

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/14/2026	
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING AT SETTLERS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3304 MONROE ST, LA PORTE, , 46350					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE			
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 468457. Intake 468457 - No deficiencies related to the allegations are cited. Survey dates: July 13 and 14, 2026 Facility number: 004458 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 7/20/26.	R 0000	Trustwell living Settlers Place. Please accept the following as the facilities credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We are also respectfully requesting desk review and have supplied all documents for our correction along with the POC.				
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	07/28/2026			

appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:

(1) The services offered to the individual resident shall be appropriate to the:

(A) scope;

(B) frequency;

(C) need; and

(D) preference;

of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

- Resident #5 service plan was updated to reflect current home health services. Copy of service plan was provided to family and resident.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

- All current facility residents have the potential to be affected by this alleged deficient practice. A complete audit was done to ensure all service plans reflected current treatment.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

DON was educated on timely service plan updates for all residents.

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	Based on record review and interview, the facility failed to ensure service plans were updated to include physical therapy for 1 of 7 records reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 7/13/26 at 2:26 p.m. The Indiana Service Assessment and Negotiated Service Plan, dated 5/4/26, indicated the resident had no cognitive decline, received assistance with medication administration, and the coordination of care section did not include therapy services. A Note, dated 3/23/26, indicated a new order was received for the resident to restart physical therapy. A referral was sent. During an interview on 7/14/26 at 11:43 a.m., the Director of Nursing indicated the resident was currently receiving physical therapy, however therapy was not something she had put on any service plans.		DON will review weekly monitor schedule for all outside vending services to review and update timely. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Administrator/Designee will audit weekly report to ensure accurate data in the service plans. • The Administrator/designee will present the summaries of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be	R 0246	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	07/28/2026

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administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 2. Resident 5's record was reviewed on 7/13/26 at 2:26 p.m. The July 2026 Physician's Order Summary indicated acetaminophen (Tylenol pain medication) 500 milligrams (mg) tablet, one tablet twice daily as needed for pain and melatonin (hormone supplement to aid with sleep) take one tablet by mouth daily at bedtime as needed. The July 2026 Medication Administration Record indicated the acetaminophen and melatonin were administered by QMA 1 on 7/12/26 at 9:04 p.m. During an interview on 7/14/26 at 11:49 a.m., the Director of Nursing indicated the QMAs do not have access to chart progress notes and only receive prior authorizations for narcotic administrations.	practice? - Resident #3,5, and 6 chart review completed and residents suffered no ill effects from PRN administration of medication. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - All current facility residents have the potential to be affected by this alleged deficient practice. QMA administration was reviewed for all residents with PRN medication administered. DON aware and no ill effects identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Clinical Staff were educated on receiving authorization from a licensed nurse prior to administration of a PRN	
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3. Resident 6's record was reviewed on 7/14/26 at 10:42 a.m.

The July 2026 Physician's Order Summary indicated loperamide (medication used to control diarrhea symptoms) two milligram capsule, one capsule as needed every 6 hours for diarrhea.

The July 2026 Medication Administration Record indicated the loperamide was administered by QMA 1 on 7/1/26 at 9:10 p.m.

During an interview on 7/14/26 at 11:49 a.m., the Director of Nursing indicated the QMAs do not have access to chart progress notes and only receive prior authorizations for narcotic administrations.

Based on record review and interview, the facility failed to ensure QMAs (qualified medication aides) received authorization from a licensed nurse prior to administering PRN (as needed) medications for 3 of 7 residents reviewed. (Residents 3, 5 and 6)

Findings include:

1. Resident 3's record was reviewed on 7/13/26 at 10:50 a.m. Diagnoses included, but were not limited to, acute respiratory failure and chronic

medication.

DON created QMA PRN medication log that will document and track authorization and administration of PRN medications.

How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- DON will audit QMA PRN medication log daily x 5 days a week to ensure prior authorization was given.
- The Administrator/designee will present the summaries of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.

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	obstructive pulmonary disease. A Physician's Order, dated 6/4/26, indicated to give buspirone (medication to treat anxiety) 10 milligrams, three times daily as needed for anxiety. The June 2026 Medication Administration Record (MAR) indicated the medication was given by QMA 1 on 6/19, 6/20 x 2, 6/21 and 6/23. There were no MAR or nursing notes that indicated a nurse had authorized the medication. During an interview on 7/14/26 at 10:45 a.m., QMA 1 indicated there was a box on the MAR that could be checked that indicated the nurse was notified. She then indicated she had not documented or checked anything for this resident. During an interview on 7/14/26 at 10:48 a.m., the Director of Nursing indicated the QMA would ask her or call her to get approval for a prn medication. If it was a narcotic, the DON would co-sign the narcotic log. Buspirone was not a narcotic and authorization was not documented.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f)	R 0273	What corrective action(s) will be accomplished for those residents found to have been	07/28/2026

(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 and interview, the facility failed to maintain proper food sanitation related to cooking and serving utensils stored incorrectly and inappropriate glove use. This had the potential to affect all 37 residents who received food from the kitchen.

Findings include:

1. During the initial kitchen tour with the Dietary Food Manager on 7/13/26 at 10:10 a.m., the plates, bowls, and mixing bowls were not stored inverted.

2. During the follow-up tour of the kitchen on 7/13/26 at 11:55 a.m., Cook 1 was observed preparing a grilled cheese sandwich. She donned a pair of gloves, picked up a large container of butter, and placed it on the preparation area. She then opened a container, picked up a bag of bread, opened the bag of bread, and took out a piece of bread with her gloved hands. She picked up a butter knife and proceeded to open the butter container and spread butter on the piece of bread while holding it in her gloved

affected by the deficient practice?

- Cook was educated immediately during service, gloves were changed and hand washed. Dishes were turned upside down on shelf. Meal service continued without ill effect to residents.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

- All current facility residents have the potential to be affected by this alleged deficient practice. Meal service was observed until finished without concern.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Kitchen staff were educated on the importance of proper usage of single use gloves, as well as how to properly store dishes on

hand. She turned on the stove top burner, placed the buttered bread on a pan, and then proceeded to prepare another piece of buttered bread with the same gloved hands.

On 7/13/26 at 12:00 p.m., Cook 1 and the Dietary Food Manager were notified of the concerns. No further information was provided.

the shelf.

Dietary Service Manager created a log to monitor meal service 5x a week to ensure proper food handling and dish storage.

How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- Dietary Service Manager will complete audit log 5x a week to ensure proper food handling and dish storage.
- The Administrator/designee will present the summaries of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.

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R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. 3. The record for Resident 5 was reviewed on 7/13/26 at 2:26 p.m. Diagnoses included, but were not limited to, right total hip replacement, osteoarthritis, and anxiety. The Indiana Service Assessment and Negotiated Service Plan, dated 5/4/26, indicated the resident required staff assistance with medication administration and medications	R 0298	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 and 6 have had a recent pharmacy review with appropriate follow-up. No other concerns identified. Resident #7 and 8 no longer reside in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - All current facility residents have the potential to be affected by this alleged deficient practice. Pharmacy reviews for 2026 have been reviewed, noted and orders have been updated to current. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? - Pharmacy was informed to send electronic review	07/28/2026
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were provided by the house pharmacy.

There were pharmacy reviews completed in April and June 2026.

The record lacked pharmacy reviews from May 2025 to March 2026.

During an interview on 7/14/26 at 2:40 p.m., the Administrator and Director of Nursing indicated they were unable to provide the pharmacy reviews as they had been sent to the previous Director of Nursing's email, which they could not access at the time.

4. The record for Resident 6 was reviewed on 7/14/26 at 10:42 a.m. Diagnoses included, but were not limited to, high blood pressure, chronic lung disease, and hypothyroidism.

The Indiana Service Assessment and Negotiated Service Plan, dated 6/19/26, indicated the resident required staff to assistance with medication administration and medications were provided by the house pharmacy.

There were pharmacy reviews completed in June 2025, April 2026 and June 2026.

The record lacked pharmacy reviews from July 2025 to March

to DON every 60 days. The reviews are then given to NP, signed and updated timely and tracked in a binder.

- DON created a log to monitor the timeliness of Pharmacy reviews monthly to ensure we are timely.

How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- DON will summarize monthly audit and present to QA committee with findings.
- Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.

2026.

During an interview on 7/14/26 at 2:40 p.m., the Administrator and Director of Nursing indicated they were unable to provide the pharmacy reviews as they had been sent to the previous Director of Nursing's email which they could not access at the time.

2. The closed record for Resident 8 was reviewed on 7/13/26 at 11:27 a.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and coronary artery disease. The resident was admitted to the facility on 9/11/25 and discharged on 3/16/26.

There was a lack of documentation any pharmacy reviews had been completed for the resident.

During an interview on 7/14/26 at 2:40 p.m., the Administrator and DON indicated they were unable to provide any pharmacy reviews prior to 4/2026. The information was in the previous DON's email and they were unable to access it.

Based on record review and interview, the facility failed to ensure the pharmacy reviewed the residents' medications every 60 days for 4 of 7 resident records reviewed. (Residents 7,

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	8, 5 and 6) Findings include: 1. Resident 7's closed record was reviewed on 7/14/26 at 10:25 a.m. The resident was admitted to the facility on 1/11/25 and expired on 6/2/26. The resident received hospice services and staff administered his medication. There was no documentation the resident's medications had been reviewed every 60 days by the pharmacist. During an interview on 7/14/26 at 2:40 p.m., the Executive Director indicated they were unable to locate the pharmacy reviews.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.	R 0409	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #4,5 and 6 have had their orders updated to reflect "Resident is free from communicable disease" with NP signatures.	07/28/2026

	2. Resident 4's record was reviewed on 7/13/26 at 10:51 a.m. The resident was admitted to the facility on 6/26/26. There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases. During an interview on 7/14/26 at 12:56 p.m., the Director of Nursing indicated there was no documentation of the Physician's annual health statement in the record. 3. Resident 5's record was reviewed on 7/13/26 at 2:26 p.m. The resident was admitted to the facility on 9/26/2025. There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases. During an interview on 7/14/26 at 12:56 p.m., the Director of Nursing indicated there was no documentation of the Physician's annual health statement in the record. 4. Resident 6's record was reviewed on 7/14/26 at 10:42 a.m. The resident was admitted to the facility on 9/29/23.		How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. • All current facility residents have the potential to be affected by this alleged deficient practice. All residents orders were reviewed with NP and signed for being free of communicable diseases. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • DON was educated on the requirement of signed yearly assessment by provider to ensure resident is free of communicable diseases. • DON created a log to audit monthly to stay in compliance. How will the corrective actions(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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There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases.

During an interview on 7/14/26 at 12:56 p.m., the Director of Nursing indicated there was no documentation of the Physician's annual health statement in the record.

Based on record review and interview, the facility failed to ensure each resident had a signed annual health statement for 4 of 7 records reviewed. (Residents 8, 4, 5, and 6)

Findings include:

1. The closed record for Resident 8 was reviewed on 7/13/26 at 11:27 a.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and coronary artery disease. The resident was admitted to the facility on 9/11/25 and discharged on 3/16/26.

There was a lack of any health statement in the record to indicate the resident was free of communicable diseases.

During an interview on 7/14/26 12:56 p.m., the Director of Nursing indicated she was unable to provide an annual health statement. When the facility transitioned to electronic

- DON will summarize monthly audit and present to QA committee with findings.
- Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.

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	records it had been left off.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. 2. The closed record for Resident 8 was reviewed on 7/13/26 at 11:27 a.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, and coronary artery disease. The resident was admitted to the facility on	R 0410	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #3 and 4 were given a new two step Mantoux. Results were negative for TB. Resident #8 no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - All current facility residents have the potential to be affected by this alleged deficient practice. All resident were given a 2 step Mantoux test to ensure compliance. All results were negative. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? - DON was educated on the requirement of a two	07/28/2026

9/11/25 and discharged on 3/16/26.

There was no documentation the resident had received a two-step Mantoux test upon admission.

During an interview on 7/14/26 at 12:56 p.m., the Director of Nursing indicated a Mantoux test had not been completed upon admission.

Based on record review and interview, the facility failed to ensure new residents were given a two-step tuberculosis test (Mantoux) upon admission for 3 of 7 residents reviewed. (Residents 3, 8 and 4)

Findings include:

1. Resident 3's record was reviewed on 7/13/26 at 10:50 a.m. The resident was admitted to the facility on 5/19/26. Diagnoses included, but was not limited to, chronic obstructive pulmonary disease and acute respiratory failure.

There was no documentation the resident had received a two-step Mantoux test upon admission.

During an interview on 7/13/26 at 1:15 p.m., the Director of Nursing indicated they did not do Mantoux testing on admission, they only required a

step Mantoux test prior to admission.

- DON created a TB Test log to audit monthly to ensure all new admits are given Mantoux to stay in compliance.

How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- DON will summarize monthly audit and present to QA committee with findings.
- Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.

chest x-ray. She indicated the resident had a Mantoux completed in the past year prior to admission.

During an interview on 7/14/26 at 9:45 a.m., the Executive Director indicated she was unable to locate the resident's previous Mantoux test.

3. Resident 4's record was reviewed on 7/13/26 at 10:51 a.m. The resident was admitted to the facility on 6/26/26.

There was no documentation related to the resident receiving a first or second step Tuberculin (TB) skin test prior to or upon admission.

During an interview on 7/14/26 at 12:56 p.m., the Director of Nursing indicated there were no tuberculin skin tests completed prior to admission. The resident had a chest x-ray prior to admission.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE Kimberly Urban-Gee

TITLE Executive Director

(X6) DATE 07/30/2026