PRINTED: 05/15/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u> COMP			ETED	
			B. WING 04/23/2025			/2025	
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ONROE ST		
TRUSTW	ELL LIVING AT SE	ETTLERS PLACE			RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	This visit was for a Survey.	State Residential Licensure	and		Submission of this response and Plan of Correction is NOT a legal admission that a		
	Survey dates: April 22 and 23, 2025				deficiency exists or, that this statement of deficiency was		
	Facility number: 004458				correctly cited, and is also N to be construed as an	ОТ	
	Residential Census	: 33			admission against interest by the facility, or any employees	-	
	These State Reside	ntial Findings are cited in			agents, or other individuals		
	accordance with 41	0 IAC 16.2-5.			who drafted or may be		
	Quality review con	npleted on 4/28/25.			discussed in the Response at Plan of Correction. In addition preparation and submission this Plan of Correction does NOT constitute an admission agreement of any kind by the facility of the truth of any facility of the correctness of any conclusions set forth in allegation by the survey agency.	n, of or e ts	
R 0349 Bldg. 00	410 IAC 16.2-5-8 Clinical Records -						
39.	failed to maintain of accurately document orders for 1 of 7 rest (Resident 7) Finding includes: Closed record revise	view and interview, the facility clinical records that were need per policy related to diet sident records reviewed.	R 03	349	Submission of this response and Plan of Correction is NO legal admission that a deficiency exists or, that this statement of deficiency was correctly cited, and is also N to be construed as an admission against interest by the facility, or any employees	T a OT	04/25/2025
	-	25 at 11:11 a.m. The resident 5/25. Diagnoses included, but			agents, or other individuals who drafted or may be		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Debbie Tanksley Executive Director 05/08/2025

Any define revetatement ending with an asterick (*) denotes a deficency which the institution may be excused from correcting providing it is determine

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/23/2025			
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD				
TRUSTWELL LIVING AT SETTLERS PLACE				3304 MONROE ST LA PORTE, IN 46350				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE			
1710		high blood pressure,	ind	discussed in the Response	DATE			
	rheumatoid arthritis	, and bipolar disorder.		Plan of Correction. In additi	•			
	A Physician Plan of	f Care, dated 3/5/25, contained		preparation and submission this Plan of Correction does				
	a Diet Information	Sheet, however there was		NOT constitute an admission				
	_	d for what type of diet the rive while a resident at the		agreement of any kind by the				
	facility.	aresident at the		facility of the truth of any fa				
	,			any conclusions set forth in				
		a.m., the Director of Health and ed of the lack of diet orders		allegation by the survey				
	and had no informa			agency.				
		•		R349 Clinical				
		p.m., the Director of Health and a Physician Plan of Care, dated		Records-Noncompliance				
	•	Diet Information Sheet filled		What corrective action(s) w	ill			
		iet selected for the resident.		be accomplished for those				
		alled the physician's office ed of the lack of diet orders for		residents found to have been affected by the deficient	en			
		y faxed over the Physician		practice;				
	Than of Care.			Resident #7suffered no nega	itive			
				outcomes related to this findi	•			
				The Physician Plan of Care was updated immediately with the				
				order and signed by the Phys				
				and placed in the chart.				
				Completed 4/23/25.				
				How the facility will identify	,			
				other residents having the potential to be affected by t	he			
				same deficient practice and	•			
				what corrective action will I	oe e			
				taken;				
				No resident suffered any neg	gative			
				consequences related to this				
				finding. To ensure that no oth residents will be impacted by				
				1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING	COMPLETED 04/23/2025
	PROVIDER OR SUPPLIER VELL LIVING AT SETTLERS PLACE	STREET ADDRESS, CITY, STATE, ZIP COI 3304 MONROE ST LA PORTE, IN 46350)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO	CROSS-REFERENCED TO THE APP	CTION (X5) JLD BE COMPLETION ROPRIATE DATE
		deficient practice the Hesservice Director complete audit on 4/24/2025 and 2 all current residents, to est that all diet orders are prodocumented and signed physician/Nurse Practitic There were no other resist were affected by this definition practice. What measures will be place or what systemic changes the facility will to ensure that the deficing practice does not recurred to the following practice does not recurred to making sunew admissions have a physician/NP signed diet. Upon each new resident admission, the Health Secure that the Physician complete and orders are documented a by the Physician. How the corrective activities will be monitored to ensure the deficient practice will in recur, i.e., what quality assurance program will into place; and The Health Services Director are resident practices.	ed a chart 4/25/25, of ensure operly by their oner. dents who icient put into make ient ; ctor a 4/24/25 he re that all corder. ervice earts to ician Plan the diet and signed put the ot be put

State Form Event ID: DYL411 Facility ID: 004458 If continuation sheet Page 3 of 10

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• •		X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		B. WING 04/23/2025				2025	
	PROVIDER OR SUPPLIER			3304 M	ADDRESS, CITY, STATE, ZIP COD ONROE ST RTE, IN 46350		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
R 0354	410 IAC 16.2-5-8.	1(a)(1-7)			for sustained compliance. Upon each new resident admission, Health Service Director complian audit on 4/25/25, of all chart to make sure that the Physician Plan of Care is completed and diet orders are documented an signed by the Physician. In addition, The Health Service Director will monitor all of the resident's diet orders, for any changes, each week for a morthen bi-weekly for a month to ensure complete medical reco are maintained. Monitoring will on going. The QI committee with determine if continued auditing necessary based on three more of consecutive compliance. By what date the systemic change will be completed. Completed date: 4/25/25	the eted ts n the and atth, n rds I be ill g is atths	
	Clinical Records -						
Bldg. 00	failed to ensure a tracompleted for 2 of (Residents 5 and 7) Findings include: 1. Record review for	r Resident 5 was completed on . Diagnoses included, but were	R 0.	354	Submission of this response and Plan of Correction is NO legal admission that a deficiency exists or, that this statement of deficiency was correctly cited, and is also N 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 a	T a OT y s,	04/25/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COMPLETE			COMPLETED	
		B. WING 04/23/2025			04/23/2025	
				CTREET	ADDRESS CITY STATE ZIR COD	
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	
TOLIOTIA	/ELL LIV/INO AT OF	TTI EDO DI AOE			IONROE ST	
IRUSIW	ELL LIVING AT SE	TILERS PLACE		LA POF	RTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(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 OF	LSC IDENTIFYING INFORMATION		TAG	DATE	
	A Service Plan, date	ed 1/3/25, indicated the			Plan of Correction. In addition	on,
	resident had not had	d any cognitive decline. He			preparation and submission	of
		vith transfers, showers,			this Plan of Correction does	
		ce, and wound care by staff in			NOT constitute an admission	n or
	conjunction with ho				agreement of any kind by the	-
					facility of the truth of any fac	
	A Nurses' Note dat	ed 4/7/25 at 3:52 p.m.,			alleged or the correctness of	II.
		nt was sent out for evaluation			any conclusions set forth in	
		nfusion, the Power of			allegation by the survey	uns
		s providing transportation.			I	
	Attorney (1 OA) wa	is providing transportation.			agency.	
	A Nurses' Note, dat	red 4/8/25 at 6:40 a.m.,			R354 Clinical	
		was contacted to check on the			Records-Noncompliance	
		pointment went. The POA			Necords Noncompilation	
		that the resident was admitted			What corrective action(s) wil	.
		a urinary tract infection.	be accomplished for those			'
	to the hospital with	a dimary tract infection.			residents found to have been	
	A Nurses' Note dat	red 4/11/25 at 4:10 p.m.,			affected by the deficient	'
		nt returned to facility via			practice;	
	family car.	nt returned to facility via			practice,	
	laminy car.				Resident 5 and Resident 7	
	The record looked t	ransfer/discharge paperwork			suffered no negative outcome	
	sent to the resident				related to this finding. Resider	
	sent to the resident	and/of 1 OA.			was provided with discharge/	11.5
	Dramin a an intanziar	2 on 4/22/25 at 2:00 m m tha				
		on 4/23/25 at 3:00 p.m., the and Wellness indicated she			transfer paperwork on 4/25/25	
					the referenced hospital transfer	₹I.
		any transfer/discharge			Resident 7 was contacted on	
	paperwork that was	sent.			04/24/2025and the POA was	4
					verbally informed of the reside	
	2.01	. C. D. :1 7			discharge/transfer paperwork	via
		view for Resident 7 was			phone. She verbalized	
		25 at 11:11 a.m. The resident			understanding and declined a	
		5/25. Diagnoses included, but			physical copy of the paperwor	K.
		high blood pressure,				
	rheumatoid arthritis	, and bipolar disorder.			How the facility will identify	
		1 0 111			other residents having the	
		he facility on 4/22/25 indicated			potential to be affected by the	ie
	Resident 7 had disc	harged home with family.			same deficient practice and	
					what corrective action will be	e
	There was no documentation in the resident's				taken;	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2025	
	PROVIDER OR SUPPLIE VELL LIVING AT S		3304 1	FADDRESS, CITY, STATE, ZIP COD MONROE ST DRTE, IN 46350	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF The date of discharge assessments, instruction of the discharge assessments are discharge. During an interview Director of Health resident had discharge was only at the face	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION arge, including but not limited harge, any transfer/discharge actions, or reason for w on 4/23/25 at 3:47 p.m., the and Wellness indicated the arged home with family as she ility for a short respite stay, but any documentation related to	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The Health Service Directed audited all of the current residents, on 4/24/25 and 4/25/2 identify any other residents we have been sent to the hospital and/or discharged to verify if individual received discharge/transfer paperwork other residents were affected the same deficient practice. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health Services Direct provided an Inservice to all N and QMAs, on 04/24/2025, all the importance of sending our discharge/transfer paperwork all residents sent to the hospital or get them to the POA, for resident that were outside of the building when sent to the hospital. This includes residents who are discharged home or to another facility. The Inservice included education on proper documentation to make sure all discharged residents have thorough discharge summary documented.	DATE DATE OF dent 5, to ho il the . No by nto se tor urses bout t with tal, ge giving s ng s er d that a
				How the corrective action(s)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		f /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		B. WING 04/23/202				2025		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3304 MONROE ST LA PORTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CR	he ut ce nd	(X5) COMPLETION DATE	
R 0356 Bldg. 00	failed to ensure the complete resident in records reviewed. (I Findings include:		R 0.	356	Submission of this response and Plan of Correction is NO legal admission that a deficiency exists or, that this statement of deficiency was correctly cited, and is also N to be construed as an admission against interest b	T a	04/29/2025	

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PRINTED: 05/15/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/23/2025	
	PROVIDER OR SUPPLIE		3304 N	address, city, state, zip coi IONROE ST RTE, IN 46350)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) JUD BE COMPLETION COMPLETION DATE
	physician contact is contact/Power of A b. Resident 5 was is and physician contact. c. Resident 6 was is and physician contact. During an interview Director of Health	nissing a hospital preference, information, and emergency attorney contact information. missing a hospital preference act information. missing a hospital preference		the facility, or any emplagents, or other individed who drafted or may be discussed in the Responsal Plan of Correction. In an apreparation and submissions this Plan of Correction of NOT constitute an admit agreement of any kind of facility of the truth of an alleged or the correction any conclusions set for allegation by the survey agency. R356 Clinical Records-Noncompliance What corrective action (above accomplished for the residents found to have affected by the deficient practice; Resident 2, Resident Resident 6 suffered no noutcomes related to this The hospital preference updated on the face sheep placed in the Emergency and resident charts on 4/4 through 4/29/25. How the facility will idea other residents having appotential to be affected same deficient practice what corrective action was accomplished for the facility will idea other residents having appotential to be affected same deficient practice what corrective action was accomplianted to the facility will idea other residents having appotential to be affected same deficient practice what corrective action was accomplished for the facility will idea other residents having appotential to be affected same deficient practice what corrective action was accomplished for the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility will idea other residents having appointment of the facility of the facility of the facility of the facility of t	nse and ddition, sision of does sision or by the hy facts ess of the in this of the sision of the interest of

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PRINTED: 05/15/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 04/23/2025
	ROVIDER OR SUPPLIER		3304 M	ADDRESS, CITY, STATE, ZIP COD ONROE ST RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 Health Service Director at Executive Directory completed audit on the Emergency Binds 4/24/25. All residents' new updated face sheets with the updated hospital preference will placed in the Emergency Binds on 4/24/25 through 4/29/2025. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health Services Direct will audit each new admission clinical record to make sure that all preferences are updated or face sheet and a copy is immediately placed in the emergency binder. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; and The Health Services Direct and Executive Director are responsible for sustained compliance. The Health Service Director will complete an audit the Emergency Binder weekly a month. Bi-weekly for a month. Monitoring will be ongoing. The committee will determine if	d an er on e

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUII B. WIN	LDING	INSTRUCTION 00	(X3) DATE COMPL 04/23 /	ETED
NAME OF PROVIDER OR SUPPLIER TRUSTWELL LIVING AT SETTLERS PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 3304 MONROE ST LA PORTE, IN 46350			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					continued auditing is necessar based on three months of consecutive compliance.	ту	
					By what date the systemic changes will be completed.		
					Completion date: 04/29/25		

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