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 10/23/2014

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SETTLERS PLACE	3304 MONROE ST LA PORTE, IN 46350

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R000000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00154977. Complaint IN00154977-Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 22 and 23, 2014 Facility number: 004458 Provider number: 004458 AIM number: N/A Survey team: Lara Richards, RN-TC Yolanda Love, RN Census bed type: Residential: 24 Total: 24 Census payor type: Other: 24 Total: 24 Sample: 8 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 27,	R000000	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 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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	2014, by Janelyn Kulik, RN.			
R000120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and 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.			

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	(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 an organized in-service education and training program was in place for the 2013 calendar year. The facility also failed to ensure all long term facility staff received the required annual three hour dementia specific training. Findings include: 1. The annual in-service education and training logs were reviewed on 10/23/14 at 9:00 a.m. There was lack of documentation indicating all facility staff received annual in-service education and training for the 2013 calendar year. 2. The annual dementia specific logs were reviewed on 10/23/14 at 9:10 a.m. There was lack of documentation indicating all long term facility staff received the required annual three hour dementia specific training for the 2013 calendar year. Interview with the Administrator on 10/23/14 at 10:05 a.m., indicated she was unable to locate any of the facility's 2013 training and education logs.	R000120	Tag # R 120 – 410 IAC 16.2-5-1.4 e (1-3) Personnel Noncompliance **Correction**: All In-services for 2014 are up to date and have been completed by all staff with the exception of the six hour dementia training. In-service training tapes have been purchased entitled "The Art of Caregiving," "Progression of Dementia" and "It's All in Your Approach," that will be used as part of the required training. The six hours of dementia training will become a part of the initial orientation for all new personnel. The three hour training will be held as a mandatory all staff each year. **Prevention**: The Executive Director will develop an in-service calendar to be posted for each year in advance. Each of the in-services required will be	11/30/2014

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			held during the same month and time each year. For instance; the Dementia in-service will be held on the third Thursday of each January. (See the Attached) In addition, the in-services will be posted on the bulletin board as well as in the communication book as reminders. **Monitoring**: The Executive Director and/or designee will perform random biweekly audits of a minimum of 2 employee files to ensure continued compliance with employee job specific and general orientation training to include dementia training for a period of six months. Findings will be reviewed through our QA process after six months in order to determine the need for ongoing monitoring. Findings suggestive of compliance will result in cessation of the monitoring plan.	
R000144	410 IAC 16.2-5-1.5(a)			

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	Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain an environment that was in a state of good repair related to marred door frames, peeling base board, peeling floor tile, stained carpet, and burnt out light bulbs in 4 of 24 occupied rooms throughout the facility as well as the common Men's and Women's bathrooms and Activity room. This had the potential to affect the 24 residents that resided in the facility. (Rooms #101, #108, #120, and #136, the Men's and Women's common bathroom and Activity room) Findings include: During the Environmental tour on 10/23/14 at 11:10 a.m., with the Maintenance Supervisor, the following was observed: a. The bathroom door frame in Room #101 was observed to be paint chipped and marred. The edge of the wall next to the shower was also paint chipped and marred. One resident resided in this room. b. The bathroom door frame in Room	R000144	Correction: (a & b) The Maintenance Director will make repairs and paint the doorframes in apartments 101 & 108. The bathroom wall in apartment 101 will be repaired and painted. The baseboard in apartment 108 will be repaired by the date of compliance.(c & d) The light bulbs in apartments 120 & 136 have been replaced.e) The activity room carpet has been cleaned.f) The vinyl flooring and baseboard in the common area Men's & Women's (public) Restrooms will be replaced by the date of compliance.Prevention: (a & b) The Maintenance Director will make weekly rounds, inspecting apartments and common areas to determine repairs that need to be made. A repair cart will be purchased and stocked with supplies; paints that match all areas, paint brushes, rags, drop clothes and light bulbs. (c & d) Light bulbs will be replace as needed during daily rounds by the Maintenance Director.e) The carpeting in the common areas and the activity room will be on a schedule to be cleaned by the Maintenace Director every two months or as needed. Stains will be addressed as they occur.Monitoring: The Executive Director or Designee will monitor	11/30/2014

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	#108 was observed to be paint chipped and marred. The base board located next to the shower was loose and peeling away from the wall. One resident resided in this room. c. Two burnt out light bulbs were observed in the light fixture over the bathroom sink in Room #120. One resident resided in this room. d. One burnt out light bulb was observed in the light fixture over the bathroom sink in Room #136. One resident resided in this room. e. There were stained areas of carpeting in the Activity Room. f. There was no baseboard and the edges of the floor tile were peeling in the Men's and Women's common bathroom. Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of repair.		for compliance utilizing daily, weekly and monthly rounds.	
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by			

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	licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure each resident's medication regime was administered as ordered related to administering the correct dose of insulin for 1 of 1 resident reviewed for sliding scale insulin coverage of the 7 records reviewed in the sample of 8. (Resident #6) Findings include: The record for Resident #6 was reviewed on 10/22/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, diabetes, dementia, and hypertension. Review of the Medication Administration Record (MAR) dated 10/2014, indicated an order for sliding scale coverage (insulin given per blood glucose test result) Novolog (insulin) subcutaneous (under the skin) three times a day, with the following doses: 125-150=2 units 151-200=4 units 201-250=6 units 251-300=8 units 301-350=10 units 351-400=12 units Call MD (medical doctor) if blood sugar is greater than 500.	R000241	Tag # R 241 – 410 IAC 16.2-5-1.4 e (1) Health Services Offense **Correction**: An individualized resident glucose monitoring form for sliding scale insulin has been created for Resident #6 that lists the sliding scale on the same page as the blood glucose monitoring results. Additionally a line has been placed between each division of the sliding scale to better differentiate the amount of units of insulin given for the blood glucose results. A review of physician orders for any residents on a sliding scale insulin order was conducted by the Care Services Manager. No other findings were noted. One other resident was noted to have a sliding scale insulin order and an individualized glucose monitoring form was created for this resident as well. **Prevention**: The Care	11/30/2014

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	Further review of the MAR dated 10/2014, indicated on 10/10, 10/14 and 10/16/14 the resident was not given insulin before breakfast. On 10/21/14 before lunch, the resident was given 10 units and before dinner the resident was given 12 units. Review of the Blood Glucose Monitoring log dated 10/2014, indicated the resident's blood glucose test result on 10/10/14 before breakfast was 132, indicating 2 units of insulin was to be administered. On 10/14/14 before breakfast, the resident's blood glucose test result was 132, indicating 2 units of insulin was to be administered. On 10/16/14, the resident's blood glucose test result was 127, indicating 2 units of insulin was to be administered. On 10/21/14 before lunch, the resident's blood glucose test result was 357, and 12 units was to be administered, and before dinner the resident's blood glucose test result was 337, and 10 units was to be administered. Interview with the Director of Nursing (DON) at 1:32 p.m., indicated the insulin should have been administered as ordered by the Physician.		Services Manager will develop a mandatory in-service to be completed by all nursing and QMA staff on medication management and diabetic medications. In addition, the clinical services manager will audit blood glucose monitoring form each week to assure the sliding scale is followed per physician orders. **Monitoring**: The Clinical Services Manager will be responsible for monitoring.	

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R000349	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. Based on clinical record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of interventions that were attempted prior to giving an as needed (prn) anti-anxiety medication and documenting increased episodes of depression for 1 of 7 records reviewed in the sample of 8. (Resident #7) Findings include: During Orientation tour on 10/22/14 at 9:30 a.m., Resident #7 was identified as being alert but confused by LPN #1. The record for Resident #7 was reviewed on 10/22/14 at 11:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's and depression. A Physician's order dated 4/1/14, indicated the resident was to receive	R000349	Tag # R 349 – 410 IAC 16.2-5-8.1(a) (1-4) Clinical Records Noncompliance **Correction**: No residents were found to be affected. The Care Services Manager reviewed the resident service notes, service plan, and medication administration record for Resident #7 with LPN #2 and re-educated on our policies and procedures pertaining to documentation and communication. **Prevention**: The Care Services Manager will re-educate all licensed staff on our policies and procedures pertaining to documentation and communication. In addition, the Care Services Manager or	11/30/2014

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	Xanax (an anti-anxiety medication) 0.25 milligrams (mg) every eight hours as needed (prn) for anxiety. Review of the September 2014 Medication Administration Record (MAR), indicated the resident received the prn Xanax on 9/2 at 7:00 a.m., 9/3 at 7:30 a.m., and 9/24/14. There was no documentation of interventions attempted prior to giving the prn Xanax. Review of the October 2014 MAR, indicated the resident received the prn Xanax on 10/3 at 8:00 p.m., 10/4 at 1:45 p.m., 10/6 at 3:10 p.m., and 10/14/14 at 9:00 a.m. Again, there was no documentation of what interventions were attempted prior to giving the prn Xanax. A Physician's fax dated 10/7/14, completed by LPN #2, indicated the following documentation "resident occasionally complains of depression and anxiety. Tearful. Currently has prn Xanax 0.25 mg every 8 hours. Noted Xanax administered 3-4 times a week. Also, she has Celexa (an antidepressant) 20 mg every morning. Requesting consideration of increase of Celexa." The Physician returned the fax on 10/7/14 and an order was given to increase the Celexa to 30 mg daily.		designee will perform random weekly review of resident charts to include service notes, service plans, and medication administration records to assure documentation of interventions are being documented as well response to interventions for residents who are found to experience a change of condition. **Monitoring**: The Clinical Services Manager will be responsible for monitoring.	

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	Review of the Nursing progress notes for the month of October 2014, indicated there were no documented episodes of increased depression. Interview with the Director of Nursing on 10/24/14 at 11:00 a.m., indicated documentation should have been completed related to what interventions were attempted prior to giving the prn Xanax and the episodes of increased depression should have also been documented.			
R000407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview, the facility failed to ensure an ongoing infection control program was maintained related to maintaining a system that enabled the facility to monitor for patterns and trends of known infectious symptoms. This had	R000407	Correction: Infection Control education including universal precautions has been completed by staff for 2014 and will be maintained annually and as needed. An Infection Control Log has been started for the community beginning October	11/30/2014

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	the potential to affect the 24 residents residing in the facility. Findings include: During the Entrance Conference with the Executive Director and Director of Nursing on 10/22/14 at 9:05 a.m., the Infection Control logs for the past six months were requested. On 10/23/14 at 10:30 a.m., the Infection Control logs for the past six months were again requested. Interview with the Director of Nursing on 10/23/14 at 11:30 a.m., indicated that she had been working at the facility since the end of July 2014. She indicated that she could not find any Infection Control logs prior to that and she also indicated that she had not maintained any Infection Control logs since she started working at the facility.		2014. Prevention: The Care Services Manager or designee will audit, track, maintain, and analyze the Infection Control Log for all infections within the community.Monitoring: The Care Services Manager or designee will be responsible for monitoring.	