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	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS PLACE	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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 10 and 11, 2021 Facility number: 004458 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/14/21.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and 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 the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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 education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel,			

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

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	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 included Resident Rights and Dementia were completed for 3 of 5 staff members reviewed. (QMA 1, CNA 1, and Cook 1) Findings include: Review of the employee records was completed on 5/11/21 at 9:00 a.m. 1. QMA 1 was hired on 4/26/12. The QMA only completed 2.25 hours of the required yearly 3 hours of Dementia training for the 2020 calendar year. The staff member also did not complete the required yearly Resident Rights training.	R 0120	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and 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 the truth of any facts	06/04/2021

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	2. CNA 1 was hired on 12/24/17. The CNA did not complete any of the required yearly hours of Dementia or Resident Rights training for the 2020 calendar year. 3. Cook 1 was hired on 6/22/17. The Cook did not complete any of the required yearly hours of Dementia or Resident Rights training for the 2020 calendar year. Interview with the Administrator on 5/11/21 at 9:30 a.m., indicated the staff did not complete the required yearly in-services for the 2020 calendar year.		alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **R120 Personnel-Noncompliance** Plan of Correction: 1.Care Services Manager provided Dementia and Resident Rights annual in-services for QMA 1, CNA 1, and Cook 1 on 5/21/2021. 2.An audit of personnel annual in-services including Resident Rights and Dementia training for staff will be completed by the Executive Director, and/or designee, by 6/4/2021 to ensure records are current. Any issues identified will be corrected. 3.The Executive Director will provide re-education to the Care Services Manager on the required personnel annual in-services, including Resident Rights and Dementia training on 5/28/2021. 4.The Executive Director is responsible for sustained compliance. The Executive Director, and/or designee, will audit the in-service training for 5 staff members weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure required personnel annual in-services are conducted. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	

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			Completion date: June 10, 2021 *On 05/11/2021 based on record review and interview, the facility failed to ensure the required personnel annual in-services which included Residents Rights and Dementia were not completed for 3 of 5 staff members reviewed (QMA-1, CNA-1, and Cook-1). QMA-1 was hired on 04/26/12. The QMA only completed 2.25 hours of required annual 3 hours of Dementia training for the 2020 calendar year. The staff member also did not complete the required annual Resident Rights training. CNA-1 was hired on 12/24/17. The CNA did not complete any of the required annual hours of Dementia or Resident Rights training for the 2020 calendar year. Cook-1 was hired on 06/22/17. The Cook did not complete any of the required annual hours of Dementia or Resident Rights training for the 2020 calendar year. Interview with the Administrator on 05/11/2021 at 9:30 a.m. indicated the staff did not complete the required annual in-services for the 2020 calendar year.* **410 IAC 16.2-5-1.4(e)(1-3) -** There shall be an organized in-service education and training program planned in advance for all personnel in all departments at	

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			least annually. Training shall include, but 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 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 (8) hours of in-service per calendar year and four (4) hours in-service per calendar year for nonnursing personnel. (2) In addition to the above required in-service hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within (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 in-service The employee will acknowledge attendance by written signature.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) 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 a clean and orderly environment, which was in a state of good repair, related to stained and frayed carpet throughout the facility. Findings include: During the Environmental tour on 5/11/21 at 8:35 a.m. with the Maintenance Supervisor, the following was observed: There were numerous stains on the carpets in the foyer area, resident hallways, and the main lounge. The carpet was frayed in many areas as well. Interview with the Maintenance Supervisor at the time, indicated the facility was scheduled for new carpet prior to COVID-19, however, that was placed on hold.	R 0144	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and 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 the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **R144 Sanitation and Safety Standards-Deficiency** Plan of Correction: 1.Identified stained carpet will be cleaned by Maintenance Tech	06/10/2021

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			on 05/28/2021. Carpet in need of replacement will be replaced by 06/08/2021. 2.An inspection of the community was completed by the Executive Director and Regional Director of Facilities on 5/21/2021 to ensure sanitation and safety standards are met. Results of audit reviewed with Regional Director of Operations. 3.The Regional Director of Facilities will provide education to the Maintenance Tech on the required sanitation and safety standards by 6/4/2021. 4.The Executive Director is responsible for sustained compliance. The Executive Director, and/or designee, will inspect common area carpeting weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure sanitation and safety standards are met. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. Completion date: June 10, 2021 *On 05/11/2021 based on observation and interview, the facility failed to maintain a clean and orderly environment, which was in a state of good repair, related to stained and frayed carpet throughout the facility. There were numerous stains on*	

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			the carpets in the foyer area, resident hallways, and the main lounge. The carpet was frayed in many areas as well. Interview with the Maintenance supervisor at the time, indicated the facility was scheduled for new carpet prior to COVID-19, however that was placed on hold. **410 IAC 16.2-5-1.5(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.	
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. Based on record review and interview, the facility failed to maintain complete clinical records related to obtaining a Physician's Order for steri strips (thin adhesive bandages used for incisions or minor cuts to keep the edges of the wound together as it heals) for a skin tear for 1 of 2 closed records reviewed. (Resident 8) Finding includes: The closed record for Resident 8 was reviewed	R 0349	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of	06/10/2021

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	on 5/10/21 at 1:50 p.m. Diagnoses included, but were not limited to, high blood pressure, anemia, renal cell cancer, hypothyroidism, insomnia, and anxiety. Nurses' Notes, dated 4/28/21 at 5:30 p.m., indicated the resident was observed on the floor in the doorway near her walker. She stated she lost her balance and fell, crawled to try and pull the call string, but could not reach it. A skin tear was noted to the left elbow. The skin was cleaned with normal saline and 3 steri strips were applied. The area was covered with a non stick bandage and secured with roller gauze. The physician was notified. There was no Physician's Order to place the steri strips on the resident's skin tear and there was no treatment order obtained for the skin tear. Interview with Care Service Manager on 5/11/21 at 10:20 a.m., indicated she was unaware they needed to obtain a Physician's Order for steri strips and a bandage to cover the skin tear. There were no orders for any treatment of the skin tear.		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 the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **R349 Clinical Records-Noncompliance** Plan of Correction: 1.Resident 8 suffered no negative outcomes related to these findings. 2.An audit of current resident records will be completed by 6/4/2021 by the Care Services Manager and/or designee to ensure all records are accurate regarding physician orders. Any issues identified will be corrected as necessary. 3.The Care Services Manager will provide re-education to the Licensed Nurses on maintaining complete clinical records, including obtaining physician orders as required by 6/4/2021. 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager, and/or designee, will audit 5 resident records weekly for four weeks, bi-weekly for four weeks, then monthly for one month to ensure complete clinical records are maintained. The QI	

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			committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. Completion date: June 10, 2021 *On 05/10/2021 based on record review and interview, the facility failed to maintain complete clinical records related to obtaining a Physician's Order for steri-strips (thin adhesive bandages used for incisions or minor cuts to keep the edges of the wound together as it heals) for a skin tear on 1 of 2 closed records reviewed. Closed record for Resident 8 was reviewed at 1:50p.m. Nurses' notes, dated 04/28/2021 at 5:30p.m. indicated the resident was observed on the floor in the doorway near her walker. She stated she lost her balance and fell, crawled to try and pull the call string, but could not reach it. A skin tear was noted on the left elbow. The skin was cleaned with normal saline and 3 steri-strips applied to wound. The area was covered with a nonstick bandage and secured with roller gauze. The physician was notified. There was no Physician's Order to place the steri-strips on the resident's skin tear and there were no treatment orders*	

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			obtained for the skin tear. Interview with Care Service Manager on 05/11/2021 at 10:20a.m. indicated she was unaware they needed to obtain a Physician's Order for steri-strips and a bandage to cover the skin tear. **410 IAC 16.2-5-8.1(a)(1-4) –** The facility shall 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	
R 0407 Bldg. 00	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 observation, record review, and	R 0407	Submission of this response and	06/10/2021

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	interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to the lack of documentation of screening visitors, personal protective equipment (PPE) not worn at all with resident interaction, staff wearing cloth face masks, wearing gloves in the hallway, and donning gloves from a shirt pocket for random observations for infection control throughout the facility and for 1 of 5 residents during medication pass. (Resident 9) Findings include: 1. Upon entering the facility on 5/10/21 at 8:40 a.m., Housekeeper 1 opened the locked door. At that time, she was wearing a pair of disposable gloves to both hands. LPN 1 greeted the surveyors at the door and took the temperatures of both surveyors. She did not document the temperatures. The LPN opened the visitor screening book and realized there were no extra sign in forms, so she proceeded to ask the surveyors (simultaneously) the questions, however, she did not document any of the information she gathered. At that time, the LPN was wearing a cloth face mask over her mouth and nose. 2. During a random observation on 5/10/21 at 9:10 a.m., Housekeeper 1 was observed in the resident hallway wearing a pair of blue disposable gloves to both hands. She was observed pushing a vacuum cleaner. She was not wearing a face shield over her face. Interview with Housekeeper 1 at that time, indicated she does not normally wear a face shield while cleaning resident rooms. She		Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and 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 the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **R407 Infection Control – Noncompliance** Plan of Correction: 1.Resident 9 suffered no negative outcomes related to these findings. 2.Care Service Manager will conduct an infection control audit by 06/4/2021 of current staff to include required screening of visitors, personal protective equipment worn as required, appropriate mask wear, and appropriate glove usage. Identified concerns will be corrected at time of discovery as necessary. 3.Care Service Manager will provide re-education to current	

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	always wears gloves while cleaning and doing everything when in the facility in resident rooms and out in the hall. She indicated she frequently changed them, however, she wears them all the time. 3. During a random observation on 5/10/21 at 9:12 a.m., LPN 1 was observed passing medications to a resident inside their room. She was observed wearing the same cloth face mask and she was not wearing a face shield over her face. The LPN was within 6 feet of the resident. Interview with LPN 1 at that time, indicated she was unaware she was not supposed to wear a cloth face mask. She was unaware she needed to wear a face shield when within 6 feet of residents. 4. On 5/10/21 at 9:44 a.m., 2 hospice nurses entered the facility. After being screened, they both went over to the resident they were there to see. Each one of them had a face mask on, however, neither one was wearing a face shield. Both nurses were within 6 feet of the resident. 5. During a random observation on 5/10/21 at 11:33 a.m., LPN 1 was observed taking residents' temperature with the thermometer. She was not wearing a face shield at that time. The updated 5/3/21, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure," indicated "HCP will wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high)		staff on ensuring infection control guidelines are in place and implemented to properly prevent and/or contain COVID-19 related to staff, residents, and visitors. Training will include donning and doffing proper PPE, documentation of screening visitors, and appropriate mask wear for staff. 4.Executive Director is responsible for sustained compliance. Care Service Manager and/or designee will audit 3 staff members to ensure infection control guidelines are in place and implemented to properly prevent and/or contain COVID-19 related to staff, residents, and visitors five times per week for four weeks, then three times per week for four weeks, then one time per week for four weeks. Audit results will be reviewed monthly in QI meetings and QI Committee will determine in continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. Completion date: June 10, 2021 *On 05/10/2021 based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent*	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SETTLERS PLACE	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
	community transmission. If the county positivity rates increase to moderate or high substantial community transmission then eye protection should be used for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status." As of 5/10/21 the county positivity rate was 11.1% Interview with the Care Service Manager (CSM) on 5/11/21 at 10:00 a.m., indicated she was aware staff were to wear the face shield when within 6 feet of the residents, however, since all the residents were fully vaccinated they have not been wearing the face shields. No staff should be wearing gloves in the hallway. She was aware there were no screening sheets at the time the surveyors entered, as LPN 1 asked her for more sheets for the book. 6. On 5/10/21 at 12:00 p.m., LPN 1 was observed preparing medication for Resident 9. She entered the resident's room and administered the medication. The resident indicated she was not feeling well and her ear was hurting. The LPN pulled a pair of gloves out of her shirt pocket and donned them to each hand. She observed the resident's right ear and removed a piece of cotton that was in her ear. The LPN removed her gloves, threw them in trash, left the room and performed hand hygiene at the medication cart. Interview with LPN 1 on 5/10/21 at 1:45 p.m., indicated she keeps gloves in her pockets in case she needed them when she entered a resident room. The gloves that were in her pocket were from the medication room and she had placed them there earlier in the day.		*and/or contain COVID-19,related to the lack of documentation of screening visitors, personal protective equipment (PPE) not worn at all with resident interaction, staff wearing cloth face masks, wearing gloves in he hallway, and donning gloves from a shirt pocket or random observations for infection control throughout the facility and for 1 of 5 residents during medication pass (Resident 9)* **410 IAC 16.2-5-12(b)(1-4)** Infection Control – The facility must establish an infection control program that includes the following: · A system that enables the facility to analyze patterns of known infectious symptoms · Provide orientation and in-service education on infection prevention and control, including universal precautions. · Offering health information to residents, including, but not limited to, infection transmission and immunization. · Reporting communicable diseases to public health authorities.	

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	05/11/2021

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