STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE ASSISTED LIVING LLC	7252 ARTHUR BLVD, MERRILLVILLE, , 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00414189, IN00414337, IN00415017, IN00415257, and IN00416416. Complaint IN00414189 - No deficiencies related to the allegations are cited. Complaint IN00414337 - State deficiency related to the allegations is cited at R0241. Complaint IN00415017 - No deficiencies related to the allegations are cited. Complaint IN00415257 - State deficiency related to the allegations is cited at R0241. Complaint IN00416416 - No deficiencies related to the allegations are cited. Survey date: August 29 & 30, 2023 Facility number: 002392	R 0000	"This plan of correction is submitted as required under State and Federal Law. The submission of the Plan of Correction does not constitute an admission on conclusions drawn therefrom- Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	

	Residential Census: 217 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/1/23.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered by the Physician for 2 of 5 residents in the Memory Care Unit observed during a morning medication pass. (Residents M and N). The facility also failed to ensure Resident M received the correct dosage of a medication after a dosage change for a medication ordered by the Physician. Findings include:	R 0241	Medication Patch Deficiency . What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective actions put into place is, the affected resident’s family and physician was informed of the medication error. The resident was assessed and monitored for 72 hours. The nurse responsible received an education regarding the error. In addition, the order transcription was revised. . 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 completed a transdermal	09/28/2023

1. During a morning medication pass observation on 8/29/23 at 7:35 a.m., LPN 1 prepared Resident M's medication. She placed one tablet of aspirin 81 mg (milligrams), one tablet of quetiapine (antipsychotic) 50 mg, and two tablets of acetaminophen 325 mg in a medication cup and indicated there were four tablets. She then crushed the medication and placed them in a nutritional drink and administered the medications to the resident.

After the medications were administered, LPN 1 indicated the resident also received lorazepam (anti-anxiety). She drew up 0.5 milliliters (ml) of liquid from the bottle and administered the medication under the tongue (sublingually). The label on the lorazepam bottle indicated there were two mg's per ml and to administer 0.5 ml three times a day.

Resident M's record was reviewed on 8/30/23 at 11:08 a.m. The diagnoses included, but were not limited to dementia. The resident was receiving Hospice Services.

A Physician's Order, dated 8/22/23 at 3 p.m., indicated the lorazepam order had been changed to give 0.25 ml twice a day.

A Physician's Order, dated

medication audit on September 1, 2023, to ensure all transdermal medications were administered properly in accordance with physician’s orders. The facility recognizes that other residents could have been affected by the alleged deficient practice however, none were noted to be affected at that time.

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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 measures put into place to ensure the alleged practice does not recur is: all QMA’s and nurses completed an educational in-service on 9/15/23 and 9/18/23 to review a required document that must be signed daily upon administering medication patches to ensure proper placement. This two-step verification will consist of signing transdermal medications out as given in the medication records, documenting placement is confirmed and documenting again on the transdermal patch document location with the medication record.

8/4/23, indicated a 1 mg scopolamine patch (nausea and vomiting prevention) was to be administered every three days for increased secretions.

The Medication Administration Record (MAR), dated 8/2023, indicated a new patch was to be applied on 8/29/23 on the morning medication pass. The patch had not been applied and had not been signed out as administered on the MAR.

The Controlled Substance Count Sheet indicated the correct amount of lorazepam remained in the bottle and the resident received 0.5 ml of the lorazepam on 8/22/23, 8/23/23. 8/24/23, 8/25/23, 8/26/23, 8/28/23 at bedtime and received 0.5 ml of the lorazepam on 8/23/23, 8/24/23, 8/26/23, 8/27/23, 8/28/23, and 8/29/23 during the morning medication pass.

During an interview on 8/30/23 at 11:15 a.m., RN 2 acknowledged the wrong dose of lorazepam had been administered.

During an interview on 8/30/23 at 11:30 a.m., the Unit Manager indicated the lorazepam dosage had been changed.

2. LPN 1 prepared Resident N's morning medication on 8/29/23 at 7:27 a.m., which included 1 tablet of carbidopa/levodopa

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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; The corrective actions will be
monitored by the Director of Nursing and/or designee(s) 5 days per week
utilizing an audit tool to monitor compliance. The audits will continue 5 days
per week for 6 months. If quality compliance is maintained during that time,
the audits will discontinue at the end of the 6-month period. If non-compliance
is determined, the audits will continue for an additional 6 months, and
additional monthly education will be implemented monthly for 6 months.

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By what date the systemic changes will be
completed. September 22, 2023

Incorrect Dosage Deficiency

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What corrective action(s) will be

	(Parkinson's disease treatment) 25-250 mg, 1 tablet of dexamethasone (steroid) 4 mg, 1 tablet of potassium 10 milliequivalents, one tablet of escitalopram (antidepressant) 20 mg. She indicated there were four tablets and then administered the medications. Resident N's record was reviewed on 8/30/23 at 11:25 a.m.. The diagnoses included, but were not limited to dementia. A Physician's Order, dated 8/2/23, indicated omeprazole (stomach medication) 20 mg was to be given with the morning medication. The omeprazole had not been administered as ordered. This state residential finding relates to Complaints IN00414337 and IN00415257. Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered by the Physician for 2 of 5 residents in the Memory Care Unit observed during a morning medication pass. (Residents M and N). The facility also failed to ensure Resident M received the correct dosage of a medication after a dosage change for a medication ordered by the Physician.		accomplished for those residents found to have been affected by the deficient practice; The corrective actions put into place is, the affected resident's family and physician was informed of the medication error. The resident was assessed and monitored for 72 hours. The nurse responsible received an education regarding the error. In addition, the medication administration record was revised to reflect the correct dosage to be administered. . 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 completed medication order audit of all physicians order's received for the past 90 days to ensure the medication administration record reflected the current physician order, and the supply of medication on hand in the facility. . What measures will be put into place or what systemic changes the facility will	

Findings include:

1. During a morning medication pass observation on 8/29/23 at 7:35 a.m., LPN 1 prepared Resident M's medication. She placed one tablet of aspirin 81 mg (milligrams), one tablet of quetiapine (antipsychotic) 50 mg, and two tablets of acetaminophen 325 mg in a medication cup and indicated there were four tablets. She then crushed the medication and placed them in a nutritional drink and administered the medications to the resident.

After the medications were administered, LPN 1 indicated the resident also received lorazepam (anti-anxiety). She drew up 0.5 milliliters (ml) of liquid from the bottle and administered the medication under the tongue (sublingually). The label on the lorazepam bottle indicated there were two mg's per ml and to administer 0.5 ml three times a day.

Resident M's record was reviewed on 8/30/23 at 11:08 a.m. The diagnoses included, but were not limited to dementia. The resident was receiving Hospice Services.

A Physician's Order, dated 8/22/23 at 3 p.m., indicated the lorazepam order had been changed to give 0.25 ml twice a day.

make to ensure that the deficient practice
does not recur; The measures put into place to ensure the alleged practice does
not recur is: all QMA’s and nurses completed an educational in-service on 9/15/23
and 9/18/23 and scheduled for 9/20/23 to review proper medication
administration. InTouch Pharmacy has also been contacted to complete medication
and cart audits and will be conducted before 10/10/23 . In addition, all nurses
and QMA’s will complete medication administration audits to be documented and conducted
by the Director of Nursing and or designee monthly for 6 months to ensure
proper medication administration is completed. This will be verified by
utilizing an monitoring tool to confirm auditing.

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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; The corrective actions will be
monitored by the Director of

	A Physician's Order, dated 8/4/23, indicated a 1 mg scopolamine patch (nausea and vomiting prevention) was to be administered every three days for increased secretions. The Medication Administration Record (MAR), dated 8/2023, indicated a new patch was to be applied on 8/29/23 on the morning medication pass. The patch had not been applied and had not been signed out as administered on the MAR. The Controlled Substance Count Sheet indicated the correct amount of lorazepam remained in the bottle and the resident received 0.5 ml of the lorazepam on 8/22/23, 8/23/23. 8/24/23, 8/25/23, 8/26/23, 8/28/23 at bedtime and received 0.5 ml of the lorazepam on 8/23/23, 8/24/23, 8/26/23, 8/27/23, 8/28/23, and 8/29/23 during the morning medication pass. During an interview on 8/30/23 at 11:15 a.m., RN 2 acknowledged the wrong dose of lorazepam had been administered. During an interview on 8/30/23 at 11:30 a.m., the Unit Manager indicated the lorazepam dosage had been changed. 2. LPN 1 prepared Resident N's morning medication on 8/29/23 at 7:27 a.m., which included 1		Nursing and/or designee(s) 5 days per week utilizing an MAR to cart audit tool to monitor compliance. The audit tool will consist of a MAR to CART audit that will be completed weekly for 6 months to ensure correct dosages are in supply according to physician orders and will be completed by the Director of Nursing and/or designee. . The MAR to cart audits will continue weekly for 6 months. If quality compliance is maintained during that time, the audits will discontinue at the end of the 6-month period. If non-compliance is determined, the audits will continue for an additional 6 months, and additional monthly education will be implemented monthly for 6 months. . By what date the systemic changes will be completed. September 28, 2023	

	tablet of carbidopa/levodopa (Parkinson's disease treatment) 25-250 mg, 1 tablet of dexamethasone (steroid) 4 mg, 1 tablet of potassium 10 milliequivalents, one tablet of escitalopram (antidepressant) 20 mg. She indicated there were four tablets and then administered the medications. Resident N's record was reviewed on 8/30/23 at 11:25 a.m.. The diagnoses included, but were not limited to dementia. A Physician's Order, dated 8/2/23, indicated omeprazole (stomach medication) 20 mg was to be given with the morning medication. The omeprazole had not been administered as ordered. This state residential finding relates to Complaints IN00414337 and IN00415257.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE