PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 01/03/2		ETED		
	PROVIDER OR SUPPLIER		<u>-</u>	3304 M	ADDRESS, CITY, STATE, ZIP COD ONROE ST RTE, IN 46350		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	TE	(X5) COMPLETION DATE
Bldg. 00	Survey. Survey dates: Janua Facility number: 00 Residential Census:	28 atial Findings are cited in 0 IAC 16.2-5.	R 00	000	Submission of this response a Plan of Correction is NOT a legal admission that a deficiency exor, that this statement of deficiency was correctly cited, is also NOT to be construed as admission against interest by the facility, or any employees, age or other individuals who drafte may be discussed in the Response and Plan of Correct In addition, preparation and submission of this Plan of Correction does NOT constitute 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.	gal ists and s an the ents, d or ion. te an	
R 0092 Bldg. 00	disaster prepared continuity of care emergency as follows: (1) Fire exit drills in transmission of a simulation of emergency that the more except that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency and	d Management - at maintain a written fire and mess plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, overwent of nonambulatory areas or to the exterior of required. Drills shall be			TITLE		(X6) DATE

(X6) DATE

Debbie Tanksley **Executive Director** 01/17/2024

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.

State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 1 of 10

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING 00 COMPI B. WING 01/03			ETED		
NAME OF PROVIDER OR SUPPLIER SETTLERS PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 3304 MONROE ST LA PORTE, IN 46350					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Conditions. At least held every year. Whether a p.m. are announcement manaudible alarms. (2) At least every shall attempt to he in conjunction with A record of all train documented with the of the personnel	ay be used instead of six (6) months, a facility old the fire and disaster drill in the local fire department. Ining and drills shall be the names and signatures resent. It iew and interview, the facility that every 6 months, an It hold a fire and disaster drill the local fire department. This affect 28 residents who y. The Drills were reviewed on It every month between January Interview, the facility the local fire department and the local fire ted to participate in at least 1 the local fire ted to participate in at least 1 the local fire department in and the local fire department in 2023, but he couldn't find any	R 0	ID PREFIX TAG	Submission of this response a Plan of Correction against interest by the facility, or any employees, age or other individuals who drafter may be discussed in the Response and Plan of Correction against interest by the facility, or any employees, age or other individuals who drafter may be discussed in the Response and Plan of Correct In addition, preparation and submission of this Plan of Correction does NOT constitute 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;	nd gal ists and s an the ints, d or ion.	(X5) COMPLETION DATE 01/25/2024	

State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 2 of 10

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY LETED 3/2024
NAME OF F	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP	COD	
SETTLE	RS PLACE			RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
IAU	REGULATORY OF	A LOC IDENTIFITING INFURMATION	IAG	To ensure that in negatively impacted to deficient practice, the Director will and has a Fire Drills with the local pepartment to partici in a fire drill at Settler January 25, 2024 at 2 be our first and a sect for the remainder of the July 25, 2024 at 2 All Staff Mandatory III. How the facility will other residents having potential to be affect same deficient pract what corrective action taken; The facility will be negated by this deficient pract executive Director has scheduled 2 fire drills local fire department together with our staff residents to ensure concerning fire drills local fire department participate in by-annothing in future years. What measures will into place or what sychanges the facility to ensure that the department that the departme	no resident is by the executive scheduled cal Fire pate together is Place. 2:00 pm will cond fire drill this year will e:00 at the Meetings. identify ng the ted by the tice and con will be ensure No tively affected tice as the as already is with the to participate if and compliance in regulations with local fire tion. The is happy to nual fire also. I be put systemic will make efficient	DATE

State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 3 of 10

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 01/03/2024
	PROVIDER OR SUPPLIER		3304 M	ADDRESS, CITY, STATE, ZIP COD IONROE 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 measures put forward ensure the deficient practice doesn't recur is as follows: a) The Executive Director has establi 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 regular for each calendar by-annual year going forward. b) The first drill of the year is planned for January 25, 2024 2:00 All Staff meeting with the department participation. The second drill will be July 25, 20 for a second participation for 2 fire drill at the 2:00 All Staff Mandatory Meeting. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place; and The corrective action will monitored by the Executive Director and the Maintenanc Director on our State Survey Follow Up binder monitoring system monthly for 6 month: A Fire Drill reminder will be added to our teams State Survey Readiness binder. The systemic changes to add the Local Fire Departments.	shed le e e n for a fire 24 2024 the ut l be e s.

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PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/03/2024
	ROVIDER OR SUPPLIER		3304 N	ADDRESS, CITY, STATE, ZIP COD MONROE ST RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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
				Participation Fire Drill to our State Readiness Binder will complete by January 21, 202 Please see attached.	be
				By what date the systemic changes will be completed. Complete Date: Januar 25, 2024 for systemic change and completed bi-annual drills dates.	s
R 0243 Bldg. 00	in the individual 's records that indica (A) time; (B) name of medic (C) dosage (if app (D) name or initial administering the Based on record revialled to ensure slid administered as ord reviewed. (Resident Finding includes: The record for Resi at 1:56 p.m. Diagnolimited to, brittle diand dementia. A Physician's Order resident's blood sugbefore meals and H	Deficiency administering the ocument the administration a medication and treatment ate the: cation or treatment; licable); and s of the person drug or treatment. riew and interview, the facility ing scale insulin was ered for 1 of 7 records at 4) dent 4 was reviewed on 1/2/24 bees included, but were not abetes, diabetes mellitus type 2, r, dated 10/19/23, indicated the ar (BS) was to be checked umalog insulin was to be te following sliding scale:	R 0243	Submission of this response at Plan of Correction is NOT a leadmission that a deficiency exor, that this statement of deficiency was correctly cited is also NOT to be construed a admission against interest by facility, or any employees, agor other individuals who drafted may be discussed in the Response and Plan of Correction addition, preparation and submission of this Plan of Correction does NOT constituted admission or agreement of an kind by the facility of the truth any facts alleged or the	egal kists , and as an the ents, ed or kition.

State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 5 of 10

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. W	ING		01/03/	/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	2			ONROE ST			
OETTI E								
SETTLE	RS PLACE			LA POR	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	- BS 140-154, 1 uni	it			correctness of any conclusion	s		
	- BS 155-169, 2 uni	its			set forth in this allegation by the	ne		
	- BS 170-184, 3 uni	its			survey agency.			
	- BS 185-199, 4 uni	its						
	- BS 200-214, 5 uni	its			R243-Health			
	- BS 215-229, 6 uni	its			Services-Deficiency			
	- BS 230-244, 7 uni	its			What corrective action(s) wil	ı		
	- BS 245-259, 8 uni	its			be accomplished for those			
	- BS 260-274, 9 uni	its			residents found to have been	n		
	- BS 275-289, 10 ui	nits			affected by the deficient			
	- BS 290-304, 11 ui	nits			practice;			
	- BS 305-319, 12 ui	nits			Resident #4 suffered no			
	- BS 320-334, 13 ui	nits			negative outcomes related to	this		
	- BS 335-349, 14 ui	nits			finding.			
	- BS 350-364, 15 ui	nits			How the facility will identify			
	- BS 365-379, 16 uı				other residents having the			
	- BS 380-400, 17 ui				potential to be affected by th	e		
	- BS greater than 40	00, 18 units and call MD			same deficient practice and			
					what corrective action will be	ə		
		Medication Administration			taken;			
		cated the resident's before			An audit of current reside			
	_	ar on 10/29/23 was 266. No			was completed by The Health			
	· ·	out as being given. On			Services Director on 01/11/20			
	· ·	ent's before dinner blood sugar			and there are no other resider	ıts		
	_	o insulin was signed out as			were affected by the same			
	being given.				deficient practice.			
	TI D 1 202	2.3.4.D. 1. (.1.1						
		3 MAR indicated the resident's			What measures will be put in	OJI		
		ood sugar on 12/6/23 was 314.			place or what systemic	_		
	The resident received 13 units of insulin rather				changes the facility will make	е		
	than 12 units.				to ensure that the deficient			
	During on interview	on 1/3/24 at 2:15 p.m., the			practice does not recur; The Health Service Direction	ntor.		
	-	ss Director indicated the insulin						
		dministered as ordered.			completed in-services with the	;		
	Should have been at	diffinistered as ordered.			Nurses and QMAs on proper documentation, following			
					physician's orders, insulin administration with return			
					demonstration, medication			
					reconciliation and maintaining			
					Teconomation and maintaining			

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PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE		ETED		
			B. W	ING		01/03/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			ONROE ST		
SETTLFF	RS PLACE				RTE, IN 46350		
	-				,	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	-	TAG			DATE
					complete clinical records. This		
					was completed on 01/05/2024 1/8/2024.	and	
					How the corrective action(s) will be monitored to ensure t	ho	
					deficient practice will not	lile	
					recur, i.e., what quality		
					assurance program will be p	_{ut}	
					into place; and		
					The Heath Service Direct	tor is	
					responsible for sustained		
					compliance. The Health Servi	ces	
					Director will audit resident #4		
					clinical records daily for four		
					weeks, then every other day for	or a	
					month, then weekly for one me	onth	
					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	, ie	
					necessary based on three	y 15	
					consecutive months of		
					compliance.		
					By what date the systemic		
					changes will be completed.		
					Completion date: 01/08/2	2024	
						İ	
R 0349	410 IAC 16.2-5-8.	1(a)(1-4)				į	
	Clinical Records -	Noncompliance					
Bldg. 00	(a) The facility mu	st maintain clinical records					
	on each resident.	These records must be					
	maintained under	the supervision of an					
	employee of the fa	acility designated with that					

State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 7 of 10

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AND PLAN OF CORRECTION DENTIFICATION NIMBER A. BILLIONS DO COMPLETED	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
SETTLERS PLACE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (IACH DEFICURY MICST BE PRECEDED BY PLI. 1 TAG REGULATORY OR SEE DENITY MONORMATION to 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 accumely 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 meltitus type 2, and dementia. Nursed Notes, dated 10/27/23 at 10:00 p.m., indicated the resident had 2 skin tears to the upper spect of the reft hand. The resident miditated she had hit her hand against the counter while putting groceries away. The skin tears measured 1.3 centimeters (ray) 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 Direction indicated follow up documentation should have been completed prior to 11/1/23 regarding the skin tears. STREET ADDRESS, CITY, STATE, 2IP COD 3044 APPORT AND TOBER AND TO TOB	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
SETTLERS PLACE INABID SUMMARY STATEMENT OF DEFICIENCE: (PACID DEFICENCY MLST BE PERCEIDED BY FILL PRECEIDED BY FILL PRECEID BY FILL BY				B. WING		01/03/2024	
SETTLERS PLACE INABID SUMMARY STATEMENT OF DEFICIENCE: (PACID DEFICENCY MLST BE PERCEIDED BY FILL PRECEIDED BY FILL PRECEID BY FILL BY				QTDEET.	ADDRESS CITY STATE ZID COD	<u> </u>	
Date	NAME OF P	ROVIDER OR SUPPLIEF	₹				
Ox49 ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY BILL TAG REGULATORY OLS LED ENTERTHING BYORADION TAG REGULATORY OLS LED ENTERTHING BYORADION TAG REGULATORY OLS LED ENTERTHING BYORADION TAG	SETTI E	RS DI ACE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 the 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) x0.4 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. PRO349 Submission of this response and Plan of Correction is NOT a legal 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 is NOT a legal admission of this response and Plan of Correction is NOT a legal 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 is NOT a legal admission of this response and Plan of Correction is NOT a legal admission of this response and Plan of Correction is NOT a legal admission of this Plan of Correction is NOT at legal admission of this Plan of Correction is NOT at legal admission of the Plan of Correction is NOT at legal admission of the Plan of Correction is NOT at legal admission of the Plan of Correction is NOT at legal admission of the Plan	SETTLE	NO FLAGE		LAFOR			
PREFIX TAG	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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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 proceries 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 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 clis NOT a be construed as an admission that a deficiency was correctly cited, and is also NOT to be construed as an admission that a deficiency was correctly cited, and is also NOT to be construed as an admission that a deficiency was correctly cited, and is also NOT to be construed as an admission that a deficiency was correctly cited, and is also NOT to be construed as an admission that a deficiency was correctly cited, and is also NOT to be construed as an admission that a feliation of deficiency was correctly cited, and is also NOT to be construed as an admission that a feliation or the facility or the function. Records Noncompliance What corrective action(s) will	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
(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 the resident and 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 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 response and Plan of Correction is NOT a legal admission that a 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 response and Plan of Correction. In addition, preparation and submission against interest 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		responsibility. The	e records must be as				
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State Form Event ID: U43U11 Facility ID: 004458 If continuation sheet Page 8 of 10

PRINTED: 01/24/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	x3) date survey completed 01/03/2024
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				IONROE ST	
SETTLER	S PLACE		LA POI	RTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				same deficient practice and	
				what corrective action will be taken;	
				taken,	
				An audit of current resider	ıts
				was completed by The Health	
				Services Director on 01/11/202	4
,				and there are no other resident	s
				who were affected by the same	
				deficient practice.	
				What measures will be put int	0
				place or what systemic	
				changes the facility will make to ensure that the deficient	
				practice does not recur;	
				The Health Service Direct	or
				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	۵
				deficient practice will not	
				recur, i.e., what quality	
				assurance program will be pu	t
				into place; and	
				The Heath Service Directo	or is
				responsible for sustained	
				compliance. The Health Service	es
				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 clinic	ral
				records are maintained and	Jul
				resident incidents are being	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	JILDING	onstruction 00	(X3) DATE COMPL 01/03 /	ETED
NAME OF PROVIDER OR SUPPLIER SETTLERS PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 3304 MONROE ST LA PORTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) documented and monitored. Monitoring will be ongoing. Th committee will determine if continued auditing is necessal	ie QI	(X5) COMPLETION DATE
					based on three consecutive months of compliance. By what date the systemic changes will be completed. Completion date: 01/08/2	2024	

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