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	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRUSTWELL LIVING AT SETTLERS PLACE	3304 MONROE ST LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: April 22 and 23, 2025 Facility number: 004458 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/28/25.	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 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to maintain clinical records that were accurately documented per policy related to diet orders for 1 of 7 resident records reviewed. (Resident 7) Finding includes: Closed record review for Resident 7 was completed on 4/22/25 at 11:11 a.m. The resident was admitted on 3/5/25. Diagnoses included, but	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**	04/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie Tanksley	Executive Director	05/08/2025

Any defiencystatement 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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	were not limited to, high blood pressure, rheumatoid arthritis, and bipolar disorder. A Physician Plan of Care, dated 3/5/25, contained a Diet Information Sheet, however there was nothing documented for what type of diet the resident was to receive while a resident at the facility. On 4/23/25 at 10:40 a.m., the Director of Health and Wellness was notified of the lack of diet orders and had no information to provide. On 4/23/25 at 3:47 p.m., the Director of Health and Wellness provided a Physician Plan of Care, dated 3/5/25, that had the Diet Information Sheet filled out with a regular diet selected for the resident. She indicated she called the physician's office after she was notified of the lack of diet orders for the resident and they faxed over the Physician Plan of Care.		**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.** **R349 Clinical Records-Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #7suffered no negative outcomes related to this finding. The Physician Plan of Care was updated immediately with the diet order and signed by the Physician and placed in the chart. Completed 4/23/25. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** No resident suffered any negative consequences related to this finding. To ensure that no other residents will be impacted by the	

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			deficient practice the Health Service Director completed a chart audit on 4/24/2025 and 4/25/25, of all current residents, to ensure that all diet orders are properly documented and signed by their physician/Nurse Practitioner. There were no other residents who were affected by this deficient practice. **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 Service Director completed in-services on 4/24/25 with the floor nurses on the importance of making sure that all new admissions have a physician/NP signed diet order. Upon each new resident admission, the Health Service Director will audit the charts to make sure that the Physician Plan of Care is complete and the diet orders are documented and signed by the Physician. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Health Services Director and Executive Director are responsible	

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			for sustained compliance. Upon each new resident admission, the Health Service Director completed an audit on 4/25/25, of all charts to make sure that the Physician Plan of Care is completed and the diet orders are documented and 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 month, then bi-weekly for a month then once a month for a month to ensure complete medical records are maintained. Monitoring will be on going. The QI committee will determine if continued auditing is necessary based on three months of consecutive compliance. By what date the systemic changes will be completed. **Completed date: 4/25/25**	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 2 of 7 resident records reviewed. (Residents 5 and 7) Findings include: 1. Record review for Resident 5 was completed on 4/22/25 at 2:26 p.m. Diagnoses included, but were not limited to, Parkinson's disease and schizophrenia.	R 0354	**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**	04/25/2025

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	A Service Plan, dated 1/3/25, indicated the resident had not had any cognitive decline. He needed assistance with transfers, showers, medication assistance, and wound care by staff in conjunction with home health services. A Nurses' Note, dated 4/7/25 at 3:52 p.m., indicated the resident was sent out for evaluation due to increased confusion, the Power of Attorney (POA) was providing transportation. A Nurses' Note, dated 4/8/25 at 6:40 a.m., indicated the POA was contacted to check on the how the doctor's appointment went. The POA informed the caller that the resident was admitted to the hospital with a urinary tract infection. A Nurses' Note, dated 4/11/25 at 4:10 p.m., indicated the resident returned to facility via family car. The record lacked transfer/discharge paperwork sent to the resident and/or POA. During an interview on 4/23/25 at 3:00 p.m., the Director of Health and Wellness indicated she was unable to find any transfer/discharge paperwork that was sent. 2. Closed record review for Resident 7 was completed on 4/22/25 at 11:11 a.m. The resident was admitted on 3/5/25. Diagnoses included, but were not limited to, high blood pressure, rheumatoid arthritis, and bipolar disorder. A list provided by the facility on 4/22/25 indicated Resident 7 had discharged home with family. There was no documentation in the resident's		**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.** **R354 Clinical Records-Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 5 and Resident 7 suffered no negative outcomes related to this finding. Resident 5 was provided with discharge/ transfer paperwork on 4/25/25, for the referenced hospital transfer. Resident 7 was contacted on 04/24/2025and the POA was verbally informed of the resident discharge/transfer paperwork via phone. She verbalized understanding and declined a physical copy of the paperwork. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	

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	record of the discharge, including but not limited to, the date of discharge, any transfer/discharge assessments, instructions, or reason for discharge. During an interview on 4/23/25 at 3:47 p.m., the Director of Health and Wellness indicated the resident had discharged home with family as she was only at the facility for a short respite stay, but could not provide any documentation related to the discharge.		The Health Service Director audited all of the current resident charts, on 4/24/25 and 4/25/25, to identify any other residents who have been sent to the hospital and/or discharged to verify if the individual received discharge/transfer paperwork. No other residents were affected by the same deficient practice. **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 Director provided an Inservice to all Nurses and QMAs, on 04/24/2025, about the importance of sending out discharge/transfer paperwork with all residents sent to the hospital, including sending the discharge paperwork to the hospital or giving them to the POA, for residents 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 that all discharged residents have a thorough discharge summary documented. **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Health Service Director and Executive Director are responsible for sustained compliance. The Health Service Director will audit all charts, and the documentation of each resident sent out of the community to the hospital or discharged for the next three months. Monitoring will be ongoing. The QI committee will determine if continued auditing is necessary based on three months of consecutive compliance. **By what date the systemic changes will be completed.** Completion date: 04/25/25	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the Emergency Binder had complete resident information for 3 of 5 resident records reviewed. (Residents 2, 5, and 6) Findings include: The resident Emergency Binder was reviewed on	R 0356	**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**	04/29/2025

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	4/23/25 at 10:36 a.m. a. Resident 2 was missing a hospital preference, physician contact information, and emergency contact/Power of Attorney contact information. b. Resident 5 was missing a hospital preference and physician contact information. c. Resident 6 was missing a hospital preference and physician contact information. During an interview on 4/23/25 at 3:00 p.m., the Director of Health and Wellness was made aware of the missing items. No additional information was provided.		**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.** **R356 Clinical Records-Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 2, Resident 5 and Resident 6 suffered no negative outcomes related to this finding. The hospital preference were updated on the face sheets and placed in the Emergency Binders and resident charts on 4/24/25 through 4/29/25. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	

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			The Health Service Director and Executive Directory completed an audit on the Emergency Binder on 4/24/25. All residents' new updated face sheets with the updated hospital preference were placed in the Emergency Binder 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 Director will audit each new admission clinical record to make sure that all preferences are updated on the 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 put into place; and** The Health Services Director and Executive Director are responsible for sustained compliance. The Health Services Director will complete an audit of the Emergency Binder weekly for a month. Bi-weekly for a month then monthly for a month. Monitoring will be ongoing. The QI committee will determine if	

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			continued auditing is necessary based on three months of consecutive compliance. **By what date the systemic changes will be completed.** Completion date: 04/29/25	