| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 04/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TOWNE PARK ASSISTED LIVING | 503 S MURPHY AVE, BRAZIL, , 47834 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00454799 and IN00457570.<br><br>Complaint IN00454799 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00457570 - No deficiencies related to the allegations are cited.<br><br>Unrelated deficiencies are cited at R0241.<br><br>Survey date: April 21, 2025<br><br>Facility number: 014623<br><br>Residential Census: 29<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on April 23, 2025. | R 0000 | ISDH<br><br>ATT: Suzanne Williams<br><br>Director of Division Long Term Care<br><br>2 North Meridian Street<br><br>Indianapolis, Indiana 46204<br><br>Re: Complaint Survey<br><br>Towne Park Assisted living<br><br>503 S Murphy Ave<br><br>Brazil, IN 47834-0130<br><br>Dear Ms. Suzanne,<br><br>On April 21,2025 complaint survey (Complaint number IN 00454799, IN 00457570) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.<br><br>Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. | |

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| | | | We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 05/20/2025.<br><br>Please feel free to call me with any further questions at 1 (812) 446-2636.<br><br>Respectfully submitted,<br>Manoj Berry (Executive Director)<br>Towne Park Assisted Living<br>503 S Murphy Ave<br>Brazil, IN 47834-0130 | |
| R 0241 | Health Services - Offense<br><br>410 IAC 16.2-5-4(e)(1)<br><br>(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:<br><br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br><br>Based on record review and interview, the facility failed to ensure residents received | R 0241 | R 241 Health Services-Noncompliance<br><br>This Plan of correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or | 05/20/2025 |

prescribed insulin medication as ordered by a physician for 3 of 3 residents reviewed for insulin administration. (Residents C, E, and F)

Findings include:

1. During an interview with Resident C on 4/21/25 at 2:10 p.m., she indicated the staff would occasionally hold her scheduled insulin doses because they felt her blood sugar was too low. She had not mentioned this to her physician.

The clinical record review for Resident C was completed on 4/21/25 at 10:01 a.m. Diagnoses included diabetes mellitus type II with diabetic retinopathy and chronic respiratory failure with hypoxia.

A Quarterly Assisted Living Assessment was completed on 3/5/25, and indicated the resident required caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. The assessment indicated the resident was cognitively intact.

Current physician's orders included, the following:

a. Humulin R (to treat diabetes mellitus) Kwikpen, administer 240 units once each morning between 6:00 a.m. and 9:00 a.m. The order was dated

executed solely because it is required by the
provisions of federal and state law.

**1)What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**

No residents were negatively affected by the alleged deficient practice.

**2)How other residents having the potential to be affected by the same deficient practice be identified and
what corrective actions will be taken?**

Any resident who receives insulin
has the potential to be affected by the alleged deficient practice. An audit
was completed to ensure call parameters were in place, MD notified, and
orders obtained if needed.

2/18/25.

b. Humulin R Kwikpen, administer 220 units once each day between 11:00 a.m. and 1:00 p.m. The order was dated 1/8/25.

c. Humulin R Kwikpen, administer 190 units once each evening between 4:00 p.m. and 6:00 p.m. The order was dated 2/18/25.

d. An Endocrinology review report, dated 1/7/25, indicated if the resident's blood sugar was less than 80, if the resident was not hungry, or planned to increase activity, the ordered scheduled insulin should be reduced by 20 units. This documentation had not been included on the facility order.

The resident's electronic medication administration record (eMAR) for March 2025, indicated the following:

a. The 6:00 a.m. to 9:00 a.m. insulin dose was held on 3/3/25. The resident's blood sugar was documented as 93. The record indicated the medication was held for the scheduled dose, due to "resident bs [blood sugar] too low for administration."

b. The 11:00 a.m. to 1:00 p.m. dose was not administered on 3/4/25 for a blood sugar of 91, on 3/6/25 for a blood sugar of 113, and on 3/13/25 for a blood

**3)What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?**

The DON/Designee reeducated all
licensed personnel on 04/30/2025 with emphasis on insulin administration and MD notification.

**4)How will the corrective actions be monitored to ensure
the deficient practice will not recur, i.e., what quality assurance program
will be put into place?**

The Don/Designee will audit 3 insulin dependent residents three times a week for six months to ensure insulin
is administered as prescribed, and MD notifications are completed as needed. Reeducation will be provided immediately as needed. The results of these audits
will be reviewed monthly by the IDT team and adjustments will be made
accordingly.

**5)Date the systemic changes for the deficiency will be**

sugar of 114. The comments indicated the resident's blood sugar as too low for administration.

c. The 4:00 p.m. to 6:00 p.m. insulin dose was held on 3/19/25. The resident's blood sugar was documented as 87. The record indicated the medication was held for the scheduled dose due to a blood sugar of 87 and was held per nursing judgment.

The resident's eMAR for April 2025, indicated the following: the 11:00 a.m. to 1:00 p.m. insulin dose on 4/4/25 was not administered for a blood sugar of 114. The record indicated the dose was held due to the blood sugar was too low for administration.

The clinical record lacked physician notification of the insulin being held.

2. During an interview on 4/21/25 at 4:03 p.m., Resident E indicated she would not refuse her insulin doses in the morning or before meals. She had refused insulin before bedtime frequently. She feels her blood sugar may drop at night causing her to have to get up and eat in the middle of the night. She had not spoken to her doctor about this because she feels she can handle it.

The clinical record review for

**completed:**05/20/2025.

Resident E was completed on 4/21/25 at 4:10 p.m. Diagnoses included diabetes mellitus type II with diabetic chronic kidney disease and anxiety disorder.

A Quarterly Assisted Living Assessment was completed on 3/9/25, and indicated resident required caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. The assessment indicated the resident was cognitively intact.

A current physician's orders indicated to administer Lantus (to treat diabetes mellitus) Solostar 15 units at bedtime, one time from 8:00 p.m. to 10:00 p.m. The order was dated 10/23/24.

The resident's eMAR for March 2025 included the following: the resident refused the insulin administration on 3/3/25, 3/8/25, 3/21/25, 3/24/25, and 3/31/25. The insulin administration was held due to nursing judgement on 3/7/25, 3/10/25, 3/19/25, and 3/22/25. The clinical record lacked documentation of physician notification of refusals and the insulin being held.

The resident's eMAR for April 2025 included the following: the resident refused the insulin administration on 4/6/25, 4/12/25, 4/13/25, 4/15/25,

4/18/25, and 4/19/25. The insulin administration was held due to nursing judgment on 4/5/25 and 4/16/25. The clinical record lacked documentation of physician notification of refusals and the insulin being held.

3. The clinical record review for Resident F was completed on 4/21/25 at 4:55 p.m. Diagnoses included diabetes mellitus type II, pulmonary fibrosis, and rheumatoid arthritis.

A Quarterly Assisted Living Assessment was completed on 3/9/25, and indicated the resident required caregiver administration and or observation of medications requiring judgment for necessity, dosage and/or effect. The assessment indicated the resident was cognitively intact.

Current physician's orders included the following:

a. Humalog (to treat diabetes mellitus) Kwikpen, administer per sliding scale before meals and at bedtime: If blood sugar is 140 to 220, give 1 unit; if 221 to 260, give 2 units; if 261 to 300, give 3 units; if 301 to 340, give 4 units; if 341 to 380, give 5 units; if 381 to 420, give 6 units; if 421 to 460, give 7 units. If blood sugar is greater than 460, call the physician. At bedtime, only give insulin if blood sugar is greater than 200 and only give

half. The order was dated 10/5/25 and discontinued 3/19/25.

1. The insulin administration was refused by the resident on 3/2/25 at 6:00 p.m., 3/8/25 at 6:00 p.m., 3/9/25 at 12:00 p.m., 3/14/25 at 12:00 p.m., 3/15/25 at 6:00 p.m., and 3/16/25 at 12:00 p.m. The clinical record lacked documentation of physician notification of refusals.

2. The insulin administration was administered for the bedtime dose on 3/4/25 for a blood sugar of 154, on 3/6/25 for a blood sugar of 143, on 3/8/25 for a blood sugar of 144, and on 3/19/25 for a blood sugar of 192.

b. Humalog (to treat diabetes mellitus) Kwikpen, administer per sliding scale before meals: If blood sugar is 140 to 220, give 1 unit; if 221 to 260, give 2 units; if 261 to 300, give 3 units; if 301 to 340, give 4 units; if 341 to 380, give 5 units; if 381 to 420, give 6 units; if 421 to 460, give 7 units. If blood sugar is greater than 460, call the physician. The order was dated 3/19/25. The insulin administration was refused by the resident on 3/22/25 at 12:00 p.m, 3/23/25 at 6:00 p.m., 3/28/25 at 6:00 p.m., 3/29/25 at 12:00 p.m., 3/30/25 at 6:00 p.m., and 3/31/25 at 6:00 p.m. The clinical record lacked

documentation of physician notification of refusals.

c. Lantus Solostar, administer 10 units at bedtime. The order was dated 10/9/24. The insulin administration was refused by the resident on 3/7/25, 3/9/25, 3/9/25, 3/10/25, 3/14/25, 3/15/25, 3/16/25, 3/21/25, and 3/23/25. The record showed the insulin was not administered on 3/1/25, 3/11/25, 3/12/25, and 3/29/25, indicating the scheduled insulin was held due to nursing judgement.

During an interview on 4/21/25 at 2:51 p.m., LPN 5 indicated some resident's will refuse their insulin if their blood sugar was under a certain number. The standard procedure would be to contact the physician if there was a question as to providing the ordered dose of insulin. She worried some resident's blood sugar may go low when they the ordered amount of insulin. In the case of Resident C, she had reached out to the physician and he declined to make any changes to the ordered insulin doses. She still holds the insulin at times because she felt it was a lot of insulin to be giving. She had some conversations with the DON who indicated she needed to follow the physician's orders. She realizes she should be contacting the physician when the residents refuse or she holds the medications, if

she felt it was indicated.

During an interview on 4/21/25 at 3:50 p.m., LPN 8 indicated she had held insulin dosed for blood sugars under 100 because she had not felt comfortable administering the dose with a blood sugar that low. She had not notified the physician of refused doses or when she decided to hold a dose.

During an interview on 4/21/25 at 12:06 p.m., the Executive Director indicated the nursing staff should be contacting the physician if they felt it was indicated or if the resident continually refuses doses of insulin.

A current facility policy, dated 2024, titled, "Timely Administration of Insulin," provided by the Executive Director on 4/21/25 at 2:03 p.m., included the following: "Policy: It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. Policy Explanation and Compliance Guidelines: 1. All insulin will be administered in accordance with physician's orders...."

Based on record review and interview, the facility failed to ensure residents received

prescribed insulin medication as ordered by a physician for 3 of 3 residents reviewed for insulin administration. (Residents C, E, and F)

Findings include:

1. During an interview with Resident C on 4/21/25 at 2:10 p.m., she indicated the staff would occasionally hold her scheduled insulin doses because they felt her blood sugar was too low. She had not mentioned this to her physician.

The clinical record review for Resident C was completed on 4/21/25 at 10:01 a.m. Diagnoses included diabetes mellitus type II with diabetic retinopathy and chronic respiratory failure with hypoxia.

A Quarterly Assisted Living Assessment was completed on 3/5/25, and indicated the resident required caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. The assessment indicated the resident was cognitively intact.

Current physician's orders included, the following:

a. Humulin R (to treat diabetes mellitus) Kwikpen, administer 240 units once each morning between 6:00 a.m. and 9:00 a.m. The order was dated

2/18/25.

b. Humulin R Kwikpen, administer 220 units once each day between 11:00 a.m. and 1:00 p.m. The order was dated 1/8/25.

c. Humulin R Kwikpen, administer 190 units once each evening between 4:00 p.m. and 6:00 p.m. The order was dated 2/18/25.

d. An Endocrinology review report, dated 1/7/25, indicated if the resident's blood sugar was less than 80, if the resident was not hungry, or planned to increase activity, the ordered scheduled insulin should be reduced by 20 units. This documentation had not been included on the facility order.

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sugar of 114. The comments indicated the resident's blood sugar as too low for administration.

c. The 4:00 p.m. to 6:00 p.m. insulin dose was held on 3/19/25. The resident's blood sugar was documented as 87. The record indicated the medication was held for the scheduled dose due to a blood sugar of 87 and was held per nursing judgment.

The resident's eMAR for April 2025, indicated the following: the 11:00 a.m. to 1:00 p.m. insulin dose on 4/4/25 was not administered for a blood sugar of 114. The record indicated the dose was held due to the blood sugar was too low for administration.

The clinical record lacked physician notification of the insulin being held.

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The resident's eMAR for March 2025 included the following: the resident refused the insulin administration on 3/3/25, 3/8/25, 3/21/25, 3/24/25, and 3/31/25. The insulin administration was held due to nursing judgement on 3/7/25, 3/10/25, 3/19/25, and 3/22/25. The clinical record lacked documentation of physician notification of refusals and the insulin being held.

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4/18/25, and 4/19/25. The insulin administration was held due to nursing judgment on 4/5/25 and 4/16/25. The clinical record lacked documentation of physician notification of refusals and the insulin being held.

3. The clinical record review for Resident F was completed on 4/21/25 at 4:55 p.m. Diagnoses included diabetes mellitus type II, pulmonary fibrosis, and rheumatoid arthritis.

A Quarterly Assisted Living Assessment was completed on 3/9/25, and indicated the resident required caregiver administration and or observation of medications requiring judgment for necessity, dosage and/or effect. The assessment indicated the resident was cognitively intact.

Current physician's orders included the following:

a. Humalog (to treat diabetes mellitus) Kwikpen, administer per sliding scale before meals and at bedtime: If blood sugar is 140 to 220, give 1 unit; if 221 to 260, give 2 units; if 261 to 300, give 3 units; if 301 to 340, give 4 units; if 341 to 380, give 5 units; if 381 to 420, give 6 units; if 421 to 460, give 7 units. If blood sugar is greater than 460, call the physician. At bedtime, only give insulin if blood sugar is greater than 200 and only give

half. The order was dated 10/5/25 and discontinued 3/19/25.

1. The insulin administration was refused by the resident on 3/2/25 at 6:00 p.m., 3/8/25 at 6:00 p.m., 3/9/25 at 12:00 p.m., 3/14/25 at 12:00 p.m., 3/15/25 at 6:00 p.m., and 3/16/25 at 12:00 p.m. The clinical record lacked documentation of physician notification of refusals.

2. The insulin administration was administered for the bedtime dose on 3/4/25 for a blood sugar of 154, on 3/6/25 for a blood sugar of 143, on 3/8/25 for a blood sugar of 144, and on 3/19/25 for a blood sugar of 192.

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documentation of physician notification of refusals.

c. Lantus Solostar, administer 10 units at bedtime. The order was dated 10/9/24. The insulin administration was refused by the resident on 3/7/25, 3/9/25, 3/9/25, 3/10/25, 3/14/25, 3/15/25, 3/16/25, 3/21/25, and 3/23/25. The record showed the insulin was not administered on 3/1/25, 3/11/25, 3/12/25, and 3/29/25, indicating the scheduled insulin was held due to nursing judgement.

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