STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS HOUSE	3304 MONROE ST LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R0000	This visit was for Investigation of Complaints IN 00120983 and IN 00121730. Complaint IN 00120983 was Unsubstantiated due to lack of sufficient evidence. Complaint IN 00121730 was Substantiated with State deficiencies related to the allegations cited at R0242. Survey date: January 21, 2013. Facility number: 004458 Provider number: 004458 AIM number: NA Survey team: Christine Fodrea, RN, TC Census bed type: Residential: 32 Total: 32 Census payor type: Other: 32 Total: 32 Sample: 6	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also Not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of any truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	These State findings are cited in accordance with 410 IAC 16.2. Quality review completed on January 22, 2013 by Randy Fry RN.			

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R0242	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and record review the facility failed to ensure respiratory assessment was completed with respiratory treatments for 1 of 1 residents reviewed with respiratory treatments in a sample of 6. (Resident #N) Findings include: Resident #N's record was reviewed 1-21-13 at 10:58 AM. Resident #N's diagnoses included but were not limited to congestive heart failure, renal disease, and diabetes. Resident #N's physician's order dated 12-20-2012 indicated Atrovent 0.02% (a medication to prevent bronchospasm) solution 2.5 milliliters (ml) per nebulizer every 8 hours, and Proventil (a medication to open the bronchial tubes) 2.5 milligrams in 3 ml every 4 hours per nebulizer. A Medication Administration Record (MAR) dated 12-12 indicated the	R0242	No other residents were found to be affected by this deficient practice. Resident N is currenty not a resident in the communityNo other residents were found to be affected by this deficient practice. A review of current resident records was conducted with no other findings noted.Settlers House licensed nurses and QMAs were re-educated to our policy and practice regarding documentation of the effectiveness of medication and the assessment of respiratory status..The Residence Director or Wellness Director and/or designee will conduct weekly audits of all resident's charts to ensure compliance with Indiana State Regulation410IAC16.2-5-4(e)(2). Findings suggestive of compliance will result in cessation of the monitoring plan.	02/15/2013

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	Atrovent was to be given at 6 AM, 2 PM , and 10 PM. The MAR further indicated the Proventil was to be given at 3 AM, 7 AM, 11 AM, 3 PM, 7 PM, and 11 PM. A Comprehensive nursing evaluation dated 12-20-12 indicated Resident #N was dependant with medication administration and to assist with nebulizer treatments. A Medication Self Administration Assessment dated 12-20-12 indicated Resident #N was not capable of self administering medications. Under plans and comments, the form further indicated staff to administer Resident #N's medications and assess for effectiveness. Resident #N's MAR dated 12-12 indicated on 12-22,12-23, 12-25, 12,26, and 12-27 under the medications Atrovent and Proventil, the initials of the QMA working that shift were observed. There was no note regarding the effectiveness of the medication. Resident #N's MAR dated 1-13 indicated on 1-1, 1-5, 1-6 and 1-8 under the medications Atrovent and Proventil, the initials of the QMA working that shift were observed.			

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	There was no note regarding the effectiveness of the medication. A review of Nurse's notes dated 12-20-2012 through 1-16-2012 did not include assessment of Resident #N's respiratory status. In an interview on 1-21-2013 at 12:57 PM, QMA #1 identified the initials as hers. QMA #1 further indicated depending on the nurse on call or working, they allowed her to give the nebulizer treatments, but she was unable to assess Resident #N because it was out of her scope of practice. This State tag relates to Complaint IN 00121730. 16.2 5-4(e)(2)			