| 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 | 11/01/2024 |

| 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 Complaint IN00445086.<br><br>Complaint IN00445086 - State deficiencies related to the allegations are cited at R0044 and R045.<br><br>Survey date: October 31 to November 1, 2024<br><br>Facility number: 014623<br><br>Residential Census: 31<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on November 14, 2024. | R 0000 | **This plan of Correction is the center's credible allegation of compliance. 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 inthe statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** | |
| R 0044 | Residents' Right - Deficiency<br><br>410 IAC 16.2-5-1.2(r)(1-5)<br><br>(r) The transfer and discharge rights of residents of a facility are as follows: | R 0044 | **Ro44 Residents Rights** | 12/04/2024 |

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| | (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility.<br><br>(2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility.<br><br>(3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility.<br><br>(4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:<br><br>(A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility;<br><br>(B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility;<br><br>(C) the safety of individuals in the facility is endangered;<br><br>(D) the health of individuals in the facility would otherwise be endangered;<br><br>(E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or<br><br>(F) the facility ceases to operate. | | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident C and Resident K no longer reside at the facility.<br><br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. An audit has been conducted to ensure that all documentation was completed for discharges. No other concerns noted.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>The corporate clinical team reeducated Administrator and DON on discharge policy and documentation. DON/ designees reeducated licensed staff | |

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| | (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:<br><br>(A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).<br><br>(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).<br><br>Based on record review and interview, the facility failed to document discharge information for 2 of 3 residents reviewed for discharge (Residents C and K).<br><br>Findings Include:<br><br>1. On 11/1/24 at 9:28 a.m., during a phone interview with the Power of Attorney (POA) of Resident C, she indicated the resident was discharged from the facility to a hospital. She was informed she would not be allowed to return because she had eloped from the facility. The POA was not notified of the discharge till hours later. She indicated the resident was discharged back to the facility and was given one to one supervision. She was informed the facility had decided to transfer the resident to another facility, but she had not been included in this decision. She | | on discharge policy and documentation.<br><br>**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?**<br><br>Administrator or designee will audit discharge documentation for all discharges monthly for 6 months until 100 percent substantial compliance is achieved. Results of audits will be reviewed during monthly quality assurance meetings.<br><br>**By what date the systemic changes will be completed?**<br><br>12/04/2024 | |

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| | was advised since the resident had eloped she must be placed in a facility with a secure unit. The POA removed the resident the next day and placed her in a long-term care facility. She indicated at the time of the discharge she was not provided any discharge information including a list of medications and directions for care.<br><br>On 11/1/24 at 10:15 a.m., the medical record of Resident C was reviewed. Admission diagnosis included but were not limited to disorientation, bi-polar disorder (a mental illness that causes unusual shifts in a person's mood), HTN (high blood pressure), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The resident was discharged on 10/19/24.<br><br>Review of the nurse progress notes indicated the resident was seen by the Nurse Practitioner (NP) on 10/7/24. She indicated she discussed increased confusion with the resident's POA. On 10/10/24 the resident eloped from the facility. She was found walking down the street in front of the facility. She was sent to the hospital for an evaluation at 7:10 p.m., the medical record indicated the POA was notified at 7:25 p.m., The resident was discharged to the hospital and returned to the facility on 10/11/24. She was seen by a | | | |

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| | physician on the day of re-admission and referred to a long-term care facility (LTC). The medical record lacked documentation of a meeting with resident and POA to discuss discharge. The record lacked documentation of the resident being discharged home with the POA or of any discharge instructions being sent with the resident and POA.<br><br>On 10/31/24 at 2:55 p.m., during an interview, the Administrator indicated she or the DON would notify the case manager at the hospital if a resident was not going to return to the facility. They did an assessment to determine the needs of the resident. If the resident was a danger to themselves or others they would not be allowed to return.<br><br>A review of the facility residential care agreement indicated. "Section E, paragraph G ...Residents physical, mental or emotional condition or behavior is such that a resident is or is likely to become an endangerment to him or herself or others, in the sole judgement of the facility, then facility may terminate this agreement upon thirty (30) days prior to written notice to resident. Section V. Termination ...B termination by facility ... except when the resident's health or safety, or the health and safety of others | | | |

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| | is endangered the facility will give not less than thirty (30) days' notice of termination ...."<br><br>2. On 11/1/24 at 1:50 p.m., the medical record of Resident K was reviewed. The resident was admitted to the facility for a respite stay on 10/10/24. Admission diagnosis included but were not limited to, seizure, pain, HTN (high blood pressure) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). The resident was discharged home with family on 10/28/24. The record lacked documentation of discharge instructions being sent with the resident upon discharge. The record indicated medications were sent but did not indicate what medications were sent.<br><br>On 11/1/24 at 12:05 p.m., during an interview, the Administrator indicated the facility did not have a specific policy for discharge. She indicated they followed the state regulations. She was not aware the record did not contain any discharge information.<br><br>On 10/31/24 at 2:37 p.m., during an interview, the Director of Nursing (DON) indicated if a resident was planning to discharge she would contact the resident's regular pharmacy and | | | |

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| | send orders to them for medications to be filled. She would verify home healthcare needs and contact appropriate services. The day of discharge she would print the resident's orders out and send them along with medications. She documented this information and gave it to the resident but indicated she did not keep a copy of the information which was sent with the resident. If a resident was not allowed to return to the facility after discharge. She would have a conference with administration. In deciding this they would look at the safety of the residents and consider the safety of the other residents. If they are returning with more nursing care needs which are beyond what they could provide they did not allow the resident to return to the facility.<br><br>On 11/1/2024 at 1:33 p.m., the Administrator provided a copy of the Residential State Rules, and indicated it was the policy currently being used by the facility ...The administrator highlighted rule 0354 Clinical Records-Noncompliance ...."<br><br>This citation relates to Complaint IN00445086.<br><br>Based on record review and interview, the facility failed to document discharge information for 2 of 3 residents reviewed for | | | |

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| | discharge (Residents C and K).<br><br>Findings Include:<br><br>1. On 11/1/24 at 9:28 a.m., during a phone interview with the Power of Attorney (POA) of Resident C, she indicated the resident was discharged from the facility to a hospital. She was informed she would not be allowed to return because she had eloped from the facility. The POA was not notified of the discharge till hours later. She indicated the resident was discharged back to the facility and was given one to one supervision. She was informed the facility had decided to transfer the resident to another facility, but she had not been included in this decision. She was advised since the resident had eloped she must be placed in a facility with a secure unit. The POA removed the resident the next day and placed her in a long-term care facility. She indicated at the time of the discharge she was not provided any discharge information including a list of medications and directions for care.<br><br>On 11/1/24 at 10:15 a.m., the medical record of Resident C was reviewed. Admission diagnosis included but were not limited to disorientation, bi-polar disorder (a mental illness that causes unusual shifts in a person's mood), HTN (high | | | |

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| | blood pressure), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The resident was discharged on 10/19/24.<br><br>Review of the nurse progress notes indicated the resident was seen by the Nurse Practitioner (NP) on 10/7/24. She indicated she discussed increased confusion with the resident's POA. On 10/10/24 the resident eloped from the facility. She was found walking down the street in front of the facility. She was sent to the hospital for an evaluation at 7:10 p.m., the medical record indicated the POA was notified at 7:25 p.m., The resident was discharged to the hospital and returned to the facility on 10/11/24. She was seen by a physician on the day of re-admission and referred to a long-term care facility (LTC). The medical record lacked documentation of a meeting with resident and POA to discuss discharge. The record lacked documentation of the resident being discharged home with the POA or of any discharge instructions being sent with the resident and POA.<br><br>On 10/31/24 at 2:55 p.m., during an interview, the Administrator indicated she or the DON would notify the case manager at the hospital if a resident was not going to return to the facility. They did an | | | |

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| R 0045 | Residents' Rights - Deficiency<br><br>410 IAC 16.2-5-1.2(r)(6-9)<br><br>(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:<br><br>(A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:<br><br>(i) The resident.<br><br>(ii) A family member of the resident if known.<br><br>(iii) The resident ' s legal representative if known. | R 0045 | **R045 Residents Rights**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident C and Resident K no longer reside at the facility.<br><br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective** | 12/04/2024 |

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| | (iv) The local long term care ombudsman program (for involuntary relocations or discharges only).<br><br>(v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.<br><br>(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.<br><br>(vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).<br><br>(B) Record the reasons in the resident ' s clinical record.<br><br>(C) Include in the notice the items described in subdivision (9).<br><br>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.<br><br>(8) Notice may be made as soon as practicable before transfer or discharge when:<br><br>(A) the safety of individuals in the facility would be endangered;<br><br>(B) the health of individuals in the facility would be endangered;<br><br>(C) the resident ' s health improves | | **action will be taken?**<br><br>Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. Conducted audit of discharges in the last 30 days to ensure notification and discharge instructions were provided<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>The corporate clinical team reeducated Administrator and DON on discharge notifications and providing discharge instructions. DON/ designees have reeducated licensed nursing staff on discharge notifications and providing discharge instructions.<br><br>**How the corrective action(s) will be monitored to ensure** | |

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| | sufficiently to allow a more immediate transfer or discharge;<br><br>(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or<br><br>(E) a resident has not resided in the facility for thirty (30) days.<br><br>(9) For health facilities, the written notice specified in subdivision (7) must include the following:<br><br>(A) The reason for transfer or discharge.<br><br>(B) The effective date of transfer or discharge.<br><br>(C) The location to which the resident is transferred or discharged.<br><br>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any | | **the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>The administrator or designee will audit discharge notifications and discharge instructions for all discharges monthly for 6 months until 100 percent substantial compliance is achieved. Results of audits will be reviewed during monthly quality assurance meetings.<br><br>**By what date the systemic changes will be completed?**<br><br>12/04/2024 | |

questions, call the Indiana state department of health at the number listed below. " .

(E) The name of the director and the address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the state and local long term care ombudsman.

(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

Based on record review and interviews, the facility failed to notify the POA of the transfer or discharge and the reasons for the move, in writing or by conference meeting and facility failed to provide discharge instructions to the family members responsible for two of three residents reviewed for facility discharge for 2 of 3 residents reviewed for discharge (Residents C and K).

Findings Include:

1. On 11/1/24 at 9:28 a.m., during a phone interview with the Power of Attorney (POA) of Resident C, she indicated the resident was discharged from the facility to a hospital. She

indicated she was informed she would not be allowed to return because she had eloped from the facility. She indicated she was not notified of the discharge till hours later. She indicated the resident was discharged back to the facility and was given one to one supervision. She was informed the facility had decided to transfer the resident to another facility, but she had not been included in this decision. She was advised since the resident had eloped she must be placed in a facility with a secure unit. She removed the resident the next day and placed her in a long-term care facility. She indicated at the time of the discharge she was not provided any discharge information including a list of medications and directions for care.

On 11/1/24 at 10:15 a.m., the medical record of resident C was reviewed. The resident was admitted to the facility on 3/4/22. Admission diagnosis included but were not limited to disorientation, bi-polar disorder (formerly called manic-depressive illness or manic depression, is a mental illness that causes unusual shifts in a person's mood), HTN (high blood pressure), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The resident was discharged on

10/19/24.

Review of the nurse progress notes indicated the resident was seen by the Nurse Practitioner (NP) on 10/7/24. She indicated she discussed increased confusion with the resident's POA. On 10/10/24, the resident eloped from the facility. She was found walking down the street in front of the facility. She was sent to the hospital for an evaluation at 7:10 p.m. The medical record indicated the POA was notified at 7:25 p.m., The resident was discharged to the hospital and returned to the facility on 10/11/24. She was seen by a physician on the day of re-admission and referred to a long-term care facility (LTC). The medical record lacked documentation of a meeting with resident and POA to discuss discharge. The record lacked documentation of the resident being discharged home with the POA or of any discharge instructions being sent with the resident and POA.

On 10/31/24 at 2:55 p.m., during an interview with the Administrator she indicated she or the DON would notify the case manager at the hospital if a resident was not going to return to the facility. They did an assessment to determine the needs of the resident. If the resident was a danger to themselves or others they would

not be allowed to return.

A review of the facility residential care agreement indicated. "Section E, paragraph G ...Residents physical, mental or emotional condition or behavior is such that a resident is or is likely to become an endangerment to him or herself or others, in the sole judgement of the facility, then facility may terminate this agreement upon thirty (30) days prior to written notice to resident. Section V. Termination ...B termination by facility ... except when the resident's health or safety, or the health and safety of others is endangered the facility will give not less than thirty (30) days' notice of termination ...."

2. On 11/1/24 at 1:50 p.m., the medical record of Resident K was reviewed. The resident was admitted to the facility for a respite stay on 10/10/24. Admission diagnosis included but were not limited to, seizure, pain, HTN (high blood pressure) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). The resident was discharged home with family on 10/28/24. The record lacked documentation of discharge instructions being sent with the resident upon discharge. The record indicated medications

were sent but did not indicate what medications were sent.

On 11/1/24 at 12:05 p.m., during an interview, the Administrator indicated the facility did not have a specific policy for discharge. She indicated they followed the regulations. She was not aware the record did not contain any discharge information.

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allow the resident to return to the facility.

On 11/1/2024 at 1:33 p.m., the Administrator provided a copy of the Residential State Rules, and indicated it was the policy currently being used by the facility ...The administrator highlighted rule 0354 Clinical Records-Noncompliance ...."

This citation relates to Complaint IN00445086.

Based on record review and interviews, the facility failed to notify the POA of the transfer or discharge and the reasons for the move, in writing or by conference meeting and facility failed to provide discharge instructions to the family members responsible for two of three residents reviewed for facility discharge for 2 of 3 residents reviewed for discharge (Residents C and K).

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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 |
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