STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING		01/26/2022	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
TOWNE	CENTRE ASSISTI	ED LIVING LLC		ARTHUR BLVD ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
R 0000	REGULATIONTO		1110			DAIL
Bldg. 00	IN00370907 and I Complaint IN0037 Residential Findin are cited at R217. Complaint IN0037 Residential Findin are cited at R243 a Survey date: Janu Facility number: 0 Residential Census These State Reside accordance with 4	20907 - Substantiated. State gs related to the allegations 21631 - Substantiated. State gs related to the allegations and R349. ary 26, 2022 202392 s: 209 ential Findings are cited in 10 IAC 16.2-5. mpleted on 1/31/22.	R 0000	"This plan of correction is submitted as required under and Federal Law. The subm of the Plan of Correction do constitute an admission on conclusions drawn therefrom Submission of this Plan of Correction also does not constitute an admission that findings constitute a deficient that the scope and severity regarding the deficiency cite correctly applied. Any change the Community's policies an procedures should be consis subsequent remedial measu the concept is employed in 407 of the Federal Rules of Evidence and any correspon state rules of civil procedures should be inadmissible in an proceeding on that basis. Th Community submits this plan correction with the intention be inadmissible by any third in any civil or criminal action against the Community or an employee, agent, officer, din attorney, or shareholder of th Community or affiliated companies."	nission es not m- t the ncy or ed are ges to nd dered ures as Rule nding a and ny he n of that it l party n ny rector,	
R 0217 Bldg. 00	Evaluation - Define (e) Following con facility, using app					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/03/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/26/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE		
	follows: (1) The services resident shall be (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as and the resident and change. Either the may request a set (3) The agreed u signed and dated copy of the service resident upon red (4) No identificati services provided subsequent to the no need for a cha (5) If administrati provision of resid both, is needed, a involved in identificati of the services to Based on observat interview, the facil Plan was reflective daily living (ADL) reviewed. (Reside Findings include: 1. The closed recor- reviewed on 1/26/2 included, but were	on and documentation of d is needed if evaluations e initial evaluation indicate ange in services. on of medications or the ential nursing services, or a licensed nurse shall be fication and documentation be provided. on, record review, and ity failed to ensure the Service of the residents' activity of status for 2 of 4 records nts D and C) rd for Resident D was 22 at 11:00 a.m. Diagnoses not limited to, osteoarthritis, e degeneration of the brain,	R 0217	 The corrective actions the were accomplished for those residents found to be affected deficient practices: An audit were audit tool. How the facility will ident other residents having the potential to be affected by the same deficient practice and were corrective action will be taken. The facility completed a servic care plan audit on 1/28/22. All 	hat ce		

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

ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		01/26/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R	7252 A	RTHUR BLVD	
TOWNE	CENTRE ASSISTE	D LIVING LLC		ILLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				applicable service care plans	
	The Service Plan, d	lated 11/17/21, indicated the		were revised at that time to	
	resident needed min	nimal assistance with		accurately reflect Residents	
		bathing, personal hygiene,		ADL's and care needs.	
	dressing and toileti		 3. What measures the put into place and the system changes that the facility were to ensure that the deficient practice does not recur in DON and/or designee with weekly service care plan 20 service care plans utiliaudit tool. 4. How the corrective Action(s) will be monitored ensure the deficient practice not recur, i.e, what qual assurance program will be place: D.O.N. will complete the deficient place. 		lbe
		2		put into place and the systema	
	A Home Health Ev	aluation for wound care, dated		changes that the facility will m	
		the resident was dependent on		to ensure that the deficient	
		dressing, bathing, toileting,		practice does not recur include	es:
		and pivot during the transfer		-	
	-	to transfer herself, and she			
		le to ambulate and unable to		-	
		e resident had unstageable			
		ressure ulcers to the left buttock and sacrum.			
	The Hospice Evalu	ation, dated 12/18/21,		ensure the deficient practice v	vill
	-	ent required total care for		not recur, i.e., what quality	
		d broda chair bound, and		assurance program will be put	into
		on assist with transfers.		place: D.O.N. will complete re	view
	The Service Dian h	ad not been updated to reflect		20 service care plans each we weekly for 6 months then 20 p	
		esident's ADL status.		month for 6 months.	
	the decline in the re	estuent 8 ADL status.		5. The date systemic chan	des
	Interview with Dire	ector of Nursing on 1/26/22 at		will be put into place is 2/10/20	
		d the resident's Service Plan			· ·
	-	pdated to reflect her decline			
		n 1/26/22 at 10:45 a.m.,			
		served sitting in a broda chair			
		nany other residents			
		activity. The resident had her			
		s fully dressed in street			
		gs elevated. CNA 2 pushed			
		o her room as she could not			
		air. CNA 1 and CNA 2			
		a chair by the resident's bed			
	-	anket from her lap. CNA 1			
		anket from her lap. CNA I I under the resident's arms and			
		insfer her into the bed. The			
		ar any weight and was totally			
	dependent on both	CNA's to transfer. They			

Event ID: 2ITD11

Facility ID: 002392

2**392** If a

If continuation sheet

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 PRINTED:
 03/03/2022

 FORM APPROVED

 OMB NO. 0938-0391

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 01/26/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7252 ARTHUR BLVD TOWNE CENTRE ASSISTED LIVING LLC MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) 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. State Form Event ID: 2ITD11 Facility ID: 002392 If continuation sheet Page 4 of 15

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03/03/2022

	R MEDICARE & MEDI			(X2) MULTIPLE CONSTRUCTION		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED	
					01/26/2022	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
TOWNE	CENTRE ASSIST	ED LIVING LLC		ARTHUR BLVD ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	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.					
		0 1 1 1 10/2021				
		of care, updated in 12/2021,				
		ent was dependent for				
	activities of daily	living.				
	Interview with LP	N 1 on 1/26/22 at 11:15 a.m.,				
		ent was totally dependent on				
		ncontinence care, transfers,				
		rygiene, dressing, and bed				
	U . X	A's transferred the resident by				
	-	cility did not have a hoyer lift.				
	Interview with the	Director of Nursing on				
	1/26/22 at 1:30 p.1	n., indicated the Service Plan				
	was not updated to	reflect the resident's current				
	activities of daily	living status.				
	This state resident	ial finding relates to				
	Complaint IN0037	-				
R 0243	410 IAC 16.2-5-4	(e)(3)				
	Health Services					
Bldg. 00		l administering the				
-		document the administration				
	in the individual '	s medication and treatment				
	records that indic	cate the:				
	(A) time;					
	(B) name of med	ication or treatment;				
	(C) dosage (if ap	plicable); and				
	(D) name or initia	als of the person				
	-	e drug or treatment.				
		ion, record review and	R 0243	The corrective action is as	02/28/202	
		lity failed to ensure		follows: on 2/9/2022 an audit	-	
		eatments were given and/or		was conducted of all Reside	nts	
	-	red for 2 of 4 residents		medication records and		
	reviewed. (Reside	ents B and C)		medications on hand by DOI	N	
	1			and designee. The audit		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u>00</u>	COMPLETED 01/26/2022	
					01/20/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
IOWNE	CENTRE ASSIST	ED LIVING LLC	MERF	RILLVILLE, IN 46410		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Finding includes:			reflected accuracy and		
				availability of all medication		
	1. The record for	Resident B was reviewed on		records and medications at the	at	
	1/26/22 at 1:44 p.r	n. Diagnoses included, but		time. The corrective actions		
	were not limited to	o, major depressive disorder,		accomplished for residents whether the second s	no	
	dementia, and hyp	ertension.		were found to be affected by		
				deficient practice are as follow	/s	
	The January 2022	Medication Administration		DON spoke with family and		
	Record (MAR) ind	dicated on $12/13/21$, the		Intouch Pharmacy regarding		
		ions were prescribed for the		alleged deficient practice.		
	resident:			Please see attached letter from	n	
				Intouch Pharmacy.		
	- Cardizem (a bloc	od pressure medication) 360		="" b="">		
		Extended Release daily.		="" b="">		
	8 (8) =			An documented education will I	be	
	- Potassium Chlor	ide (a potassium supplement)		completed on 2/22/2022 with all		
		illiequivalents (MEQ)		nurses and QMA's regarding		
	Extended Release	· · · ·		medication ordering and		
	Entended Hereuse	aury.		reporting. DON and/or designed		
	- Fliquis (a blood)	thinner) 2.5 mg every 12 hours		will complete MAR to cart audits		
		uniner) 2.5 mg every 12 nours		weekly utilizing an audit tool for		
	Eurosemide (a w	ater pill) 40 mg twice a day		months, then two times per mor		
	- Fulosennue (a w	ater pinj 40 mg twice a day		for 3 months, then monthly for 3		
	The resident had r	ot received the medications		months.	,	
		anuary and the orders were		Orders were obtained for		
		MAR. There were no		Orders were obtained for		
	-	s indicating the medications		pressure sores, Resident has		
	had been discontir	iuea.		been discharged due to requirin	9	
	The I	MAD indicated the wee'l (a higher level of care.		
	-	MAR indicated the resident		On 2/1/2022 DON	ath	
		thyroxine (a medication to		On 2/1/2022, DON contacted bo	סמו	
		evels) 75 micrograms (mcg)		hospice companies visiting		
		and $1/2/22$. The resident had		patients at facility. Both parties		
	not received the m	edication 1/3 through 1/26/22.		(Hospice and Facility) agreed to		
				conduct weekly service care pla	in	
		eceived Donepezil (a dementia		meetings to ensure accurate		
		at bedtime 1/1 through 1/21		communication, discuss		
	and 1/24/22.			transcription and implementation	n	
				of orders, discuss wounds and		
	The resident had r	eceived Zoloft (an	1	Residents level of care. Any		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		· - /	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
			B. WING		01/2	6/2022
NAME OF	PROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP COD	E	
IN THE OF	ROVIDER OR SOTTEM		7252 A	ARTHUR BLVD		
TOWNE	CENTRE ASSIST	ED LIVING LLC	MERR	ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPE	LD BE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NOT MATE	DATE
	antidepressant) 50	mg daily 1/1 through 1/26/22.		Resident found to require	0	
				level of care than what th	•	
		seen at her Physician's office		is able provide will be saf	•	
	on 1/11/2022. Dis	scharge instructions indicated		discharged post care plan	า	
	the Donepezil had	been suspended and the the		meeting with all appropria	ate	
	resident was to rec	ceive 75 mg of Zoloft. The		parties.		
	resident's Exelon	(a dementia medication) was to				
	be increased from	3 mg to 4.5 mg twice a day.		On 2/5/2022, DON visited	d with all	
				Residents to evaluate Re	sidents	
	The Exelon was n	ot increased until 1/18/22.		ADL's and level of care.	DON will	
				conduct weekly visits with	า 25	
	Interview with the	Director of Nursing (DON) on		Residents to evaluate car	re needs	
	1/26/22 at 3:50 p.1	m., indicated the resident's		and document completion	n utilizing	
	family takes her to	her appointments and they had		an audit tool weekly for 2	5 weeks	
	been instructed in	the past to give the discharge		then monthly for 5 month	s.	
	instructions to nur	sing staff when they returned.				
	She indicated the	instructions from the $1/11/22$		Date systemic changes w	/ill be	
	doctor's appointm	ent were not received until		implemented is 2/28/22		
	1/18/22. The DO	N also indicated the resident's		="" b="">		
	Physician needed	to be contacted and a				
		v needed to be completed.2.				
	On 1/26/22 at 10:4	45 a.m., Resident C was				
	observed sitting in	a broda chair in the library				
	with many other r	esidents participating in an				
	activity. The resid	lent 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 resid	ent was observed with short				
	_	th of her arms were covered				
	with dark red, pur	ple, and blue bruises. Her face				
		tive bandage noted with				
	-	t side. When queried as to				
	e	NA 2 indicated "supposedly she				
		broda chair on Sunday." CNA 1				
	and CNA 2 reached under the resident's arms a					
		ansfer her into the bed. The				
		rved with heel protectors to				

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	00	X3) DATE SURVEY COMPLETED 01/26/2022	
	PROVIDER OR SUPPLIEI		7252 A	ADDRESS, CITY, STATE, ZIP CO RTHUR BLVD ILLVILLE, IN 46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	both feet. CNA 2 r protector and sock. injury noted to the and purple in color. protector and sock. to the right heel dat loose and falling of a large open area w dried blood noted. there was a white k to the right knee. T bandage. CNA 2 ro side with the help of removed the incont with urine. The bu and there was no ba The record for Resi 1/26/22 at 11:45 a. were not limited to, confusion, dementi osteoarthritis, Parki degeneration of the A Service Plan, dat resident had mild in person. The reside with mobility/ambu assistance with mea personal hygiene. T falls and appropriat implemented. Hosp rendered for the res heel and coccyx wo to be on both arms information about a the right knee.	emoved the left heel There was a deep tissue left heel. The area was red She removed the right heel There was a bandage noted ed 1/24/22. The bandage was if of the open sore. There was ith black necrotic tissue and They removed her pants and erlix bandage with dried blood here was no date on the kerlix lled the resident onto her left of CNA 1. Both CNA's then inent brief, which was wet ttocks area was red in color andage on either buttock. dent C was reviewed on n. Diagnoses included, but , altered mental status, a, anxiety, depression, inson's, and senile brain. ed 10/15/21, indicated the mpairment and was oriented to nt did not require assistance alation, transfers, toileting, al consumption, bathing, and The resident was at risk for e interventions should be pice services were being ident. The resident had left ounds and texas sleeves were at all times. There was no a wound to the right heel or indicated the hospice CNA				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 01/26/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7252 ARTHUR BLVD TOWNE CENTRE ASSISTED LIVING LLC MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 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 State Form Event ID: 2ITD11 Facility ID: 002392 If continuation sheet Page 9 of 15

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03/03/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 B. WING 01/26/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7252 ARTHUR BLVD TOWNE CENTRE ASSISTED LIVING LLC MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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 State Form Event ID: 2ITD11 Facility ID: 002392 If continuation sheet Page 10 of 15

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u></u>	Сом 01/2	(X3) DATE SURVEY COMPLETED 01/26/2022	
	PROVIDER OR SUPPLIE		7252	et address, city, state, zip co 2 ARTHUR BLVD 2 RILLVILLE, IN 46410	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
R 0349 Bldg. 00	to have the geri sla was not aware ther resident's right known Interview with the indicated they were hospice nurse biw "simmered down" only meeting with This state resident Complaint IN0037 410 IAC 16.2-5-8 Clinical Records (a) The facility m on each resident maintained unde employee of the responsibility. The follows: (1) Complete. (2) Accurately do (3) Readily access (4) Systematicall Based on observat interview, the facili records that were of documented relate depression and inj 2 of 4 residents rev Findings include: 1. The record for 1/26/22 at 1:44 p.r	DON on 1/26/22 at 3:45 p.m., e previously meeting with the eekly, however, it had a little bit. Now they were hospice every other week. (a) finding relates to 1631. .1(a)(1-4) - Noncompliance ust maintain clinical records . These records must be r the supervision of an facility designated with that e records must be as cumented. ssible.	R 0349	 The corrective ac were accomplished for residents found to be a deficient practices: An conducted on 1/28/202 an audit tool. How the facility other residents having potential to be affected same deficient practice corrective action will be The facility completed a care plan audit on 1/28 applicable service care 	those ffected by audit was 2 utilizing will identify the by the and what taken. a service /22. All	02/28/202	

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	x3) date survey completed 01/26/2022
	PROVIDER OR SUPPLIE		7252 A	ADDRESS, CITY, STATE, ZIP CODE RTHUR BLVD ILLVILLE, IN 46410	
X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	DATE
	Nurses' Notes, date	d 12/20/21 for the A.M. shift,		were revised at that time to	
	indicated the reside	ent was in bed during the A.M.		accurately reflect Residents	
	medication pass. T	he resident appeared to be		ADL's and to ensure accurate	
	-	l withdrawn at that time. Staff		documentation as it relates to	
		tion without success and		change in condition, ADLS and	
	-	encourage the resident and		care needs. A educational	
	maintain safety.	-		in-service regarding	
		The next documented entry in the Nursing		documentation and change of	
	The next document			condition is scheduled to be	
		s dated 12/25/21 at 6:00 p.m.		conducted on 3/03/2022 to	
	The entry indicated	the front desk called for a		educate all clinical staff regardi	ng
	-	the resident making a		Resident assessments and	°
	statement about kil	ling herself. The resident's		documentation as it relates to	
		ly were notified and orders		change in condition.	
	were received.			3. What measures that will	be
				put into place and the systemat	tic
	Interview with the	Director of Nursing on		changes that the facility will ma	
		., indicated follow up		to ensure that the deficient	
	-	uld have been completed prior		practice does not recur include	s:
		to the resident's depressive		DON and/or designee will perfo	orm
		.6/22 at 10:45 a.m., Resident		weekly service care plan audits	
	-	ting in a broda chair in the		20 service care plans including	
		other residents participating in		the monitoring of documentatio	
		sident had her eyes closed and		utilizing an audit tool to ensure	
	was fully dressed in	n street clothes with her legs		service plan assessments	
	elevated. CNA 2 p	ushed the resident down to her		accurately reflects ADLS and	
	_	not propel the broda chair.		care needs.	
		positioned the broda chair by		4. How the corrective	
		nd removed the blanket from		Action(s) will be monitored to	
	her lap. The reside	nt was observed with short		ensure the deficient practice wi	II
	sleeves on and both	of her arms were covered		not recur, i.e, what quality	
	with dark red, purp	le, and blue bruises. Her face		assurance program will be put	into
	had a clear protecti	ve bandage noted with		place: D.O.N. will complete rev	iew
	bruising to the left	side. When queried as to		20 service care plans each wee	ek
	what happened, CN	IA 2 indicated "supposedly she		weekly for 6 months then 20 pe	er
	lunged out of the b	roda chair on Sunday. We		month for 6 months to monitor	and
	were not here when	it happened." CNA 1 and		ensure accurate documentation	ו ו
	CNA 2 reached une	der the resident's arms and		and assessments as it relates t	0
	picked her up to tra	nsfer her into the bed. They		change in condition. DON will a	lso
	removed her pants	and there was a white kerlix		conduct weekly risk assessmer	nt

Facility ID: 002392

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	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/26/2022	
	PROVIDER OR SUPPLIE		7252 A	address, city, state, zip code RTHUR BLVD ILLVILLE, IN 46410	-	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) d blood to the right knee. There	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) meetings with the clinical staf		(X5) OMPLETIC DATE
	was no date on the The record for Res 1/26/22 at 11:45 a were not limited to confusion, dement osteoarthritis, Parl degeneration of th A Service Plan, da resident had mild person. The reside with mobility/amb assistance with mo personal hygiene. falls and appropria implemented. Ho rendered for the re Nurses' Notes, dat indicated the write thump from the fo observed lying fac laceration to the le left eye. There wa and pressure dress Vital signs were c 911 was notified a hospital. Nurses' Notes, dat indicated the resid There was a hema her face and a clea Vital signs were c	sident C was reviewed on .m. Diagnoses included, but o, altered mental status, ia, anxiety, depression, cinson's, and senile e brain. ted 10/15/21, indicated the impairment and was oriented to ent did not require assistance pulation, transfers, toileting, eal consumption, bathing, and The resident was at risk for ate interventions should be spice services were being esident. ed 1/23/22 at 4:35 p.m., er heard screaming and a loud yer (lobby). The resident was a ed own the floor. There was a eff forehead and underneath the as a laceration to the right knee ings were applied to all areas. hecked and hospice was called. Ind the resident was sent to the ed 1/24/22 at 3:15 a.m., ent returned to the facility. toma noted to the left side of ur tegaderm bandage in place.		meetings with the clinical staf discuss any Residents that ha had a change of condition. Revised documentation will b reviewed at that time These meetings will be conducted w for 6 months. Findings will be documented utilizing the serv care plan audit tool. 5. The date systemic chan will be put into place is 2/28/2	as e eekly ice nges	

NTERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. 1	MULTIPLE CC BUILDING WING	DNSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 01/26/2022	
				STREET A	ADDRESS, CITY, STATE, ZI	P CODE		
NAME OF	PROVIDER OR SUPPLIEF	2			RTHUR BLVD			
TOWNE	CENTRE ASSISTE	D LIVING LLC		MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE	
	Nurses' Notes data	d 1/24/22 at 10:45 p.m.,						
		de of resident's forehead and						
		and vital signs were checked.						
	Numaal Natas data	$d \frac{1}{25}$						
		d 1/25/22 at 11:00 a.m., nt had a previous fall and her						
		g was clean, dry and intact. Vital signs lecked and she had no pain. Notes, dated 1/25/22 at 10:00 p.m.						
	-							
	Nurses' Notes, date							
		nt was in bed and was easily						
		e monitoring the resident and						
	skin concerns were	clean and intact.						
	There was no docur	nentation regarding the						
	resident's laceration	to the right knee after the						
	-	re not consistently checked						
		as there an actual assessment						
	forehead and face.	ary sustained to her left						
	Physician's Orders	dated 1/23-1/26/22,						
		e no orders for any type of						
	bandage for the righ							
	The incident report	for the fall, read by the						
	-	(DON) on 1/23/22 at 4:35						
	~	resident was found face down						
		s screaming out loud. Staff						
		on to left forehead under the						
	left eye and a lacera	ation to the right knee.						
		DON on 1/26/22 at 3:45 p.m.,						
		no follow up documentation						
		ceration after the fall. There						
	completed for the la	Orders for a treatment to be						
	This state residentia	l finding relates to						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	TERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			ETED
			B. WING 01/26/20				/2022
	NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATC.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Complaint IN00371	631.					
							l

State Form	Event ID:	2ITD11	Facility ID:	002392	If continuation sheet	Page 15 of 15	