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	02/25/2025

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 IN00450879, IN00451374, IN00451396, IN00452221, IN00453232, IN00453712, and IN00453719. Complaint IN00450879 - State deficiencies related to the allegations are cited at R0036 and R0241. Complaint IN00451374 - No deficiencies related to the allegations are cited. Complaint IN00451396 - State deficiencies related to the allegations are cited at R0154. Complaint IN00452221 - State deficiencies related to the allegations are cited at R0036, R0154 and R0241. Complaint IN00453232 - No deficiencies related to the allegations are cited. Complaint IN00453712 - No deficiencies related to the allegations are cited. Complaint IN00453719 - State deficiencies related to the allegations are cited at R0090. Survey date: 2/25/25 Facility number: 002392 Residential Census: 211 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/27/25.	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."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rikki Ford	Executive Director	03/10/2025

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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R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to notify a resident's physician and responsible party of a low blood pressure which resulted in a heart medication not being administered. The facility also failed to ensure the physician and responsible party were notified of the heart medication not being administered for multiple days after the physician ordered parameters for the heart medication to be administered for 1 of 3 residents reviewed for physician and responsible party notification. (Resident B) Finding includes: Resident B's record was reviewed on 2/25/25 at 10:30 a.m. The diagnoses included, but were not limited to, atrial fibrillation. A Physician's Order, dated 8/18/24, indicated Metoprolol (heart medication), 25 mg (milligrams) was to be given daily. The Medication Administration Record (MAR), dated 12/2024, indicated the Metoprolol was not administered on December 4, 5, and 6, 2024 due to a low blood pressure. The MAR, dated 1/2025, indicated the Metoprolol was not administered on January 2, 2025 due to a low blood pressure. The physician and responsible party had not been notified of the low blood pressure and medication not administered. A Physician's Order, dated 1/29/25, indicated a	R 0036	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. On March 3, 2025 the attending physician and family members were notified regarding multiple blood pressure readings and medications being held/not 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; On March 5, 2025 the Director of Nursing and unit manager completed an audit using an audit tool reviewing all nurses' notes, medication books and treatment books for the past 90 days to ensure no other residents were affected by deficient practice. • 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; a) March 5, 2025 an all-pertinent nursing staff in-service was completed, regarding proper notification per ISDH regulations. b) An audit will be completed by the Director of nursing and/or designee 3 times a week for 90 days then monthly for 6 months. c) monthly educational in-services will continue for 6 months • How the corrective action(s) will	03/13/2025

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	blood pressure was to be checked prior to the administration of the Metoprolol 25 mg. If the systolic blood pressure (upper number) was less than 110, the Metoprol was to be held/not administered. The MAR, dated 2/205, indicated the Metoprolol was not administered on February 6, 7, 8, 13, 16, 21, and 24, 2025 due to a low blood pressure. The physician and responsible party had not been notified of the multiple low blood pressures and medication not administered. During an interview on 2/25/25 at 11:06 a.m., the Memory Care 1 Unit Manager indicated the physician and responsible party should have been notified of the low blood pressures and the medication not administered. An undated physician and responsible party notification policy, received as current from the Administrator on 2/25/25 at 11:59 a.m., indicated the resident's family and physician were to be notified promptly of a resident's condition change, which included changes in a health status and medications. Updates that could impact treatment or medication were to be communicated without delay to the physician and responsible party. This citation relates to Complaints IN00450879 and IN00452221		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The corrective actions will be monitored by the Director or Nursing and/or designee using audit tools. • By what date the systemic changes will be completed. Changes will be put into place by 3/13/2025	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on record review and interview, the facility failed to report a major accident that occurred in the facility to the Indiana Department of Health (IDOH) within 24 hours for 1 of 3 residents	R 0090	**1. Corrective Action for Affected Resident:** The resident involved in the	03/13/2025

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	reviewed for reportable incidents to the IDOH. (Resident F) Finding includes: On 2/3/25, an incident was reported to IDOH that occurred on 1/31/25 at 7:55 a.m. Resident F had an unwitnessed fall and was found on her bedroom floor. The resident indicated she heard someone knocking on her door and she had gotten up to answer it. She had lost her balance and fell and hit her head. The housekeeper was knocking on the door and confirmed the sequence of events. The nurse was notified and assessments were completed. The resident had an abrasion that was noted on her forehead. The resident was sent out to the hospital via 911. A follow up, added on 2/5/25, indicated Resident F had experienced brain swelling and bleeding after the fall. The resident and her family decided against surgical intervention and the resident passed away. Resident F's record was reviewed on 2/25/25 at 11:53 a.m. The diagnoses included, but were not limited to, dementia, hypertension (high blood pressure), depression, stroke, renal disease, and psychotic disorder. A Nurse's Note, dated 1/31/25 at 8:30 a.m., indicated 911 was called and Emergency Medical Services (EMS) was activated. The Nurse Practitioner was notified and agreed with a transfer to the Emergency Room (ER). A Nurse's Note, dated 1/31/25 at 12:00 p.m., indicated an update was received from the ER and the resident had brain bleeding. The hospital had suggested surgery, and the family declined intervention due to the resident's request to be a do not resuscitate (DNR).		incident has unfortunately passed away, and we acknowledge the failure to report the incident within 24 hours. Although the incident cannot be corrected, we have reviewed the circumstances surrounding the event and have taken immediate steps to ensure this does not happen in the future. We have ensured that the appropriate documentation and notification protocols have been put in place for future incidents to comply with state regulations. **2. Identifying Other Residents at Risk and Corrective Actions:** To identify any other residents who may be affected by this same deficiency, on March 4th, 2025, the Executive Director conducted a review of all reported incidents in the past 90 days utilizing an audit tool by ensuring compliance with the 24-hour reporting requirement. On 3/7/2025 all relevant staff members will be retrained on the importance of timely reporting. 3**. Systemic Changes to Prevent Recurrence:** The following systemic changes will be implemented to ensure this deficiency does not recur: **Training**: All relevant staff will undergo mandatory training monthly for 6 months on incident reporting protocols, with a focus on the 24-hour reporting requirement, effective March 7, 2025. **Designated Reporting Team**:	

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	A Nurse's Note, dated 1/31/25 at 3:00 p.m., indicated Resident F's daughter called and notified the facility that the resident had expired. During an interview on 2/25/25 at 12:28 p.m., the Memory Care 2 Unit Manager indicated she thought she had three days to report an incident. She did not report the incident from the weekend until Monday February 3, 2025. During an interview on 2/25/25 at 2:59 p.m., the Administrator indicated she did not know she needed to report on the weekend. In her 18 years in administration, she had never reported on the weekend. She was not aware she only had 24 hours. This citation relates to Complaint IN00453719.		We have designated specific individuals (Executive Director, Director of Nursing, Unit Managers) responsible for tracking all incidents and ensuring that reporting is completed within the required 24-hour timeframe. This process will include immediate reporting to the team via email. Then a reporting team member will report the incident no later than 24 hours from the identified date. Email confirmation from ISDH will be printed and documents will be audited weekly utilizing an audit tool by Executive Director, Director of Nursing or designee. **4. Monitoring and Quality Assurance Measures:** To monitor and ensure that the corrective actions are effective, we will implement the following quality assurance measures: **Monthly Audits**: The Designated Reporting Team will conduct documented monthly audits for 6 months of all incidents reported during that period. This will include verifying the timeliness of reports and ensuring that documentation is complete and accurate. **5. Date for Completion of Systemic Changes:** The systemic changes outlined above will be fully implemented by March 13, 2025 Plan of Correction for Wet	

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R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, record review, and interview, the facility failed to ensure 1 of 2 dining areas and utensils were kept clean and sanitary related to food on the floor and silverware still wet from washing being placed in plastic bags ready to use on the tables. (Memory Care 1 Dining Room on the first floor) Findings include: 1. During an observation of the Memory Care 1 first floor dining room on 2/25/25 at 9:15 a.m., there were food containers on the tables and there was food on the floor throughout the dining room. The Unit Manager indicated the dining room had not been cleaned after breakfast yet. 2. During an observation of the Memory Care 1 first floor dining room on 2/25/25 at 10:20 a.m., Dietary Aide 1 was setting the the tables for the lunch meal. She had placed at total 15 settings (placemats, napkins, and silverware stored in a plastic bag) on the tables in the dining room. The food on the floor, observed at 9:15 a.m., remained on the floor. The silverware for 6 of the place settings observed remained wet with moisture on the inside of the plastic bags. During an interview at the time of the observation, Dietary Aide 1 indicated she was setting the dining room up for the lunch meal. She was unsure who was responsible for cleaning the dining room. She acknowledged the silverware remained wet inside the plastic bags.	R 0154	Silverware and Crumbs of **1. Corrective action(s) for residents found to have been affected by the deficient practice:** For silverware: No residents were found to be affected by wet silverware. All silverware was immediately collected. All residents were provided with clean, dry silverware, and the situation was addressed immediately. For food crumbs on the floor: No residents were found to be affected. On February 26, 2025 all floors were thoroughly cleaned to ensure there were no crumbs remaining. Residents' meal environments were promptly restored to maintain comfort and safety. **2. How the facility will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:** For wet silverware: On February 26, 2025 an audit was conducted consisting of a visual inspection of all meal settings was conducted to ensure silverware was fully dry prior to serving.	03/12/2025

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	During an interview on 2/25/25 at 11:43 a.m., the Dietary Manager indicated Dietary Aide 1 had reported the wet silverware and the silverware was replaced with dried ones. During an observation on 2/25/25 at 12:08 p.m., there were seven residents in the dining room eating their meals. The food observed at 9:15 a.m. and 10:20 a.m. remained on the floor. During an interview at the time of the observation, CNA 2 indicated there was food on the floor. An undated kitchen sanitation policy, received from the Administrator as current on 2/25/25 at 1:14 p.m., indicated floors would be swept and cleaned after each meal. The utensils were to be thoroughly air dried prior to storage. This citation relates to Complaints IN00451396 and IN00452221.		For food crumbs: A facility-wide documented inspection was conducted after every meal on February 26, 2025 through March 1, 2025, to ensure the dining room floors were free from crumbs. On February 26, 2025 all dietary staff were in-serviced regarding their duties to thoroughly clean areas where food is served and consumed before and after mealtimes. No residents were found to be affected during that time. **3. Measures or systemic changes the facility will make to ensure that the deficient practice does not recur:** For wet silverware: On February 26, 2025 all dietary staff were re-trained on proper silverware handling and drying procedures to prevent similar occurrences. The facility will implement a daily documented check system, where silverware will be inspected by the dietary director and/or designee before being served to residents. The frequency and duration of the documented check system will be daily for 6 months. The Dietary Director and/or designee will be responsible for monitoring For food crumbs: A revised daily cleaning checklist will be introduced to all dietary staff on March 11, 2025, whereas the Dietary Director and/or scheduled dietary staff will be assigned to	

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			check the dining areas immediately after meals throughout the day to ensure cleanliness. Checks will be documented daily indefinitely and monitored by the Dietary Director and/or designee. Additionally, dining room attendants will be in-serviced monthly for 6 months utilizing educational literature documenting acknowledgment and completion. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Corrective monitoring includes the completion of a checklist document after each meal, confirming that all necessary actions are taken (e.g., checking silverware, inspecting the floor, cleaning dining areas), and these checklists will be reviewed daily using an audit tool by the Dietary Director and/or designee. 5. By what date the systemic changes will be completed: Systemic changes will be completed by March 12, 2025.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interview, the facility failed to ensure a medication was administered as	R 0241	What corrective action will be accomplished for those residents	03/13/2025

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	ordered by the physician for 1 of 3 residents reviewed for medication administration. (Resident B) Finding includes: Resident B's record was reviewed on 2/25/25 at 10:30 a.m. The diagnoses included, but were not limited to, atrial fibrillation. A Physician's Order, dated 8/18/24, indicated Metoprolol (heart medication), 25 mg (milligrams) was to be given daily. A Physician's Order, dated 1/29/25, indicated a blood pressure was to be checked prior to the administration of the Metoprolol 25 mg. If the systolic blood pressure (upper number) was less than 110, the Metoprol was to be held/not administered. The Medication Administration Record, dated 2/2025, indicated the following: The Metoprolol was held on February 10, 11, 12, 14, 19, 20, 22, 23, and 25, 2025. There were no blood pressures checked/documented. The Metoprolol was administered without the blood pressure being checked on February 1, 2, 3, 4, 5, 9, and 15, 2025. The blood pressure was not obtained and the Metoprolol was not administered on February 17 and 18, 2025. During an interview on 2/25/25 at 10:51 a.m., the Memory Care 1 Unit Manager indicated the blood pressure was to be documented every day it was checked and was to be checked prior to the		found to have been affected by the deficient practice. On February 26, 2025 the residents had blood pressure was taken, the physician and family were notified of the results. No new orders were received at that time. 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. On March 5, 2025, using an audit tool, a review of all resident medication and treatment records for the past 90 days was completed by the Director of Nursing and unit manager to determine if any other residents were affected by deficient practice. No other residents were affected at that time. 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. On March 3, 2025 an all-pertinent staff in-service was completed to educate staff regarding medication administration and following physician orders. An audit will be completed by the Director of nursing and/or designee 3 times a week for 90 days then monthly for 6 months. c) monthly educational in-services regarding medication administration and following	

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	administrations of the Metoprolol. She was unable to determine if the medication had been administered on February 17 and 18, 2025. An undated facility medication administration policy, received as current from the Director of Nursing on 2/25/25 at 12:16 p.m., indicated the medications were to be administered in a timely manner and documented accurately. The correct dose of the medication was to be administered. This citation relates to Complaints IN00450879 and IN00452221.		physician's order's, will continue for 6 months 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; and The corrective actions will be monitored by the Director or Nursing and/or designee using an audit tool that details the date, frequency of audit, room numbers audited and compliance fulfillment results. The systemic date of completion is 3/13/25	