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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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: January 2 and 3, 2024 Facility number: 004458 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/9/24.	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 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie Tanksley	Executive Director	01/17/2024

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to affect 28 residents who resided in the facility. Finding includes: The Fire and Disaster Drills were reviewed on 1/3/24 at 9:00 a.m. A fire drill was held every month between January and December 2023. There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months. During an interview on 1/3/24 at 9:30 a.m., the Maintenance Director indicated he thought he reached out to the local fire department in February or March 2023, but he couldn't find any documentation of doing so.	R 0092	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. **R092-Administration and Management-Non compliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	01/25/2024

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			To ensure that no resident is negatively impacted by the deficient practice, the Executive Director will and has scheduled Fire Drills with the local Fire Department to participate together in a fire drill at Settlers Place. **January 25, 2024 at 2:00 pm** will be our first and a second fire drill for the remainder of this year will be **July 25, 2024 at 2:00 at the All Staff Mandatory Meetings**. **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;** The facility will ensure No resident will be negatively affected by this deficient practice as the Executive Director has already scheduled 2 fire drills with the local fire department to participate together with our staff and residents to ensure compliance in accordance with the regulations concerning fire drills with local fire department participation. The local fire department is happy **to participate in by-annual fire drills in future years also**. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			The measures put forward to ensure the deficient practice doesn't recur is as follows: a) The Executive Director has established regular by-annual local fire department drills along with the staff and residents at Settlers Place. We have posted on the calendar to do a drill with them every 6 months to meet regulation for **each calendar by-annual year going forward**. b) The first drill of the year is planned for January 25, 2024 for a 2:00 All Staff meeting with the fire department participation. The second drill will be July 25, 2024 for a second participation for 2024 fire drill at the 2:00 All Staff Mandatory Meeting. **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 corrective action **will be monitored by the Executive Director and the Maintenance Director on our State Survey Follow Up binder monitoring system monthly for 6 months**. **A Fire Drill reminder will be added to our teams State Survey Readiness binder**. The systemic changes to **add the Local Fire Department**	

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			Participation Fire Drill to our State Readiness Binder will be complete by January 21, 2024. Please see attached. **By what date the systemic changes will be completed.** Complete Date: **January 25, 2024** for systemic changes and completed bi-annual drills dates.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered for 1 of 7 records reviewed. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 1/2/24 at 1:56 p.m. Diagnoses included, but were not limited to, brittle diabetes, diabetes mellitus type 2, and dementia. A Physician's Order, dated 10/19/23, indicated the resident's blood sugar (BS) was to be checked before meals and Humalog insulin was to be administered per the following sliding scale: - BS less than 140, no insulin	R 0243	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	01/08/2024

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	- BS 140-154, 1 unit - BS 155-169, 2 units - BS 170-184, 3 units - BS 185-199, 4 units - BS 200-214, 5 units - BS 215-229, 6 units - BS 230-244, 7 units - BS 245-259, 8 units - BS 260-274, 9 units - BS 275-289, 10 units - BS 290-304, 11 units - BS 305-319, 12 units - BS 320-334, 13 units - BS 335-349, 14 units - BS 350-364, 15 units - BS 365-379, 16 units - BS 380-400, 17 units - BS greater than 400, 18 units and call MD The October 2023 Medication Administration Record (MAR) indicated the resident's before breakfast blood sugar on 10/29/23 was 266. No insulin was signed out as being given. On 10/30/23, the resident's before dinner blood sugar was 390. Again, no insulin was signed out as being given. The December 2023 MAR indicated the resident's before breakfast blood sugar on 12/6/23 was 314. The resident received 13 units of insulin rather than 12 units. During an interview on 1/3/24 at 2:15 p.m., the Health and Wellness Director indicated the insulin should have been administered as ordered.		correctness of any conclusions set forth in this allegation by the survey agency. **R243-Health Services-Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #4 suffered no negative outcomes related to this finding. **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;** An audit of current residents was completed by The Health Services Director on 01/11/2024 and there are 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 Service Director completed in-services with the Nurses and QMAs on proper documentation, following physician's orders, insulin administration with return demonstration, medication reconciliation and maintaining	

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			complete clinical records. This was completed on 01/05/2024 and 1/8/2024. **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 Heath Service Director is responsible for sustained compliance. The Health Services Director will audit resident #4 clinical records daily for four weeks, then every other day for a month, then weekly for one month to ensure complete clinical records are maintained. In addition, the Health Services Director will audit 5 resident records weekly for four weeks then bi-weekly for a month then monthly for a month to ensure complete clinical records are maintained. Monitoring will be on going. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. **By what date the systemic changes will be completed.** Completion date: 01/08/2024	
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			

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
	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 ensure clinical records were complete and accurately documented related to monitoring of skin tears for 1 of 7 records reviewed. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 1/2/24 at 1:56 p.m. Diagnoses included, but were not limited to, brittle diabetes, diabetes mellitus type 2, and dementia. Nurses' Notes, dated 10/27/23 at 10:00 p.m., indicated the resident had 2 skin tears to the upper aspect of her left hand. The resident indicated she had hit her hand against the counter while putting groceries away. The skin tears measured 1.3 centimeters (cm) x 0.4 cm and 2.3 cm x 0.2 cm. The next documented entry related to the skin tears was not until 11/1/23. During an interview on 1/3/24 at 1:30 p.m., the Health and Wellness Director indicated follow up documentation should have been completed prior to 11/1/23 regarding the skin tears.	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 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 #4 suffered no negative outcomes related to these findings. **How the facility will identify other residents having the potential to be affected by the**	01/08/2024

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			same deficient practice and what corrective action will be taken; An audit of current residents was completed by The Health Services Director on 01/11/2024 and there are no other residents who 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 Service Director completed in-services with the Nurses and QMAs on proper follow-up, documentation, and maintaining complete clinical records related to resident needs/incidents. This was completed on 01/05/2024 and 1/8/2024. **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 Heath Service Director is responsible for sustained compliance. The Health Services Director will audit 5 residents clinical records daily for four weeks, then bi-weekly for four weeks, then monthly for one month to ensure complete clinical records are maintained and resident incidents are being	

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	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
			documented and monitored. Monitoring will be ongoing. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. **By what date the systemic changes will be completed.** Completion date: 01/08/2024	