PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. W	NG		05/11/	2021
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				3304 M	ONROE ST		
SETTLEF	RS PLACE			LA POF	RTE, IN 46350		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E	DATE
R 0000		,					
110000							
Bldg. 00							
Diag. 00	This visit was for a	State Residential Licensure	R 0	000	Submission of this response a	nd	ı
	Survey.	State Residential Electionic	I K U	000	Plan of Correction is NOT a le		
	Burvey.				admission that a deficiency ex	_	
	C 1. M	10 111 2021			or, that this Statement of	1515	
	Survey dates: May	10 and 11, 2021					
		MA 4 5 0			Deficiency was correctly cited,		
	Facility number: 00	14438			and is also NOT to be construct		
	Residential Census: 32				as an admission against intere		
					by the facility, or any employed		
					agents, or other individuals wh		
		itial Findings are cited in			drafted or may be discussed in	Ì	
	accordance with 410) IAC 16.2-5.			the Response and Plan of		
					Correction. In addition,		
	Quality review com	pleted on 5/14/21.			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 a	ny	
					conclusions set forth in this	•	
					allegation by the survey agend	V.	
						,	
R 0120	410 IAC 16.2-5-1.4	4(e)(1-3)					'
	Personnel - Nonco						
Bldg. 00		an organized inservice					
	` '	ning program planned in					
		rsonnel in all departments					
	-	Fraining shall include, but is					
	-	dents' rights, prevention					
		ction, fire prevention,					
		evention, the needs of					
		tions served, medication					
		d nursing care, when					
	appropriate, as fol						
		and content of inservice					
		ning programs shall be in					
		ne skills and knowledge of					
	the facility personr	nel. For nursing personnel,					
					<u> </u>		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	3	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.

Page 1 of 15 State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ì í	LDING	nstruction <u>00</u>	(X3) DATE COMPL 05/11 /	ETED
SETTLE	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3304 MONROE ST LA PORTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	inservice per cale hours of inservice nonnursing person (2) In addition to to inservice hours, so residents shall had hours of dementia (6) months and the thereafter to meet or both, of cognitive effectively and to current standards dementia. (3) Inservice reconshall indicate the fet (A) The time, date (B) The name of the (D) The names of (E) The program of the employee will be by written signature Based on record reconstruction facility failed to ensanual inservices we and Dementia were members reviewed. The employee will be an ensanual inservices we and Dementia were members reviewed. Review of the emplor on 5/11/21 at 9:00 at 1. QMA 1 was hire completed 2.25 hours of Dementia year. The staff merital construction in the staff merital construction.	the above required taff who have contact with we a minimum of six (6) aspecific training within six ree (3) hours annually the needs or preferences, wely impaired residents gain understanding of the of care for residents with reds shall be maintained and following: a, and location. The instructor. The participants. Content of inservice. I acknowledge attendance receive and interview, the sure the required personnel which included Resident Rights completed for 3 of 5 staff (QMA 1, CNA 1, and Cook	R 012	20	Submission of this response at Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiency was correctly cited, and is also NOT to be construted as an admission against interest by the facility, or any employed agents, or other individuals which are defined as an admission of Correction. In addition, preparation and submission of Correction and submission of Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts	gal ists ed est es, no n	06/04/2021

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 2 of 15

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2021
ROVIDER OR SUPPLIER		3304 N	ADDRESS, CITY, STATE, ZIP CODE MONROE ST RTE, IN 46350	
SUMMARY S (EACH DEFICIEN REGULATORY OR 2. CNA 1 was hire not complete any or Dementia or Reside 2020 calendar year. 3. Cook 1 was hire not complete any or Dementia or Reside 2020 calendar year. Interview with the 29:30 a.m., indicated	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Id on 12/24/17. The CNA did If the required yearly hours of ent Rights training for the Id on 6/22/17. The Cook did If the required yearly hours of ent Rights training for the			ency. Iliance sident r QMA nual ent g for e sure ues will Care quired s, nd 021. s vill for 5 ur eks, to annual The QI sary
			compliance. Monitoring will ongoing.	be

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 3 of 15

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING On		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/11/2021
			_		03/11/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
05771.5				MONROE ST	
SETTLE	RS PLACE		LA POI	RTE, IN 46350	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETION PRIATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				Completion date: June 10,	
				On 05/11/2021 based on re	
				review and interview, the fa	
				failed to ensure the require	
				personnel annual in-service	
				which included Residents F and Dementia were not	Nigritis
				completed for 3 of 5 staff	
				members reviewed (QMA-1	1.
				CNA-1, and Cook-1). QMA	
				hired on 04/26/12. The QM	
				completed 2.25 hours of re	•
				annual 3 hours of Dementia	
				training for the 2020 calend	lar
				year. The staff member als	
				not complete the required a	nnual
				Resident Rights training. C	NA-1
				was hired on 12/24/17. The	CNA
				did not complete any of the	
				required annual hours of	
				Dementia or Resident Righ	
				training for the 2020 calend	lar
				year. Cook-1 was hired on	
				06/22/17. The Cook did not	
				complete any of the require	
				annual hours of Dementia	
				Resident Rights training for 2020 calendar year. Intervi	
				with the Administrator on	5VV
				05/11/2021 at 9:30 a.m. inc	dicated
				the staff did not complete the	
				required annual in-services	
				the 2020 calendar year.	
				410 IAC 16.2-5-1.4(e)(1-3)	
				There shall be an organized	
				in-service education and tra	
				program planned in advance	
				all personnel in all departm	ents at

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 4 of 15

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLET	
			B. WING		05/11/20)21
NAME OF P	DOMDED OF GURDANE		STREET	ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF P	ROVIDER OR SUPPLIEF	t .	3304 M	ONROE ST		
SETTLEF	RS PLACE			RTE, IN 46350		
(X4) ID	SIIWWADV S	TATEMENT OF DEFICIENCIES	ID	<u> </u>	T	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC	TION	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
IAG	REGULATORT OR	LESC IDENTIF TING INFORMATION)	IAG	least annually. Training s	hall	DATE
				include, but not limited to		
				residents rights, prevention		
				control of infection, fire	on and	
				prevention, safety, accide	ant	
				prevention, the needs of	, iii	
				specialized populations s	erved	
				medication administration		
				nursing care, when appro		
				as follows:	F,	
				(1) The frequency and co	ontent of	
				education and training pr		
				shall be in accordance wi	-	
				skills and knowledge of the		
				personnel. For nursing pe	-	
				this shall include at least		
				of in-service per calendar	` '	
				and four (4) hours in-serv	-	
				calendar year for nonnurs	·	
				personnel.		
				(2) In addition to the abo	ve	
				required in-service hours	staff	
				who have contact with re-	sidents	
				shall have a minimum of	six (6)	
				hours of dementia-specifi		
				training within (6) months		
				three (3) hours annually t	hereafter	
				to meet the needs or pref	, ,	
				or both, of cognitively imp		
				residents effectively and	•	
				understanding of the curr		
				standards of care for resi	dents	
				with dementia.		
				(3) Inservice records sha		
				maintained and shall indi	cate the	
				following:		
				a) The time, date, and I		
				b) The name of the inst		
				c) The title of the instru		
				d) The names of the pa	rticipants	

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 5 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/11/2021	
	PROVIDER OR SUPPLIER		3304 N	ADDRESS, CITY, STATE, ZIP CODE MONROE ST PRTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				e) The program content of in-service The employee will acknowled attendance by written signature	
R 0144	410 IAC 16.2-5-1.	, ,			
Bldg. 00	a state of good reland shall provide residents. Based on observation failed to maintain a environment, which related to stained and the facility. Findings include: During the Environ 8:35 a.m. with the Mollowing was observation. There were numero foyer area, resident lounge. The carpet well. Interview with the Mollowing with the Mollowing was observation.	all be clean, orderly, and in pair, both inside and out, reasonable comfort for all on and interview, the facility clean and orderly a was in a state of good repair, and frayed carpet throughout	R 0144	Submission of this response at Plan of Correction is NOT a leadmission that a deficiency exor, 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 employed agents, or other individuals with drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission or 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 a conclusions set forth in this allegation by the survey agence R144 Sanitation and Safety Standards-Deficiency	gal cists ed est es, no n f this
				1.Identified stained carpet w be cleaned by Maintenance T	

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 6 of 15

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u></u>				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
SETTLEF	RS PLACE			IONROE ST RTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				on 05/28/2021. Carpet in need replacement will be replaced by 06/08/2021. 2.An inspection of the community was completed by Executive Director and Region Director of Facilities on 5/21/2 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 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, biweek for four weeks, then monthly frome month to ensure sanitation and safety standards are met. QI committee will determine if continued auditing is necessal based on 3 consecutive month compliance. Monitoring will be ongoing. Completion date: June 10, 2020 On 05/11/2021 based on observation and interview, the facility failed to maintain a clear and orderly environment, which was in a state of good repair, related to stained and frayed carpet throughout the facility. There were numerous stains of the property of the property of the facility. There were numerous stains of the property of the property of the facility. There were numerous stains of the property of the property of the facility. There were numerous stains of the property of the prope	the hall 1021 The has of the hall 21 The has of the hall 21 The hall 21 The hall 31 The hall 32 The hal			

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 7 of 15

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2021
	ROVIDER OR SUPPLIER		3304 M	ADDRESS, CITY, STATE, ZIP CODE IONROE ST RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				the carpets in the foyer area, resident hallways, and the malounge. The carpet was frayed many areas as well. Interview with the Maintenance superviate the time, indicated the facility was scheduled for new carper prior to COVID-19, however the was placed on hold. 410 IAC 16.2-5-1.5(a)- The facility shall be clean, orderly, in a state of good repair, both inside and out, and shall provinces onable comfort for all residents.	d in sor ity t that
R 0349 Bldg. 00	on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on record rev facility failed to ma records related to of for steri strips (thin incisions or minor of wound together as i of 2 closed records Finding includes:	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as umented. sible.	R 0349	Submission of this response at Plan of Correction is NOT a leadmission that a deficiency exor, that this Statement of Deficiency was correctly cited and is also NOT to be construas an admission against interruby the facility, or any employe agents, or other individuals will drafted or may be discussed if the Response and Plan of	egal kists , ded est ess, ho

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 8 of 15

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE S COMPL 05/11/	ETED
	PROVIDER OR SUPPLIEF	t	3304 M	ADDRESS, CITY, STATE, ZIP COI MONROE ST RTE, IN 46350	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	were not limited to, renal cell cancer, hy anxiety. Nurses' Notes, date indicated the reside in the doorway near lost her balance and the call string, but of was noted to the left cleaned with normal applied. The area who bandage and secure physician was notified. There was no Physistrips on the resident treatment order obtaining the call of the call strips and a bandage and secure physician was notified.	b.m. Diagnoses included, but high blood pressure, anemia, pothyroidism, insomnia, and d 4/28/21 at 5:30 p.m., and the was observed on the floor of her walker. She stated she lefell, crawled to try and pull could not reach it. A skin tear of elbow. The skin was all saline and 3 steri strips were was covered with a non stick d with roller gauze. The field. Cian's Order to place the steri and there was no sained for the skin tear. E Service Manager on 5/11/21 ated she was unaware they Physician's Order for steri e to cover the skin tear. Ers for any treatment of the		Correction. In addition, preparation and submiss Plan of Correction does constitute an admission agreement of any kind be facility of the truth of any alleged or the correctness conclusions set forth in the allegation by the survey R349 Clinical Records-Noncompliant Plan of Correction: 1.Resident 8 suffered in negative outcomes related these findings. 2.An audit of current records will be complete 6/4/2021 by the Care See Manager and/or designed ensure all records are act regarding physician order issues identified will be consumed as necessary. 3.The Care Services Movilla provide re-education Licensed Nurses on main complete clinical records including obtaining physician orders as required by 6/4. The Care Services Movilla provides as required by 6/4.	NOT or y the r facts ss of any his agency. ce no ed to esident d by ervices ee to ccurate ers. Any corrected Manager to the ntaining s, ician 4/2021. Manager ned ervices ee, will weekly y for four one te clinical	

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
			D. WING		05/11/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				MONROE ST	
SETTLEF	RS PLACE		LA POI	RTE, IN 46350	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				committee will determine if continued auditing is necess	on/
				based on 3 consecutive mon	•
				compliance. Monitoring will be	
				ongoing.	
				Completion date: June 10, 2	
				On 05/10/2021 based on red	
				review and interview, the fac	ility
				failed to maintain complete clinical records related to	
				obtaining a Physician's Orde	or for
				steri-strips (thin adhesive	101
				bandages used for incisions	or
				minor cuts to keep the edges	
				the wound together as it hea	
				for a skin tear on 1 of 2 close	•
				records reviewed. Closed re-	cord
				for Resident 8 was reviewed	at
				1:50p.m. Nurses' notes, date	ed
				04/28/2021 at 5:30p.m. indic	
				the resident was observed of	
				floor in the doorway near her	
				walker. She stated she lost h	
				balance and fell, crawled to t	- I
				and pull the call string, but co	Julu
				noted on the left elbow. The	skin
				was cleaned with normal sal	
				and 3 steri-strips applied to	
				wound. The area was covered	ed
				with a nonstick bandage and	<i>!</i>
				secured with roller gauze. Th	ne
				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	
			I		

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 10 of 15

PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
			B. WIN	lG		05/11/	/2021
				CED FEE	ADDRESS OF THE STREET STREET		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
OFTTI F					ONROE ST		
SETTLE	RS PLACE			LA POF	RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
					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 obtai	n a	
					Physician's Order for steri-stri	ps	
					and a bandage to cover the sl	kin	
					tear.		
					410 IAC 16.2-5-8.1(a)(1-4) – T	he	
					facility shall maintain clinical	110	
					records on each resident. The	se	
					records must be maintained u		
					the supervision of an employe		
					the facility designated with tha		
					responsibility. The records mu		
					be as follows:		
					1) Committee		
					1) Complete		
					2) Accurately documented		
					3) Readily accessible4) Systematically organized		
					3ysternatically organized		
R 0407	410 IAC 16.2-5-1 Infection Control	. , . ,					
Bldg. 00		- Noncompliance ust establish an infection					
Blug. 00	. ,	that includes the following:					
		enables the facility to					
		of known infectious					
	symptoms.	of Miowif Infododo					
		ntation and in-service					
	' '	ection prevention and					
		universal precautions.					
	_	h information to residents,					
	· , ,	: limited to, infection					
	transmission and						
		mmunicable disease to					
	public health auth						
		ion, record review, and	R 04	07	Submission of this response a	ınd	06/10/2021

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 11 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
			B. WING			05/11/	/2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
OETTI EI					ONROE ST		
SETTLE	RS PLACE			LA POF	RTE, IN 46350		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROP	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	interview, the facili	ty failed to ensure infection			Plan of Correction is NOT a le	gal	
	control guidelines v	were in place and			admission that a deficiency ex	ists	
	implemented, inclu	ding those specific to			or, that this Statement of		
	properly prevent an	d/or contain COVID-19,			Deficiency was correctly cited,		
	related to the lack of	of documentation of screening			and is also NOT to be constru	ed	
	visitors, personal pr	rotective equipment (PPE)			as an admission against intere	est	
	not worn at all with	resident interaction, staff			by the facility, or any employee	es,	
	wearing cloth face	masks, wearing gloves in the			agents, or other individuals wh	10	
	hallway, and donning	ng gloves from a shirt pocket			drafted or may be discussed ir	า	
	for random observa	tions for infection control			the Response and Plan of		
	throughout the facil	lity and for 1 of 5 residents			Correction. In addition,		
	during medication pass. (Resident 9)				preparation and submission of	this	
					Plan of Correction does NOT		
	Findings include:				constitute an admission or		
					agreement of any kind by the		
	1. Upon entering th	e facility on 5/10/21 at 8:40			facility of the truth of any facts		
	a.m., Housekeeper	1 opened the locked door. At			alleged or the correctness of a	iny	
	that time, she was v	vearing a pair of disposable			conclusions set forth in this		
	gloves to both hand	ls. LPN 1 greeted the			allegation by the survey agend	y.	
	-	or and took the temperatures			R407 Infection Control –		
	-	She did not document the			Noncompliance		
		LPN opened the visitor					
	_	realized there were no extra			Plan of Correction:		
		e proceeded to ask the					
		neously) the questions,			1.Resident 9 suffered no		
		ot document any of the			negative outcomes related to		
		hered. At that time, the LPN			these findings.		
		n face mask over her mouth			2.Care Service Manager will		
	and nose.				conduct an infection control au		
					by 06/4/2021 of current staff to)	
	_	n observation on 5/10/21 at			include required screening of		
		eper 1 was observed in the			visitors, personal protective		
	_	earing a pair of blue			equipment worn as required,		
	disposable gloves to both hands. She was				appropriate mask wear, and		
		vacuum cleaner. She was not			appropriate glove usage.		
	wearing a face shie	Id over her face.			Identified concerns will be		
					corrected at time of discovery	as	
		sekeeper 1 at that time,			necessary.		
		not normally wear a face			3.Care Service Manager will		
	shield while cleanir	ng resident rooms. She			provide re-education to curren	t	

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 12 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WING		05/11/2021		
							2021
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVIVIL OF I	KO VIDEK OK SCI I EIEI			3304 M	IONROE ST		
SETTLERS PLACE				LA POF	RTE, IN 46350		
					,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	always wears gloves while cleaning and doing				staff on ensuring infection con	trol	
	everything when in the facility in resident rooms				guidelines are in place and		
	and out in the hall. She indicated she frequently changed them, however, she wears them all the time.				implemented to properly preve	ent	
					and/or contain COVID-19 related		
					to staff, residents, and visitors		
					Training will include donning and		
	2.5	5/10/01			_	na	
	3. During a random observation on 5/10/21 at				doffing proper PPE,		
	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				documentation of screening		
					visitors, and appropriate mask		
					wear for staff.		
					4.Executive Director is		
	face. The LPN was within 6 feet of the resident.				responsible for sustained		
					compliance. Care Service		
	Interview with LPN 1 at that time, indicated she			Manager and/or designee will			
	was unaware she was not supposed to wear a			audit 3 staff members to ensure			
	cloth face mask. She was unaware she needed to		infection control guidelines are in place and implemented to properly				
	wear a face shield when within 6 feet of residents.				1 -	-	
					prevent and/or contain COVID	-19	
					related to staff, residents, and		
		44 a.m., 2 hospice nurses			visitors five times per week for		
	· ·	After being screened, they			four weeks, then three times p		
	both went over to the	ne resident they were there to			week for four weeks, then one		
	see. Each one of th	em had a face mask on,			time per week for four weeks.		
	however, neither or	ne was wearing a face shield.			Audit results will be reviewed		
	Both nurses were w	vithin 6 feet of the resident.			monthly in QI meetings and Q	l	
					Committee will determine in		
	5. During a randon	n observation on 5/10/21 at			continued auditing is necessar	v	
	_	was observed taking residents'			based on three consecutive	,	
	· ·	<u>c</u>					
	temperature with the thermometer. She was not			months of compliance.			
	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				Monitoring will be ongoing.		
					Completion date: June 10, 202	<u> </u>	
					On 05/10/2021 based on		
					observation, record review, an	d	
					interview, the facility failed to		
					ensure infection control		
	provide essential di	rect care within 6 feet of the			guidelines were in place and		
	resident, regardless of COVID-19 status, when				implemented, including those		
	there is moderate to substantial (high)						
uiere is moderate to substantiai (iligii)					specific to properly prevent		

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 13 of 15

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		B. WING			05/11/2021		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
05771.51	DO DI 405				ONROE ST		
SETTLERS PLACE			LA PORTE, IN 46350				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID) PROVIDENCE N. AN OF CONDECTION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		TC .	COMPLETION
TAG				TAG	DEFICIENCY)	16	DATE
	community transmission. If the county positivity				and/or contain COVID-19,relat		
	-	oderate or high substantial			to the lack of documentation of		
	community transmission then eye protection should be used for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status."				screening visitors, personal		
					protective equipment (PPE) not worn at all with resident		
					interaction, staff wearing cloth		
					_	ho	
	As of 5/10/21 the co	ounty positivity rate was			face masks, wearing gloves in he		
	11.1%	- ^			hallway, and donning gloves from		
					a shirt pocket or random		
	Interview with the Care Service Manager (CSM) on 5/11/21 at 10:00 a.m., indicated she was				observations for infection cont	-	
					throughout the facility and for	1 of	
	aware staff were to wear the face shield when			5 residents during medication			
	within 6 feet of the residents, however, since all				pass (Resident 9)		
	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						
					410 IAC 16.2-5-12(b)(1-4) Infection Control – The facility		
					must establish an infection cor	ntrol	
		_			program that includes the		
	surveyors entered, as LPN 1 asked her for more sheets for the book.				following:		
	6. On 5/10/21 at 12	2:00 p.m., LPN 1 was			A system that enables the facility to analyze patterns of		
		medication for Resident 9.					
		ident's room and administered			known infectious symptoms		
		e resident indicated she was			 Provide orientation and 		
		I her ear was hurting. The			in-service education on infection	on	
	_	of gloves out of her shirt			prevention and control, includi	ng	
		them to each hand. She			universal precautions.		
		nt's right ear and removed a			 Offering health information 	n	
	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				to residents, including, but not		
					limited to, infection transmission	on	
					and immunization.		
	medication cart.				 Reporting communicable 		
	modelation curt.				diseases to public health		
	Interview with I PN	V 1 on 5/10/21 at 1:45 p.m.,			authorities.		
	indicated she keeps gloves in her pockets in case						
	_	hen she entered a resident					
		hat were in her pocket were					
	from the medication room and she had placed						
	them there earlier in the day.						

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 14 of 15

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2021	
NAME OF PROVIDER OR SUPPLIER SETTLERS PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3304 MONROE ST LA PORTE, IN 46350			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
			I				

State Form Event ID: 95WF11 Facility ID: 004458 If continuation sheet Page 15 of 15