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

FORM APPROVED
OMB NO. 0938-039

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	06/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 IN00403733, IN00404683, IN00406236, IN00409478, and IN00409562. Complaint IN00403733 - State deficiency related to the allegations is cited at R0090. Complaint IN00404683 - No deficiencies related to the allegations are cited. Complaint IN00406236 - No deficiencies related to the allegations are cited. Complaint IN00409478 - State deficiency related to the allegations is cited at R0090. Complaint IN00409562 - State deficiency related to the allegations is cited at R0090. Survey date: June 5 & 6, 2023 Facility number: 002392 Residential Census: 220 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/8/23.	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 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rikki Ford	Administrator	07/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.			

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	(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for abuse. (Resident E) Finding includes: Review of a facility Grievance/Concern Form, dated 5/11/23, indicated Resident E reported to the Admission's Coordinator that staff are abusive towards her. During an interview on 6/5/23 at 3:33 p.m., the Admission's Coordinator indicated she had reported the concern to the Executive Director (ED), though she was unsure when it was reported. During an interview on 6/5/23 at 3:38 p.m., the ED indicated the allegation had not been reported to the IDOH. She had been informed of the allegation immediately and when she attempted to talk to the resident to investigate, she refused to speak with her or anyone else in the facility. The facility Abuse Policy, dated 2/19/16 and received from the ED as current, indicated the facility must report incidents to the IDOH within 23 hours of learning of the occurrence. This state residential finding relates to Complaints IN00403733, IN00409478, and IN00409562.	R 0090	The corrective actions accomplished for the resident to have been affected by the deficient practice is; the allegation was immediately reported to ISDH on 6/5/2023. Currently, this resident continues to decline to meet with the Administrator with or without family present or any other staff present. On 6/14/2023 through 6/16/2023, all grievances and concerns from November 2023 through June 2023 were carefully reviewed to ensure all allegations were reported. No other allegations were noted at that time. No other residents were noted to have been affected. The systemic changes put into place to ensure the deficient practice does not recur is: The facility's administrator and all facility employees will complete an educational in-servicing on 6/26/2023 through 6/30/2023 to review the facility's abuse policy in accordance with ISDH reporting requirements to ensure knowledge and compliance. in addition, all pertinent grievances and allegations will be reviewed by the Administrator, Human Resources Director, Administrative	07/07/2023

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			Liaison, Director of Nursing and/or designee 5 days a week for 12 months to monitor allegations and ensure proper response and reporting compliance. On 6/20/2023 designees completed an educational in-service regarding the ISDH gateway and reporting process including portal sign in information. The corrective actions will be monitored utilizing a 5-day weekly audit document that will be completed by the Administrator, Human Resources Director, Director of Nursing, Administrative Liaison, and or/designee. and stored with grievance reports. The completion date is 7/7/2023	