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 11/10/2015

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SETTLERS PLACE	3304 MONROE ST LA PORTE, IN 46350

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00183542. Complaint IN00183542-Substantiated. State deficiencies related to the allegation are cited at R150. Survey dates: November 9 & 10, 2015 Facility number: 004458 Provider number: 004458 AIM number: N/A Census bed type: Residential: 47 Total: 47 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed by 26143, on November 15, 2015.	R 0000	Settlers Place respectfully requests paper compliance.	
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			

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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	legal representative when the facility has 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 Physician was promptly notified of blood sugars greater than 350 for 1 of 7 residents reviewed in the sample of 7. (Resident #4) Finding includes: The record for Resident #4 was reviewed on 11/9/15 at 10:40 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus. Physician Orders dated 9/30/13 and on the current 11/2015 Physician recap, indicated Sliding Scale Insulin parameters: 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if blood sugar was less than 60 or greater than 350 call the Medical Doctor. Check blood sugar before breakfast and dinner. The Medication Administration Record (MAR) for 9/2015 was reviewed. The resident's blood sugar was greater than	R 0036	Tag #036 Resident's Rights Correction – Review of physician orders for resident's on sliding scale insulin was conducted by the Care Service Manager. No other findings were noted. The blood glucose results for Resident #4 were reviewed with the physician on November 20, 2015. Prevention – The Care Service Manager or designee will develop an in-service to be attended by Nursing and QMA staff on prompt notification of physician and Enlivant policies pertaining to documentation and communication. In addition, the Care Service Manager of designee will monitor blood glucose monitoring weekly for 2 weeks and then monthly thereafter and respective charts for appropriate documentation and physician notification. In service will be completed by December 15, 2015. Monitoring – Care Service Manager will be responsible ongoing. Results of monitoring will be taken to the	12/15/2015

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	350 before dinner on: 9/9-480 9/12-357 9/13-363 9/22-388 The 10/2015 MAR was reviewed. The resident's blood sugar was greater than 350 before dinner on: 10/10-400 10/12-359 10/15-363 10/16-363 10/23-377 10/31-374 Nurse's Notes for the above dates were reviewed. There was no indication the resident's Physician was notified of the blood sugars greater than 350. Interview with LPN #1 on 11/9/15 at 2:20 p.m., indicated if the evening shift Nurse notified the Physician it should have been documented in the Nurse's Notes. She further indicated there was no documentation in Nurse's Notes the Physician had been notified of the resident's blood sugar greater than 350 for the above mentioned dates.		Quality and Safety meeting monthly and committee will make further recommendations as needed.	
R 0044	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency			

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Bldg. 00	(r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision			

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	(4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D). Based on record review and interview, the facility failed to ensure the resident received discharge instructions to provide continuity of care for 1 of 2 closed records reviewed in the sample of 7. (Resident #2) Finding includes: The closed record for Resident #2 was reviewed on 11/9/15 at 1:05 p.m. The resident's diagnoses included, but were not limited to, dementia, pacemaker, and cardiovascular disease. The resident was discharged home on 10/15/15. Nursing Progress Notes were reviewed. The last documented Nurse's Note was on 9/21/15. There were no discharge instructions related to the resident's discharge available for review. Interview with the Director of Nursing (DoN) on 11/9/15 at 1:20 p.m., indicated the facility does not give discharge instructions to residents when they were discharged. She further indicated the facility gives the family members the resident's medications because they had already paid for them. She indicated the Nurse then has the family member sign	R 0044	Tag R044 – Resident's Rights Correction – Review of Residents who have transferred or discharged from community in 2015 was conducted by Care Service Manager. No other findings were noted. Prevention – Care Service Manager will develop an in-service to be attended by nursing and QMA staff on policies and procedures pertaining to documentation related to discharge and transfer of residents. The Care Service Manager or designee will audit transferred and discharged resident charts for completeness of documentation. In-Service will be completed by December 15, 2015. Monitoring – The Care Service Manager or Designee will monitor with results being taken to Quality and Safety meeting and committee will make further recommendations as needed.	12/15/2015

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	the medication sheet, however, at this time, no copies were made of the signed medication sheets. Interview with LPN #1 on 11/9/15 at 2:20 p.m., indicated there was no discharge instruction sheet given to residents when they leave the facility. She further indicated at the time of discharge, she usually made a copy of the resident's medications and went over them with the family. She indicated she was not working the day Resident #2 was discharged. The current 7/1/14 Release of Medications Policy provided the the DoN on 11/10/15 at 8:45 a.m., indicated "Medications will also be released to a resident or the resident's responsible party at the time of discharge as required or allowed by stage regulations. Documentation of the release will be as noted above."			
R 0150 Bldg. 00	410 IAC 16.2-5-1.5(g) Sanitation & Safety Standards -Noncompliance (g) Each facility shall have a policy concerning pets. Based on observation, record review, and interview, the facility failed to follow	R 0150	Tag # R150 Sanitation and Safety	12/15/2015

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	their pet policy regarding pets in the dining room. Finding includes: On 11/09/15 at 8:40 a.m., the facility dog was observed in the Dining Room eating food off the floor. At that time, there were 12 Residents in the dining room eating breakfast, and 2 Resident Care Providers (RCP). Neither of the two RCP's removed the dog from the dining area. Interview with RCP #1, at that time, indicated the dog was not supposed to be in the dining room while the residents were eating. Interview with the Administrator, at that time indicated the dog was new and he normally does not go into the dining room during meal times. Confidential interview with an alert and oriented resident on 11/09/15 at 2:10 p.m., indicated "(Dog's name) sneaks in the dining room occasionally while we are eating." On 11/10/2015 at 9:45 a.m., interview with the Administrator, indicated she was aware the dog was not supposed to go into the dining room and they have tried		Correction: The dog is being trained is now responding. He stays out of the dining room when wet floor signs are positioned near the entry way of the dining room. Staff has been instructed to place wet floor signs at entrance to dining room at meal times. If the dog is summoned into the dining room by residents, he is placed into his kennel for the remainder of the meal. The Executive Director will also be consulting with a dog trainer on other suggestions to deter dog from entering dining room. Prevention – Staff have been instructed to keep the dog out of the dining room. If resident's are heard calling the dog while eating, they are reminded that the dog is not allowed in the dining room during meal times. If the dog responds and enters the dining room during meal time, he will be placed in his kennel for the remainder of the meal. Monitoring – Executive Director or designee will randomly monitor meals ongoing until dog is determined to be trained.	

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	to train him to stay out of the dining room while residents were eating. She further indicated the residents call the dog in the dining room with food. Review of the the Enlivant Appendix D Resident Handbook Indiana Residences, IN Residency Agreement - Appendix D Revised 12/01/2011 provided by the Administrator, on 11/10/2015 at 10:30 a.m., indicated on Page 7 under the title Pets....."The pet is strictly forbidden from entering the dining room or food preparation areas." This Residential tag relates to Complaint IN00183542.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to store and serve food under sanitary conditions related to the storage of food in the reach in cooler, dirty stove top, oven, and cabinets for 1 of 1 kitchens observed. (The Main Kitchen) Findings include:	R 0273	Tag # 273 Food and Nutrition Correction – Outdated food was immediately removed from refrigerator. During interview with one of the chefs, this chef admitted to intentionally mislabeling containers and leaving outdated food in refrigerator to “sabotage” the community and fellow chef. The chef who made these	12/15/2015

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	1. On 11/9/15 at 8:45 a.m., the following was observed during the Brief Kitchen Sanitation tour in the reach in cooler: a. A container of pudding with an use by date of 10/11/5. b. A container of tuna salad with no label or use by date noted. c. An open package of tortillas with no date open. d. Two packages of Swiss cheese with an open date of 9/18/15. e. One open pack of Swiss cheese with no date opened. f. Fifteen American cheese slices open with no label. g. A pack of 7 English muffins open with no date opened. h. A container of cottage cheese with an use by date of 10/30/15. i. A container of strawberry yogurt with an use by date of 10/18/15. j. A container of vanilla yogurt with an use by date of 10/7/15.		confessions has been terminated. The Head Chef (who remains) received additional training on November 20, 2015 by Enlivant Regional Support. This chef will continue to be monitored for ongoing compliance. Prevention – The Executive Director or designee will check the refrigerators and perform kitchen sanitation check 4 days weekly to ensure all expired food is removed from refrigerator, proper dating of items and cleanliness in kitchen. Monitoring – Executive Director or Designee will be responsible ongoing. Results of audits will be taken to Quality and Safety meeting and this committee will make further recommendations as needed.	

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	k. An open container of cottage cheese with no label of when opened. l. A container of vanilla yogurt with an use by date of 10/25/15. Interview with the Dietary Food Manager at that time, indicated all food stored in the reach in cooler should be labeled with an open date and an use by date and discarded on the use by date. 2. On 11/9/15 at 11:55 a.m. the following was observed during the Full Kitchen Sanitation tour: a. There was a large accumulation of burned food in the bottom of the ovens. b. There was a large accumulation of dried and burned food on top of the stove. c. The serving scoops were observed in the flour and sugar containers. d. The inside and outside of the white cabinets by the sink were dirty and sticky to touch. The current 7/1/14 Leftovers and Prepared Food policy provided by the Administrator was reviewed on 11/10/15			

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	at 9:45 a.m. The policy indicated all prepared foods should be in an appropriate container and covered. There should be a label on the container with type of food and the date. Leftover foods that cannot be frozen must be discarded after three days from the refrigerator if not used. Non-leftover items discarded after 7 days. Interview with the Dietary Food Manager on 11/10/15 at 10:15 a.m., indicated all of the above was in need of cleaning.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Base on record review and interview, the facility failed to ensure clinical records were complete and accurate related to an assessment of a resident at the time of discharge for 1 of 2 closed records reviewed and the indication for the use of an Antianxiety medication of Ativan for 1 of 7 residents reviewed in the sample of 7. (Residents #2 and #4)	R 0349	Tag #R349 Clinical Records Correction – The Care Service Manager reviewed current MARs for residents. No other findings were noted. Prevention – The Care Service Manager will develop an in-service to be attended by nursing and QMA staff on policies and procedures pertaining to documentation of PRN medication usage. The	12/15/2015

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	Findings include: 1. The closed record for Resident #2 was reviewed on 11/9/15 at 1:05 p.m. The resident's diagnoses included, but were not limited to, dementia, pacemaker, and cardiovascular disease. The resident was discharged home on 10/15/15. Nursing Progress Notes were reviewed. The last documented Nurse's Note was on 9/21/15. There was no documentation of an assessment of the resident's condition at the time of discharge on 10/15/15. Interview with LPN #1 on 11/9/15 at 2:20 p.m., indicated at the time of a resident's discharge the Nurse was supposed to document in the Nurse's Notes when the resident left, and the condition they left in. She indicated she was not working the day Resident #2 was discharged. Interview with the Director of Nursing on 11/9/15 at 2:45 p.m., indicated there was no assessment of the resident's condition the day she was discharged. 2. The record for Resident #4 was reviewed on 11/9/15 at 10:40 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, seizures,		Care Service Manager or designee will perform random audits of PRN medication. Audits will be done weekly for 2 months and then monthly thereafter, with results being taken to the Quality and Safety Meeting and this Committee will make further recommendations as needed. In Service will be completed by December 15, 2015. Monitoring – The Care Service Manager or Designee will be responsible.	

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	stroke, high blood pressure, and anxiety. The current 9/6/15 Service Plan indicated the resident was forgetful at times. Physician Orders on the 10/2015 recap indicated Ativan 0 .5 milligrams (mg) twice a day as needed for anxiety. The 10/2015 Medication Administration Record (MAR) was reviewed. The resident received the Ativan on 10/16 at 5:00 p.m., 10/18 at 7:00 p.m., 10/19 at 5:00 p.m., and on 10/20/15 at 6:00 p.m. Continued review of the MAR indicated there was no documentation of the resident's anxiety. Nursing Progress Notes for the above mentioned dates indicated there was no documentation of the resident having any signs or symptoms of anxiety. The PRN (as needed) Intervention log was reviewed. Interventions of 1 to 1, redirection, and television were documented on 10/16, 10/19 and 10/20/15 before the administration of the Ativan, however, there was no documentation of any anxiety the resident was displaying. Interview with LPN #1 on 11/9/15 at 2:20 p.m., indicated there should have			

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	been a Nurse's Note related to the resident's anxiety before administering the as needed Ativan to the resident.			