STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/26/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00370907 and IN00371631. Complaint IN00370907 - Substantiated. State Residential Findings related to the allegations are cited at R217. Complaint IN00371631 - Substantiated. State Residential Findings related to the allegations are cited at R243 and R349. Survey date: January 26, 2022 Facility number: 002392 Residential Census: 209 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/31/22.	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."	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, record review, and interview, the facility failed to ensure the Service Plan was reflective of the residents' activity of daily living (ADL) status for 2 of 4 records reviewed. (Residents D and C) Findings include: 1. The closed record for Resident D was reviewed on 1/26/22 at 11:00 a.m. Diagnoses included, but were not limited to, osteoarthritis, hypertension, senile degeneration of the brain, dementia, and congestive heart failure.	R 0217	1. The corrective actions that were accomplished for those residents found to be affected by deficient practices: An audit was conducted on 1/28/2022 utilizing an audit tool. 2. 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 service care plan audit on 1/28/22. All	02/10/2022

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	The Service Plan, dated 11/17/21, indicated the resident needed minimal assistance with mobility, transfers, bathing, personal hygiene, dressing and toileting. A Home Health Evaluation for wound care, dated 12/7/21, indicated the resident was dependent on staff for grooming, dressing, bathing, toileting, able to bear weight and pivot during the transfer process but unable to transfer herself, and she was chairfast (unable to ambulate and unable to wheel herself). The resident had unstageable pressure ulcers to the left buttock and sacrum. The Hospice Evaluation, dated 12/18/21, indicated the resident required total care for ADL's, was bed and broda chair bound, and required a two person assist with transfers. The Service Plan had not been updated to reflect the decline in the resident's ADL status. Interview with Director of Nursing on 1/26/22 at 3:50 p.m., indicated the resident's Service Plan should have been updated to reflect her decline in her ADL's. 2. On 1/26/22 at 10:45 a.m., Resident C was observed sitting in a broda chair in the library with many other residents participating in an activity. The resident had her eyes closed and was fully dressed in street clothes with her legs elevated. CNA 2 pushed the resident down to her room as she could not propel the broda chair. CNA 1 and CNA 2 positioned the broda chair by the resident's bed and removed the blanket from her lap. CNA 1 and CNA 2 reached under the resident's arms and picked her up to transfer her into the bed. The resident did not bear any weight and was totally dependent on both CNA's to transfer. They		applicable service care plans were revised at that time to accurately reflect Residents ADL's and care needs. 3. What measures that will be put into place and the systematic changes that the facility will make to ensure that the deficient practice does not recur includes: DON and/or designee will perform weekly service care plan audits of 20 service care plans utilizing an audit tool. 4. 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: D.O.N. will complete review 20 service care plans each week weekly for 6 months then 20 per month for 6 months. 5. The date systemic changes will be put into place is 2/10/2022.	

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	removed her pants and rolled the resident onto her left side. The resident did not help with bed mobility. Both CNA's then removed the incontinent brief, which was wet with urine. Interview with the both CNA's at that time, indicated the resident was totally dependent on staff for all care, including transfers, bed mobility, dressing, personal hygiene, eating, toileting, and bathing. She was a 2 assist for transfers, but when they only had 1 staff member on the unit, they had to transfer her by themselves. CNA 1 indicated she has had to transfer the resident by herself before because there was no one else to help. The record for Resident C was reviewed on 1/26/22 at 11:45 a.m. Diagnoses included, but were not limited to, altered mental status, confusion, dementia, anxiety, depression, osteoarthritis, Parkinson's, and senile degeneration of the brain. A Service Plan, dated 10/15/21, indicated the resident had mild impairment and was oriented to person. The resident did not require assistance with mobility/ambulation, transfers, toileting, assistance with meal consumption, bathing, and personal hygiene. The resident was at risk for falls and appropriate interventions should be implemented. Hospice services were being rendered for the resident. The hospice binder, indicated the hospice CNA was there 5 days a week in the early morning around 8:00 a.m., to provide morning care. The hospice nurse was at the facility 2 to 3 times a week to provide wound care and assess the resident.			

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	The hospice nurse had been at the facility on 12/28, 12/29/21, 1/5, 1/7, 1/12, 1/14, 1/19, 1/21, and 1/24/22. The hospice plan of care, updated in 12/2021, indicated the resident was dependent for activities of daily living. Interview with LPN 1 on 1/26/22 at 11:15 a.m., indicated the resident was totally dependent on staff for feeding, incontinence care, transfers, bathing, personal hygiene, dressing, and bed mobility. The CNA's transferred the resident by themselves, the facility did not have a hoyer lift. Interview with the Director of Nursing on 1/26/22 at 1:30 p.m., indicated the Service Plan was not updated to reflect the resident's current activities of daily living status. This state residential finding relates to Complaint IN00370907.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, record review and interview, the facility failed to ensure medications and treatments were given and/or completed as ordered for 2 of 4 residents reviewed. (Residents B and C)	R 0243	**The corrective action is as follows: on 2/9/2022 an audit was conducted of all Residents medication records and medications on hand by DON and designee. The audit**	02/28/2022

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	Finding includes: 1. The record for Resident B was reviewed on 1/26/22 at 1:44 p.m. Diagnoses included, but were not limited to, major depressive disorder, dementia, and hypertension. The January 2022 Medication Administration Record (MAR) indicated on 12/13/21, the following medications were prescribed for the resident: - Cardizem (a blood pressure medication) 360 milligrams (mg) Extended Release daily. - Potassium Chloride (a potassium supplement) micro tablet 10 milliequivalents (MEQ) Extended Release daily. - Eliquis (a blood thinner) 2.5 mg every 12 hours - Furosemide (a water pill) 40 mg twice a day The resident had not received the medications for the month of January and the orders were crossed out on the MAR. There were no Physician's Orders indicating the medications had been discontinued. The January 2022 MAR indicated the resident had received Levothyroxine (a medication to treat low thyroid levels) 75 micrograms (mcg) upon rising on 1/1 and 1/2/22. The resident had not received the medication 1/3 through 1/26/22. The resident had received Donepezil (a dementia medication) 5 mg at bedtime 1/1 through 1/21 and 1/24/22. The resident had received Zoloft (an		**reflected accuracy and availability of all medication records and medications at that time. The corrective actions accomplished for residents who were found to be affected by deficient practice are as follows DON spoke with family and Intouch Pharmacy regarding alleged deficient practice. Please see attached letter from Intouch Pharmacy.** ="" b=""> ="" b=""> An documented education will be completed on 2/22/2022 with all nurses and QMA's regarding medication ordering and reporting. DON and/or designee will complete MAR to cart audits weekly utilizing an audit tool for 3 months, then two times per month for 3 months, then monthly for 3 months. Orders were obtained for pressure sores, Resident has been discharged due to requiring a higher level of care. On 2/1/2022, DON contacted both hospice companies visiting patients at facility. Both parties (Hospice and Facility) agreed to conduct weekly service care plan meetings to ensure accurate communication, discuss transcription and implementation of orders, discuss wounds and Residents level of care. Any	

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	antidepressant) 50 mg daily 1/1 through 1/26/22. The resident was seen at her Physician's office on 1/11/2022. Discharge instructions indicated the Donepezil had been suspended and the the resident was to receive 75 mg of Zoloft. The resident's Exelon (a dementia medication) was to be increased from 3 mg to 4.5 mg twice a day. The Exelon was not increased until 1/18/22. Interview with the Director of Nursing (DON) on 1/26/22 at 3:50 p.m., indicated the resident's family takes her to her appointments and they had been instructed in the past to give the discharge instructions to nursing staff when they returned. She indicated the instructions from the 1/11/22 doctor's appointment were not received until 1/18/22. The DON also indicated the resident's Physician needed to be contacted and a medication review needed to be completed.2. On 1/26/22 at 10:45 a.m., Resident C was observed sitting in a broda chair in the library with many other residents participating in an activity. The resident had her eyes closed and was fully dressed in street clothes with her legs elevated. CNA 2 pushed the resident down to her room as she could not propel the broda chair. CNA 1 and CNA 2 positioned the broda chair by the resident's bed and removed the blanket from her lap. The resident was observed with short sleeves on and both of her arms were covered with dark red, purple, and blue bruises. Her face had a clear protective bandage noted with bruising to the left side. When queried as to what happened, CNA 2 indicated "supposedly she lunged out of the broda chair on Sunday." CNA 1 and CNA 2 reached under the resident's arms and picked her up to transfer her into the bed. The resident was observed with heel protectors to		Resident found to require a higher level of care than what the facility is able provide will be safely discharged post care plan meeting with all appropriate parties. On 2/5/2022, DON visited with all Residents to evaluate Residents ADL's and level of care. DON will conduct weekly visits with 25 Residents to evaluate care needs and document completion utilizing an audit tool weekly for 25 weeks then monthly for 5 months. Date systemic changes will be implemented is 2/28/22 ="" b="">	

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	both feet. CNA 2 removed the left heel protector and sock. There was a deep tissue injury noted to the left heel. The area was red and purple in color. She removed the right heel protector and sock. There was a bandage noted to the right heel dated 1/24/22. The bandage was loose and falling off of the open sore. There was a large open area with black necrotic tissue and dried blood noted. They removed her pants and there was a white kerlix bandage with dried blood to the right knee. There was no date on the kerlix bandage. CNA 2 rolled the resident onto her left side with the help of CNA 1. Both CNA's then removed the incontinent brief, which was wet with urine. The buttocks area was red in color and there was no bandage on either buttock. The record for Resident C was reviewed on 1/26/22 at 11:45 a.m. Diagnoses included, but were not limited to, altered mental status, confusion, dementia, anxiety, depression, osteoarthritis, Parkinson's, and senile degeneration of the brain. A Service Plan, dated 10/15/21, indicated the resident had mild impairment and was oriented to person. The resident did not require assistance with mobility/ambulation, transfers, toileting, assistance with meal consumption, bathing, and personal hygiene. The resident was at risk for falls and appropriate interventions should be implemented. Hospice services were being rendered for the resident. The resident had left heel and coccyx wounds and texas sleeves were to be on both arms at all times. There was no information about a wound to the right heel or the right knee. The hospice binder indicated the hospice CNA was there 5 days a week in the early morning			

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	around 8:00 a.m., to provide morning care. The hospice nurse was at the facility 2 to 3 times a week to provide wound care and assess the resident. The hospice nurse had been at the facility on 12/27, 12/28, 12/29/21, 1/3, 1/5, 1/7, 1/12, 1/14, 1/19, 1/21, and 1/24/22. A hospice nurse note, dated 12/27/21, indicated a left heel open area, measuring 1 centimeter (cm) by 1 cm by 0.4 cm. The nurse indicated the wound was "chronic." A hospice nurse note, dated 1/3/22, indicated a left heel open area measuring 0.5 cm by 0.8 cm by 0.3 cm classified as chronic stage 2. The right heel was boggy (spongy tissue). Heel protectors were added. A hospice nurse note, dated 1/11/22, indicated a left heel open area measuring 0.7 cm by 0.8 cm by 0.3 cm. There was no assessment completed on the right heel. A hospice nurse note, dated 1/14/22, indicated a new open area to the right buttock which measured 0.6 cm by 0.5 cm. There was no description of the wound. The left heel open area remained. A hospice nurse note, dated 1/17/22, indicated a new open area to the right heel unstageable which measured 3 cm by 2 cm. Left heel pressure sore measured 0.8 cm by 0.9 cm by 0.3 cm and the right buttock wound measured 0.9 cm by 0.8 cm. There were treatments for each of the areas. The right heel was to be cleansed with normal saline, pat dry and apply a foam dressing and put on heel protectors. The left heel was to be cleansed with			

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	normal saline, pat dry and apply Medihoney (a wound debriding agent) and cover with gauze and secure with kerlix and put on heel protectors. The right buttock was to be cleansed with normal saline, pat dry, apply Medihoney and cover with a foam dressing. The treatments were to be completed three times a week by hospice and prn by facility staff for soilage. Nurses' Notes, dated 1/23/22 at 4:35 p.m., indicated the writer heard screaming and a loud thump from the foyer (lobby). The resident was observed lying face down on the floor. There was a laceration to the left forehead and underneath the left eye. There was a laceration to the right knee and pressure dressings were applied to all areas. Vital signs were checked and hospice was called. 911 was notified and the resident was sent to the hospital. Physician's Orders, dated 1/14/22, indicated right buttock, clean with normal saline or wound cleanser, apply Medihoney then cover with dry dressing, three times weekly and prn. Physician's Orders, dated 8/9/21, indicated texas sleeves, apply from wrists to arms pits wear 24/7 change if dirty. There were no Physician's orders for the left or right heel pressure sores. There were no orders for the right knee laceration sustained from the fall. The 1/2022 Treatment Administration Record (TAR), indicated there were no treatments for the right knee laceration or the left and right heel pressure sores. Interview with Director of Nursing (DON) on			

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	1/26/22 at 1:30 p.m., indicated the resident was to have the geri sleeves on at all times and she was not aware there was a bandage on the resident's right knee. Interview with the DON on 1/26/22 at 3:45 p.m., indicated they were previously meeting with the hospice nurse biweekly, however, it had "simmered down" a little bit. Now they were only meeting with hospice every other week. This state residential finding relates to Complaint IN00371631.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to increased episodes of depression and injuries sustained from a fall for 2 of 4 residents reviewed. (Residents B and C) Findings include: 1. The record for Resident B was reviewed on 1/26/22 at 1:44 p.m. Diagnoses included, but were not limited to, major depressive disorder and dementia.	R 0349	1. The corrective actions that were accomplished for those residents found to be affected by deficient practices: An audit was conducted on 1/28/2022 utilizing an audit tool. 2. 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 service care plan audit on 1/28/22. All applicable service care plans	02/28/2022

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	Nurses' Notes, dated 12/20/21 for the A.M. shift, indicated the resident was in bed during the A.M. medication pass. The resident appeared to be quite depressed and withdrawn at that time. Staff encouraged interaction without success and would continue to encourage the resident and maintain safety. The next documented entry in the Nursing Progress Notes was dated 12/25/21 at 6:00 p.m. The entry indicated the front desk called for a safety check due to the resident making a statement about killing herself. The resident's Physician and family were notified and orders were received. Interview with the Director of Nursing on 1/26/22 at 3:50 p.m., indicated follow up documentation should have been completed prior to 12/25/21 related to the resident's depressive episode. 2. On 1/26/22 at 10:45 a.m., Resident C was observed sitting in a broda chair in the library with many other residents participating in an activity. The resident had her eyes closed and was fully dressed in street clothes with her legs elevated. CNA 2 pushed the resident down to her room as she could not propel the broda chair. CNA 1 and CNA 2 positioned the broda chair by the resident's bed and removed the blanket from her lap. The resident was observed with short sleeves on and both of her arms were covered with dark red, purple, and blue bruises. Her face had a clear protective bandage noted with bruising to the left side. When queried as to what happened, CNA 2 indicated "supposedly she lunged out of the broda chair on Sunday. We were not here when it happened." CNA 1 and CNA 2 reached under the resident's arms and picked her up to transfer her into the bed. They removed her pants and there was a white kerlix		were revised at that time to accurately reflect Residents ADL's and to ensure accurate documentation as it relates to change in condition, ADLS and care needs. A educational in-service regarding documentation and change of condition is scheduled to be conducted on 3/03/2022 to educate all clinical staff regarding Resident assessments and documentation as it relates to change in condition. 3. What measures that will be put into place and the systematic changes that the facility will make to ensure that the deficient practice does not recur includes: DON and/or designee will perform weekly service care plan audits of 20 service care plans including the monitoring of documentation utilizing an audit tool to ensure service plan assessments accurately reflects ADLS and care needs. 4. 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: D.O.N. will complete review 20 service care plans each week weekly for 6 months then 20 per month for 6 months to monitor and ensure accurate documentation and assessments as it relates to change in condition. DON will also conduct weekly risk assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/26/2022

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	bandage with dried blood to the right knee. There was no date on the kerlix bandage. The record for Resident C was reviewed on 1/26/22 at 11:45 a.m. Diagnoses included, but were not limited to, altered mental status, confusion, dementia, anxiety, depression, osteoarthritis, Parkinson's, and senile degeneration of the brain. A Service Plan, dated 10/15/21, indicated the resident had mild impairment and was oriented to person. The resident did not require assistance with mobility/ambulation, transfers, toileting, assistance with meal consumption, bathing, and personal hygiene. The resident was at risk for falls and appropriate interventions should be implemented. Hospice services were being rendered for the resident. Nurses' Notes, dated 1/23/22 at 4:35 p.m., indicated the writer heard screaming and a loud thump from the foyer (lobby). The resident was observed lying face down the floor. There was a laceration to the left forehead and underneath the left eye. There was a laceration to the right knee and pressure dressings were applied to all areas. Vital signs were checked and hospice was called. 911 was notified and the resident was sent to the hospital. Nurses' Notes, dated 1/24/22 at 3:15 a.m., indicated the resident returned to the facility. There was a hematoma noted to the left side of her face and a clear tegaderm bandage in place. Vital signs were checked. Nurses' Notes, dated 1/24/22 at 10:00 a.m., indicated the left side of the resident's face was assessed and vital signs were checked.		meetings with the clinical staff to discuss any Residents that has had a change of condition. Revised documentation will be reviewed at that time These meetings will be conducted weekly for 6 months. Findings will be documented utilizing the service care plan audit tool. 5. The date systemic changes will be put into place is 2/28/2022.	

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	Nurses' Notes, dated 1/24/22 at 10:45 p.m., indicated the left side of resident's forehead and face were assessed and vital signs were checked. Nurses' Notes, dated 1/25/22 at 11:00 a.m., indicated the resident had a previous fall and her dressing was clean, dry and intact. Vital signs were checked and she had no pain. Nurses' Notes, dated 1/25/22 at 10:00 p.m. indicated the resident was in bed and was easily aroused. Staff were monitoring the resident and skin concerns were clean and intact. There was no documentation regarding the resident's laceration to the right knee after the fall. Vital signs were not consistently checked after the fall, nor was there an actual assessment of the resident's injury sustained to her left forehead and face. Physician's Orders, dated 1/23-1/26/22, indicated there were no orders for any type of bandage for the right knee laceration. The incident report for the fall, read by the Director of Nursing (DON) on 1/23/22 at 4:35 p.m., indicated the resident was found face down on the floor and was screaming out loud. Staff observed a laceration to left forehead under the left eye and a laceration to the right knee. Interview with the DON on 1/26/22 at 3:45 p.m., indicated there was no follow up documentation of the right knee laceration after the fall. There were no Physician's Orders for a treatment to be completed for the laceration. This state residential finding relates to			

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	Complaint IN00371631.			