CNAs in the kitchenette who were not wearing hairnets. They were placing prepared food from the steam warmer into bowls and placing them onto serving carts. CNA 1 indicated they did not have any hairnets available. A policy related to proper kitchen attire was received but did not pertain to hairnets.		for two weeks, weekly for two (2) weeks, and monthly for two (2) months to ensure staff are following procedures. The Executive Chef/Designee will monitor staff for proper hair net compliance. **How will the corrective action(s) be monitored to ensure the deficiency will not recur, i.e., what quality assurance program will be put into place:** Executive Chef/Designee will monitor thawing and hair net procedures daily for two weeks, weekly for two (2) weeks, and monthly for two (2) months to ensure staff are following procedures. See Attachment C. **By what date the systemic changes will be completed:** April 11, 2025 Attachment A Attachment B Attachment C **R273** Executive Chef/Designee will monitor thawing procedures daily for two (2) weeks, weekly for two (2) weeks, and monthly for two (2) months to ensure staff are following procedures. Meat thawing Week 1 Date	

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			Initial Monday Tuesday Wednesday Thursday Friday Saturday Sunday Week 2 Monday Tuesday Wednesday Thursday	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Friday Saturday Sunday Week 3 Week4 Month 1 Month 2 Proper Use of Hairnets Week 1 Date	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Initial Monday Tuesday Wednesday Thursday Friday Saturday Sunday Week 2 Monday Tuesday Wednesday Thursday	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Friday Saturday Sunday Week 3 Week4 Month 1 Month 2	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency Based on record review and interview, the facility failed to ensure there was a physician's order for a diet for 1 of 7 residents reviewed for dietary orders. (Resident 6) Finding includes:	R 0275	**R275** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not	03/28/2025

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		A. BUILDING 00 B. WING	03/27/2025

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	Record review for Resident 6 was completed on 3/27/25 at 9:23 a.m. The resident was admitted on 12/31/22. Diagnoses included, but were not limited to, depression, high blood pressure, and high cholesterol. There was a lack of documentation of any physician's orders for a diet in the record. During an interview on 3/27/25 at 12:55 p.m., the Health and Wellness Director indicated she was unable to provide any further information.		to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** Resident 6 was affected by this deficient practice. The residents did not experience any negative consequences related to the deficient concerns. All diet orders for the resident have been properly documented. **How will the facility identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:** All facility residents had the potential to be affected by this deficient practice. Dietary orders were corrected for resident 6. All resident dietary orders have been audited and documented. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** Dietary orders will be audited 2xs	

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			per month to ensure compliance by the Wellness Director/Designee. See attachment A **How will the corrective action(s) be monitored to ensure the deficiency will not recur, i.e.., what quality assurance program will be put into place:** Audits will remain ongoing until 100% compliance is maintained for two (2) months. After compliance is met, quarterly audits will be completed. **By what date the systemic changes will be completed:** March 28, 2025 Attachment A **R275** Dietary orders will be audited 2xs per month to ensure compliance by the Wellness Director/Designee. Practice will remain on-going until 100% compliance is maintained for two (2) months. Resident Name Dietary Orders in PCC Physician Orders followed Documented	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Auditor's Name:_____ Date:_____	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to lack of documentation of timely follow up related to a new physician's order for 1 of 7 residents reviewed. (Resident 4) Finding includes:	R 0349	**R349** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of	04/05/2025

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	Resident 4's record was reviewed on 3/26/25 at 2:10 p.m. Diagnoses included, but were not limited to, dementia. The Service Plan, dated 8/26/24, indicated the resident was on hospice care and required assistance from staff for activities of daily living and medication management. A Physician's Order, dated 12/24/24, indicated the resident was to receive Eliquis (blood clot preventative) 2.5 milligrams (mg), 1 tablet twice daily. The order had a discontinue date of 2/13/25. A Nurses' Note, dated 2/12/25 at 12:10 p.m., indicated the hospice company sent over new orders to discontinue Eliquis 2.5 mg twice daily and start Xarelto 15 mg daily. A Physician's Order, dated 2/27/25, indicated Xarelto (blood clot preventative) 15 mg, 1 tablet once daily. There was no documentation in the record indicating the reason the medication was not started as ordered on 2/12/25. During an interview on 3/27/25 at 10:48 a.m., the Health and Wellness Director indicated the facility staff communicated with the pharmacy on 2/27/25 about a high copay and needing the family to authorize prior to filling the order, but there was no communication before 2/27/25.		correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** Resident 4 was affected by this deficient practice. The residents did not experience any negative consequences related to the deficiency concerns. Clinical orders were checked for accuracy and following the physician's plan. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All facility residents had the potential to be affected by this deficient practice. Community will collaborate with physicians for proper communication on all future order changes. Staff reeducated, via in-service, on documenting all communication for new orders received. **What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur:**	

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			The Wellness Director/Designee will audit all new orders received for one (1) month. Orders will then be audited every other week for one (1) month. See attachment A **How will the corrective action(s) be monitored to ensure the deficient will not recur, i.e.., what quality assurance program will be put into place:** Bi-weekly audits will remain ongoing until 100% compliance is maintained for two (2) consecutive months. **By what date the systemic changes will be completed:** April 5, 2025 Attachment A R349 Wellness Director/Designee will audit all new orders received for one(1) month. Orders will then be audited every other week for one(1) month. Resident Name Medication /Order Change Date Changed Start Date	

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			Auditor Name:_____ _____ Month:_____	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 7 resident records reviewed. (Resident 6) Finding includes: Record review for Resident 6 was completed on 3/27/25 at 9:23 a.m. The resident was admitted on 12/31/22. Diagnoses included, but were not limited to, depression, high blood pressure, and high cholesterol. A Nurse's Note, dated 10/28/24, indicated the resident returned to the facility from a skilled nursing facility. Previous Nurse's Notes lacked documentation of the resident going to the hospital. There was no documentation of a transfer/discharge assessment, instructions, or reason for discharge completed for the resident. During an interview on 3/27/25 at 12:55 p.m., the Health and Wellness Director indicated the resident had discharged to a skilled nursing facility, but could not provide any documentation related to the transfer.	R 0354	**R354** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the deficient practice:** Resident 6 was affected by this deficient practice. The residents did not experience any adverse outcomes related to the deficient concern. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/13/2025

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			taken: The Community realizes that all residents have the potential to be affected by the deficient practice. Staff members are reeducated on timely and thorough documentation process and the importance of maintaining accurate clinical records. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** The Wellness Director/Designee will conduct five (5) weekly chart audits until 100% compliance is achieved for three (3) months. See attachment A **How will the corrective action(s) be monitored to ensure the deficiencies will not recur, i.e.., what quality assurance program will be put into place:** Once 100% compliance is achieved for three (3) consecutive months quarterly audits on five (5) charts will be completed. **By what date the systemic changes will be completed:** April 13, 2025 **R354** The Wellness Director/Designee will conduct five (5) weekly chart audits until 100% compliance is achieved for three	

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			(3) months. Attachment A Resident Name Transfer/Discharge Documentation Complete Comments	

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R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the Emergency Binder had complete resident information for 4 of 5 resident records reviewed. (Residents 2, 3, 5 and 6) Findings include: The resident Emergency Binder was reviewed on 3/27/25 at 1:15 p.m. a. Resident 2 was missing a photograph, physician, hospital preference, allergies and code status. b. Resident 3 was missing a photograph, hospital preference and code status. c. Resident 5 was missing hospital preference. d. Resident 6 was missing hospital preference and	R 0356	**R356** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Due to the relatively low scope and severity of this survey, the community respectfully requests a desk review in lieu of a post-survey visit. **What corrective action(s) will be accomplished for those residents who were found to have been affected by the**	04/13/2025

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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
	code status. During an interview on 3/27/25 at 2:55 p.m., the Executive Director and Health and Wellness Director were made aware of the missing items. No additional information was provided.		**deficient practice:** Residents 2,3,5 and 6 were affected by this deficient practice. Resident information has been updated in the emergency binder. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All facility residents had the potential to be affected by this deficient practice. The emergency binder has been audited with complete resident records updated. **What measures will be put into place or systemic changes will the facility make to ensure that the deficient practice does not recur:** All emergency binders will be audited 2xs per month to ensure compliance by the Executive Director/Designee (see attachment A). Practice will remain ongoing until 100% compliance is maintained for three (3) consecutive months **How will the corrective action(s) be monitored to ensure the deficient will not recur, i.e.., what quality assurance program will be put into place:** Once 100% compliance is achieved in monthly audits, quarterly audits will be completed for one year. See Attachment B	

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	03/27/2025

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

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			By what date the systemic changes will be completed: April 13, 2025 Attachment A **R356** All emergency binders will be audited 2xs per month to ensure compliance by the ED. Practice will remain on-going until 100% compliance is maintained for three consecutive months. Neighborhood Emergency Binder Completed Week 1 AL 2 AL 3 MC Crabtree MC Magnolia MC Oaks Week 2 AL 2 AL 3 MC Crabtree MC Magnolia	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			MC Oaks Auditor's Name:_____ __ Date:_____	