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	08/30/2023

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414189, IN00414337, IN00415017, IN00415257, and IN00416416. Complaint IN00414189 - No deficiencies related to the allegations are cited. Complaint IN00414337 - State deficiency related to the allegations is cited at R0241. Complaint IN00415017 - No deficiencies related to the allegations are cited. Complaint IN00415257 - State deficiency related to the allegations is cited at R0241. Complaint IN00416416 - No deficiencies related to the allegations are cited. Survey date: August 29 & 30, 2023 Facility number: 002392 Residential Census: 217 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/1/23.	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 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rikki Ford	Administrator	09/18/2023

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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	shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered by the Physician for 2 of 5 residents in the Memory Care Unit observed during a morning medication pass. (Residents M and N). The facility also failed to ensure Resident M received the correct dosage of a medication after a dosage change for a medication ordered by the Physician. Findings include: 1. During a morning medication pass observation on 8/29/23 at 7:35 a.m., LPN 1 prepared Resident M's medication. She placed one tablet of aspirin 81 mg (milligrams), one tablet of quetiapine (antipsychotic) 50 mg, and two tablets of acetaminophen 325 mg in a medication cup and indicated there were four tablets. She then crushed the medication and placed them in a nutritional drink and administered the medications to the resident. After the medications were administered, LPN 1 indicated the resident also received lorazepam (anti-anxiety). She drew up 0.5 milliliters (ml) of liquid from the bottle and administered the medication under the tongue (sublingually). The label on the lorazepam bottle indicated there were two mg's per ml and to administer 0.5 ml three times a day. Resident M's record was reviewed on 8/30/23 at 11:08 a.m. The diagnoses included, but were not limited to dementia. The resident was receiving	R 0241	Medication Patch Deficiency · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective actions put into place is, the affected resident's family and physician was informed of the medication error. The resident was assessed and monitored for 72 hours. The nurse responsible received an education regarding the error. In addition, the order transcription was revised. · 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 transdermal medication audit on September 1, 2023, to ensure all transdermal medications were administered properly in accordance with physician's orders. The facility recognizes that other residents could have been affected by the alleged deficient practice however, none were noted to be affected at that time. · What measures will be put into place or what systemic	09/28/2023

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	Hospice Services. A Physician's Order, dated 8/22/23 at 3 p.m., indicated the lorazepam order had been changed to give 0.25 ml twice a day. A Physician's Order, dated 8/4/23, indicated a 1 mg scopolamine patch (nausea and vomiting prevention) was to be administered every three days for increased secretions. The Medication Administration Record (MAR), dated 8/2023, indicated a new patch was to be applied on 8/29/23 on the morning medication pass. The patch had not been applied and had not been signed out as administered on the MAR. The Controlled Substance Count Sheet indicated the correct amount of lorazepam remained in the bottle and the resident received 0.5 ml of the lorazepam on 8/22/23, 8/23/23. 8/24/23, 8/25/23, 8/26/23, 8/28/23 at bedtime and received 0.5 ml of the lorazepam on 8/23/23, 8/24/23, 8/26/23, 8/27/23, 8/28/23, and 8/29/23 during the morning medication pass. During an interview on 8/30/23 at 11:15 a.m., RN 2 acknowledged the wrong dose of lorazepam had been administered. During an interview on 8/30/23 at 11:30 a.m., the Unit Manager indicated the lorazepam dosage had been changed. 2. LPN 1 prepared Resident N's morning medication on 8/29/23 at 7:27 a.m., which included 1 tablet of carbidopa/levodopa (Parkinson's disease treatment) 25-250 mg, 1 tablet of dexamethasone (steroid) 4 mg, 1 tablet of potassium 10 milliequivalents, one tablet of		changes the facility will make to ensure that the deficient practice does not recur; The measures put into place to ensure the alleged practice does not recur is: all QMA's and nurses completed an educational in-service on 9/15/23 and 9/18/23 to review a required document that must be signed daily upon administering medication patches to ensure proper placement. This two-step verification will consist of signing transdermal medications out as given in the medication records, documenting placement is confirmed and documenting again on the transdermal patch document location with the medication record. · 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; The corrective actions will be monitored by the Director of Nursing and/or designee(s) 5 days per week utilizing an audit tool to monitor compliance. The audits will continue 5 days per week for 6 months. If quality compliance is maintained during that time, the audits will discontinue at the end of the 6-month period. If non-compliance is determined, the audits will continue for an additional 6 months, and	

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	escitalopram (antidepressant) 20 mg. She indicated there were four tablets and then administered the medications. Resident N's record was reviewed on 8/30/23 at 11:25 a.m.. The diagnoses included, but were not limited to dementia. A Physician's Order, dated 8/2/23, indicated omeprazole (stomach medication) 20 mg was to be given with the morning medication. The omeprazole had not been administered as ordered. This state residential finding relates to Complaints IN00414337 and IN00415257.		additional monthly education will be implemented monthly for 6 months. · By what date the systemic changes will be completed. September 22, 2023 Incorrect Dosage Deficiency · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective actions put into place is, the affected resident's family and physician was informed of the medication error. The resident was assessed and monitored for 72 hours. The nurse responsible received an education regarding the error. In addition, the medication administration record was revised to reflect the correct dosage to be administered. · 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 medication order audit of all physicians order's received for the past 90 days to ensure the medication administration record reflected the current physician order, and the supply of medication on hand in the facility.	

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			· What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The measures put into place to ensure the alleged practice does not recur is: all QMA's and nurses completed an educational in-service on 9/15/23 and 9/18/23 and scheduled for 9/20/23 to review proper medication administration. InTouch Pharmacy has also been contacted to complete medication and cart audits and will be conducted before 10/10/23 . In addition, all nurses and QMA's will complete medication administration audits to be documented and conducted by the Director of Nursing and or designee monthly for 6 months to ensure proper medication administration is completed. This will be verified by utilizing an monitoring tool to confirm auditing. · 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; The corrective actions will be monitored by the Director of Nursing and/or designee(s) 5 days per week utilizing an MAR to cart audit tool to monitor compliance.	

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			The audit tool will consist of a MAR to CART audit that will be completed weekly for 6 months to ensure correct dosages are in supply according to physician orders and will be completed by the Director of Nursing and/or designee. · The MAR to cart audits will continue weekly for 6 months. If quality compliance is maintained during that time, the audits will discontinue at the end of the 6-month period. If non-compliance is determined, the audits will continue for an additional 6 months, and additional monthly education will be implemented monthly for 6 months. · By what date the systemic changes will be completed. September 28, 2023	