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	10/24/2023

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

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R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00412422 and IN00412687 completed on 7/19/23. This visit was done in conjunction with the PSR to Investigation of Complaint IN00398471 completed on 6/1/23. This visit was done in conjunction with the State Residential Licensure Survey and the Investigation of Complaint IN00419038. Complaint IN00412422 - Not Corrected Complaint IN00412687 - Not Corrected Complaint IN00398471 - Corrected Complaint IN00419038 - No deficiencies related to the allegations are cited. Survey dates: October 23 and 24, 2023 Facility number: 013825 Residential Census: 96 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/30/23.	R 0000	The submission of the Plan of Correction does not indicate an admission by Storypoint of Schereville that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Story Point of Schereville. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has			

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

Karen Yarnell Rumple | Administrator | 12/06/2023

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

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	noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's Responsible Party and/or Physician were notified timely after a fall, obtaining a skin tear, bruising, and areas of excoriation for 3 of 11 records reviewed. (Residents D, K, and F) Findings include: 1. The record for Resident D was reviewed on 10/23/23 at 1:00 p.m. Diagnoses included, but were not limited to, dementia and constipation. Nurses' Notes, dated 9/13/23 at 7:09 a.m., indicated the resident was observed sitting on her bottom on the floor of the Oaks hallway. The resident was assessed and was asked why she was without her rollator. The resident indicated, "because I think I normally walk without it or the people will carry me." The resident denied hitting her head, any pain, and her current condition was consistent with her condition prior to the fall. The Director of Nursing (DON) and the Physician were made aware, family notification was pending at that time. There was no further documentation indicating the resident's family was notified of the fall. Nurses' Notes, dated 9/17/23 at 12:01 a.m., indicated the resident was found sitting on the floor in the Oaks common area without her walker. The resident indicated she did not know how she fell. She complained of mild pain which she later	R 0036	1. Residents D, K and F will have their respective service plans updated to reflect the events. 2. All residents have the potential to be affected. 3. The Wellness Director/designee will review the 24 hour report daily for physician and legal representative notifications upon change of condition. If concerns are noted, The Wellness Director/Executive Director will be notified immediately for corrective action. 4. To ensure on-going compliance with this corrective action, The Wellness Director/designee will be responsible for the completion of the The Physician and legal representative audit tool daily for two weeks, then weekly for two weeks. Weekly audits will continue until 100% compliance is achieved. Once 100% compliance is achieved in the weekly audits, monthly audits will be reviewed for quality assurance purposes for a period of three additional months.	12/08/2023

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	denied during the assessment. A light red bruise was noted to her right knee and slight edema was noted to her right heel. The Assistant Director of Health Services was made aware. The resident's physician and emergency contact were to be notified. Will continue to monitor. There was no documentation indicating the resident's physician and emergency contact were notified. Nurses' Notes, dated 10/10/23 at 8:54 p.m., indicated the resident was observed with a new skin tear to the right forearm. The area was cleansed with normal saline and a dry dressing was applied. The Executive Director and the Physician were sent notification. POA (Power of Attorney) notification was pending. There was no further documentation indicating the resident's POA was notified. Nurses' Notes, dated 10/19/23 at 6:56 a.m., indicated staff were called to the resident's room due to her sitting on the edge of the bed and she slid off. The resident denied hitting her head. A reddened area was observed on the right upper region of her back. The Executive Director was notified and communication was sent to the physician. POA notification was pending at that time. There was no further documentation indicating the resident's POA was notified. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no further documentation related to the family being notified of the above incidents. 2. The record for Resident K was reviewed on 10/23/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, atherosclerotic heart disease, and hypertension.			

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	Nurses' Notes, dated 10/9/23 at 1:45 a.m., indicated the resident was found on the floor on her buttocks. She was unable to explain how she ended up on the floor. The resident was assisted back to bed by staff. The Executive Director and the Physician were notified. Power of Attorney (POA) notification was pending at that time. There was no further documentation regarding POA notification. Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no further documentation related to the family being notified of the resident's fall. 3. The record for Resident F was reviewed on 10/23/23 at 1:45 p.m. Diagnoses included, but were not limited to, syncope, mild protein-calorie malnutrition, orthostatic hypotension, history of falling, hypertension, Depression, acute cystitis without hematuria and atrial fibrillation. The resident was admitted on 7/21/22. Nurses' Notes, dated 9/9/23 at 2:33 a.m., indicated the resident was observed with a purple-bluish bruise to the abdomen above the left hip and left knee that may have developed from the last fall on 9/3/23. A communication document was faxed to the physician. Nurses' Notes, dated 9/12/23 at 3:08 p.m., indicated the NP (Nurse Practitioner) responded to communication sent regarding the discoloration to the left abdomen, hip, and knee. The NP will see the resident next time they were at the facility. There was no documentation the resident's family was notified of the bruising. Nurses Notes, dated 10/1/23 at 11:54 p.m., indicated the resident was observed with redness			

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	and excoriation to the buttocks. A communication document was faxed to the physician requesting an as needed order for barrier cream. A Nurses' Note, dated 10/4/23 (3 days later) at 1:02 p.m., indicated new orders were obtained to start Calazime cream every 6 hours for excoriation. There was no other documentation indicating the physician was notified again on 10/2 and 10/3/23 for an order for the excoriation Interview with the Executive Director on 10/24/23 at 1:15 p.m., indicated there was no documentation the resident's family was notified of the bruised areas, nor was there continued attempts to reach the physician timely regarding the excoriation.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation and interview, the facility failed to ensure residents were free from involuntary seclusion related to automatic door locks which locked the resident's room door once inside for 15 resident rooms on all three memory care units. (Crabtree, Magnolia, and Oaks units). This had the potential to affect all 51 residents who resided on the three memory care units. Findings include: 1. On 10/24/23 at 11:30 a.m., on the Oaks memory care unit, all the resident rooms were observed	R 0052	1. Residents who were part of the 15 identified apartments during the survey were affected by the deficient practice. 2. All residents had the potential to be affected by the deficient practice. 3. Residents of all three Memory Care Neighborhoods have had their locks removed and replaced with free entry doorknobs.	12/08/2023

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	with a silver key pad lock on the outside of the doors. The handle was turned on one of the doors, however, it was locked. QMA 1 indicated all the doors were locked and the combination to get inside was either the resident's room number or 1234. The QMA indicated only a few residents had the key pad locks before, but just recently the facility had put the key pad locks on all the doors. Upon entering room 1041 using the room number as the pass code and by pressing the unlock icon on the key pad, the door was unlocked and opened easily. After entering the room, the door automatically shut and locked on its own. The locked changed from a vertical position (unlocked) to a horizontal positron (locked). The room was empty as the resident was in the lounge. The door lock had to be manually turned to a vertical position to open and leave the room. 2. On 10/24/23 at 11:33 a.m., room 1042 was observed. The resident's room number was used as the code to enter the room. After walking inside the room, the room door automatically closed and the door lock automatically turned to a horizontal position and was locked. The resident was not in the room at the time. The door lock had to be manually turned to a vertical position to open and leave the room. Interview with the Executive Director ED) on 10/24/23 at 11:42 a.m. indicated the key pad locks were not intended to auto lock once inside. If the doors were automatically being locked once inside, the nursing staff should have informed maintenance the doors were auto locking. Interview with the Maintenance Supervisor on 10/24/23 at 11:50 a.m., indicated the doors were not supposed to be set to auto lock and he does		4. Maintenance to perform weekly rounds to ensure compliance as an on-going practice.	

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	not routinely check the doors to see if they were set to auto lock. On 10/24/23 at 12:05 p.m., the Maintenance Supervisor came back after checking all 3 units and the key pad locks and indicated 15 rooms had the auto door lock turned on. He had no idea why they were turned on, or maybe the families wanted it that way so no other residents would enter the rooms. Interview with the ED on 10/24/23 at 1:15 p.m., indicated the keypad entry system were placed on all the resident doors in early 2023, however, she could not remember the exact date. She indicated most families wanted the rooms locked due to other residents wandering and going in and out of other resident rooms. All rooms had the keypad entry doors system on all 3 locked memory care units. Crabtree was a high functioning unit, Magnolia was a moderate functioning unit and the residents on the Oaks unit were low functioning and required the most assistance. The residents on all 3 memory care units had some level of cognition impairment.			
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			

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	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 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 the required personnel annual inservices, which include Dementia, were completed for 2 of 5 staff members reviewed. (HHA 1 and Concierge) Findings include: Review of the employee records was completed on 10/24/23 at 9:12 a.m. 1. The Concierge was hired on 7/7/21. The Concierge only completed 1.5 hours of the required yearly 3 hours of Dementia training for	R 0120	1. The residents under the care/services of HHA 1 and Concierge were affected by the deficient practice. 2. The Community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. HHA 1 and the Concierge have completed the dementia training. All staff members have had their Relias training audited to ensure	12/08/2023

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	the 2022 calendar year. 2. HHA (Home Health Aide) 1 was hired on 12/10/21. HHA 1 only completed 1.75 hours of the required yearly 3 hours of Dementia training for the 2022 calendar year. Interview with Executive Director on 10/24/23 at 2:48 p.m., indicated the employees should have completed 3 hours of annual Dementia training.		three hours of dementia training has been completed. 4. The Memory Care Coordinator and Executive Director will ensure the training has been completed prior to working in Memory Care. Anyone not in compliance with the training will be removed from the schedule until such time that they become compliant with the training.	