

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/13/2026	
NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Intake 470727. Intake 470727 - State deficiency related to the allegations are cited at R0052. Survey date: July 13, 2026 Facility number: 002392 Residential Census: 222 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 7/14/26.	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.				

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R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from neglect, related to a lack of thorough and ongoing assessments of skin wounds, completion of treatments as ordered, and no physician notification of the change in condition, resulting in a hospitalization for treatment of infection of the wounds and cellulitis for 1 of 2 residents reviewed for wounds. (Resident B) Finding includes: Resident B's record was reviewed on 7/13/26 at 10:36 a.m. The diagnoses included, but were not limited to stroke and bilateral lower extremity edema.	R 0052	1. Corrective Action for Resident B Resident B was transferred to the hospital on 6/27/26 and had not returned to the facility at the time of the survey. Prior to any return to the facility, the Director of Nursing/designee will review Resident B's current clinical status, hospital/rehabilitation discharge information, skin and wound status, treatment orders, and level-of-care needs to ensure the facility can safely meet the resident's needs. Upon return, A comprehensive skin assessment will be completed by a licensed nurse. All skin concerns/wounds will be documented with location, type/appearance, measurements when applicable, drainage, surrounding skin condition, pain, and other pertinent findings. All physician/NP treatment orders will be reviewed, transcribed accurately to the MAR/TAR, and implemented as ordered. The physician/NP and responsible party will be notified of identified skin changes or changes in condition, with	07/21/2026
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The resident had been transferred from the facility to the hospital on 6/27/26 at 11:15 p.m. and had not returned to the facility at the time of the record review.

An Assessment and Service Plan, dated 3/11/26, indicated extensive assistance was required for bathing, hygiene, dressing and toileting. The resident was incontinent of bowel and bladder, required incontinent monitoring during the day and night and wore adult briefs.

A Physician's Order, dated 6/11/26, indicated zinc oxide 20% cream was to be applied daily to the buttock related to urinary incontinence and contact dermatitis and calmoseptine cream was to be applied to the buttocks every shift and as needed for chaffing.

A Nurse's Progress Note, dated 6/24/26 and identified as a late entry with no time documented, indicated there was a closed area to the buttocks. No complaints of pain or discomfort and zinc oxide was applied as ordered.

An untimed Nurse's Progress Note, dated 6/24/26, indicted there was a closed area on the buttocks and a treatment was in place.

notification documented in the clinical record.

The resident's service plan will be reviewed and updated to reflect current skin integrity needs, incontinence care, repositioning/off-loading needs if applicable, treatments, and other interventions.

Appropriate wound care/home health or other third-party clinical services will be initiated when ordered or clinically indicated.

2. Identification of Other Residents Who May Be Affected

On July 29, 2026, the Director of Nursing/designee completed an audit of all current residents charts using an audit tool to identify residents within the past 60 Days.

Current wounds, pressure injuries, skin tears, excoriation, dermatitis, redness, scratches, open areas, or other alterations in skin integrity.

Physician/NP orders for skin or wound treatments.

Incontinence that places the resident at increased risk for skin breakdown.

Recent changes in skin condition documented in nursing notes, skin assessments,

A Nurse Practitioner's (NP) Progress Note, dated 6/24/26 at 9:30 a.m., indicated the staff reported excoriation to the buttocks and scant drainage from the area on his buttocks. There was an area on the right buttock with an area of pink pigmentation that was consistent with a previous open wound. There was no drainage, pain, or discomfort. There was redness and irritation to the scrotum with superficial skin loss. The physical exam indicated an excoriation to the posterior scrotum. The rash appeared consistent with dermatitis. The staff were to provide "swift" incontinent care and apply zinc oxide twice a day to the area and as needed.

The order from the NP on 6/24/26 to change the zinc oxide to twice a day had not been completed.

The Treatment Administration Record (TAR), dated 6/2026, indicated the zinc oxide had been applied to the right buttock daily. The Zinc Oxide order had not been changed to apply to the buttocks daily on 6/11/26 nor to be applied to the buttocks twice daily on 6/24/26.

The TAR, dated 6/2026, indicated the calmoseptine had been applied to the buttock every shift.

MAR/TARs, or 24-hour reports.

For residents identified with skin concerns, the Director of Nursing/designee will verify (using a documentation tool) that:

A complete skin assessment has been performed and documented.

Current treatment orders match the MAR/TAR and are being completed as ordered.

Physician/NP and responsible party notifications have been completed and documented when indicated.

Service plans reflect current skin conditions, risks, treatments, and interventions.

Appropriate follow-up and ongoing monitoring are in place.

Any discrepancies identified during the audit will be corrected and documented immediately, and the physician/NP and responsible party will be notified when clinically indicated.

3. Systemic Changes to Prevent Recurrence

All licensed nursing staff will be re-educated on 7/27/2026 regarding skin integrity management, change-of-condition reporting,

A Nurse's Progress Note, dated 6/25/26 at 11 p.m., indicated there were self-inflicted scratches to the buttocks and left thigh. The areas were bleeding and there was blood under the resident's fingernails. The zinc oxide was applied to the affected areas.

There was no thorough assessment of the areas that indicated the number of scratches and the size of the scratches. The Physician/NP and Responsible Party had not been notified.

A Nurse's Progress Note, dated 6/26/26 at 10:40 a.m., indicated no pain or discomfort. There was no assessment of the resident's skin.

A Weekly Skin Assessment, dated 6/26/26 with no time documented, indicated scratches were observed to the left side buttocks. There was no description of the scratches. The Physician and Responsible Party had not been notified of the areas.

The Service Plan had been revised on 6/26/26 and indicated there were scratches on the left buttock. Education would be provided not to scratch the areas and zinc oxide would be used on the buttock area.

There were no further Nurses'

treatment order implementation, and documentation requirements.

Education will included:

Any new or worsening skin condition must receive a thorough nursing assessment.

Documentation must include the location, appearance, size/measurements when applicable, drainage, surrounding skin condition, pain, and other relevant findings.

Staff may not document only general terms such as "scratch," "red area," "open area," or "skin breakdown" without completing and documenting an appropriate assessment.

Any significant new or worsening skin condition must be reported promptly to the physician/NP and responsible party, with notification and any resulting orders documented in the resident's record.

New or changed physician/NP orders must be transcribed accurately and implemented promptly on the MAR/TAR and will be verified through 2-step verification process using an physician order audit tool.

Licensed nurses are responsible for verifying that treatment orders on the MAR/TAR match

Progress Notes until 6/27/26 at 9:50 p.m. The Progress Note indicated the resident requested to be transferred to the hospital. The resident complained of blood and burning inside of his brief and itching of the skin. The NP and Responsible Party was notified. There was no assessment of the skin area.

A Nurse's Progress Note, dated 6/27/26 at 11:15 p.m., indicated the resident was transferred to the Hospital Emergency Room.

The Hospital Transfer Form, dated 6/27/26, indicated the reason for the transfer was due to a "raw/chaffed bottom and oozing".

The Emergency Room Physician's Notes, dated 6/28/26 at 12:09 a.m., indicated the resident had complained to the staff at the facility about the pain and itching for several days without any intervention, so he requested to come to the hospital. He complained of persistent pain over his bilateral buttocks and posterior thighs. There were extensive areas of mixed stage one (reddened/discoloration of skin) and stage two (superficial skin break) pressure ulcers over the sacrum, bilateral buttocks and posterior thighs. No drainage was present. The redness extended to the inferior margin of the scrotum. The areas

the current physician/NP orders by initialing the audit tool. Director of Nursing and/or designee will be responsible for completing the audits Daily for 2 weeks, Weekly for 8 weeks, Monthly for 3 months

Residents with identified skin concerns will receive ongoing assessments and follow-up until the condition is resolved, stabilized, transferred to an appropriate provider, or otherwise addressed by the physician/NP.

Weekly skin assessments forms will be completed for residents with identified skin integrity concerns and updated with any changes.

Changes in condition will be communicated during shift-to-shift report and documented on the facility's 24-hour report/communication system to ensure continuity and follow-up.

Staff will provide prompt incontinence care and follow individualized interventions intended to reduce prolonged exposure to moisture and prevent skin breakdown.

appeared to be infected and intravenous antibiotics were initiated due to the extent of the wounds. The resident was admitted into the hospital for further evaluation and management and a diagnosis of cellulitis.

During an interview on 7/13/26 at 11:20 a.m., the Director of Nursing (DON) indicated she had observed the areas on 6/26/26 and they were scratches. She indicated the nurse who found the areas had not assessed the areas. There was no documentation in the Progress Notes the areas had drainage. The Physician and Responsible Party had not been notified with the change in status and there were no thorough assessments of the areas.

An undated facility abuse policy, received from the DON on 7/13/26 at 2:03 p.m., indicated the failure to provide goods and services to avoid physical harm, mental anguish or mental illness was identified as neglect.

An undated policy for assistance with pressure care, received from the DON on 7/13/26 at 11:48 a.m., indicated the resident would be assisted with the ordered treatment. Changes in the skin conditions would be reported to the Executive Director, Wellness Director

The service plan will be reviewed and updated when a resident develops a new or worsening skin condition or when interventions change.

Nursing staff will be educated by July 25, 2026 that failure to assess, report, document, follow treatment orders, or provide necessary follow-up may result in delayed treatment to the residents.

Education will be completed by July 25, 2026 by the Director of Nursing/designee. Newly hired licensed nursing staff will receive education regarding these requirements during orientation

4. Monitoring and Quality Assurance

The Director of Nursing/designee will implement a Skin Integrity, Service care Plan and Treatment Staff Education and Audit on 7/15/2026 through 7/25/2026.

The audit will be conducted by Director of Nursing Daily for 2 weeks, Weekly for 8 weeks, Monthly for 3 months using an audit tool to review residents with current skin concerns and/or treatment orders to verify:

A thorough assessment is documented for new or changed

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and/or Physician.

A facility notification policy, dated 11/9/22 and received from the DON as current, indicated any change in the resident's condition must be immediately communicated to the resident's family members. Staff were to ensure all communication is clear, accurate and documented appropriately. The Physician was to be notified of any significant changes in the resident's condition. The notification was to be documented thoroughly in the resident's record. The family and physician were to be notified as soon as possible after identifying any change of condition.

This citation relates to Intake 470727.

skin conditions.

Physician/NP and responsible party notifications are completed and documented when required.

Physician/NP treatment orders match the MAR/TAR.

Ordered treatments are completed and documented as prescribed.

Follow-up assessments are completed and documented.

Weekly skin assessments are current for residents requiring monitoring.

Service plans have been updated when indicated.

Changes in condition are communicated through the 24-hour report/shift-to-shift handoff process. Compliance will be audited and completed by Director of Nursing using an audit tool:

Daily for 2 weeks, Weekly for 4 weeks, Monthly for 3 months

Any identified deficiency will be corrected and documented immediately.

Audit findings and trends will be reviewed by the Director of Nursing and/or designee following audit frequency of :daily for 3 weeks, weekly for 3

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FORM APPROVED

OMB NO. 0938-0391

			months, and monthly for 3 months. Systemic date of completion August 13, 2026	
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 SIGNATURERikki Ford		TITLEExecutive Director		(X6) DATE07/31/2026