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	10/18/2022

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 IN00389230, IN00390925, and IN00391642. This visit was in conjunction with the Post Survey Revisit (PSR) to the State Residential Licensure Survey and the PSR to the Investigation of Complaints IN00377550, IN00379284, IN00381495, and IN00384290 completed on 7/27/22. Complaint IN00389230 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00390925 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00391642 - Substantiated. State deficiencies related to the allegations are cited at R0041 and R0053. Complaint IN00377550 - Corrected. Complaint IN00379284 - Corrected. Complaint IN00381495 - Corrected. Complaint IN00384290 - Corrected. Survey dates: October 17 and 18, 2022 Facility number: 002392 Residential Census: 225 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/20/22.	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."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rikki Ford	Administrator	11/14/2022

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 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on record review and interview, the facility failed to implement abuse policies related to staff not immediately notifying the Administrator of an allegation of verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: The record for Resident B was reviewed on 10/18/22 at 10:45 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and Alzheimer's disease. Nurses' Notes, dated 9/19/22 (no time), indicated the writer received a call from the resident's daughter, who proceeded to show the writer "a disturbing video" of an employee using curse words in the presence of the resident. Nurses' Notes, dated 9/19/22 (no time), indicated the resident's family brought in a video of a nurse in the resident's room. The video revealed a nurse using profanity in the presence of the resident. There was no physical abuse and no injury was noted to the resident. An investigation was immediately initiated.	R 0041	The corrective actions put into place is: The staff nurse was immediately suspended and terminated to prevent any further encounters with residents. A complete head to toe assessment was completed of Resident B to ensure no physical abuse occurred. The resident was also interviewed to ensure Resident B was not injured and felt safe. The facility identified other residents having the potential to be affected by the deficient practice by completing one on one interviews with all residents to ensure no physical, verbal, sexual, mental abuse occurred. The measures put into place to ensure the deficient practice does not recur is: an all staff in-service will be conducted on 11/4/2022 to educate staff regarding proper communication and the use of profanity. The staff CNA who failed to immediately report the incident	11/17/2022

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	The allegation of verbal abuse, dated 9/19/22, indicated a staff member used a curse word in front of a resident. The employee was suspended and later terminated. The Administrator called the Community Liaison on 9/19/22 at 1:15 p.m. and requested she meet with the resident's son. She met with the son on the third floor in the library at 2:00 p.m. He then showed her the video of the nurse making threats stating "I'm not getting beat up by a F****** [word not able to be understood] and if you kick me I swear to God, I'll call the cops on you." There was a second employee in the room encouraging the resident to get in the bed. Once they left the room, the resident calmly got into the bed. The Community Liaison then contacted the Administrator and told her what was in the video and asked the son to give permission to send the video to the Administrator and he said he would do that. CNA 1, who was in the room during the incident, did not inform any staff of the allegation of verbal abuse until asked about it the next day. Interview with the Director of Nursing via phone on 10/18/22 at 11:00 a.m., indicated the resident's daughter called her that morning and left a message indicating her loved one had been verbally abused and it was caught on the camera. The CNA did not report the allegation of the verbal abuse. Interview with the Administrator on 10/18/22 at 12:35 p.m., indicated CNA 1 actually defended LPN 1 indicating she was a good nurse, however, she did not report the incident to anyone. The current 2/19/16 "Abuse Prevention Policy" provided by the Administrator on 10/18/22 at 12:48 p.m., indicated "All personnel must report		was also terminated. Also, all staff received an educational in-serving reviewing the facility's abuse policy particularly immediately reporting concerns. The facility will complete monthly educational in-servicing regarding the facility's abuse policy utilizing a tracking tool monthly for 6 months then semi-annually for 24 months. Facility to complete an abuse audit weekly for 6 months that includes 20 resident interviews and observations to ensure there have been no unreported allegations of abuse. The corrective actions will be monitored utilizing a monitoring tool by the Administrator and/or designee. The date of the systemic changes will be 11/17/2022	

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	the following: knowledge of or reasonable cause to believe a resident has been or is being abused, mistreated, or neglected, including injuries of unknown source, or misappropriation of resident property. The report must be made immediately to the Facility Administrator, the Director of Nursing or a direct supervisor." This State Residential Finding relates to Complaint IN00391642.			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: The record for Resident B was reviewed on 10/18/22 at 10:45 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and Alzheimer's disease. Nurses' Notes, dated 9/19/22 (no time), indicated the writer received a call from the resident's daughter, who proceeded to show the writer a "disturbing video" of an employee using curse words in the presence of the resident. Nurses' Notes, dated 9/19/22 (no time), indicated the resident's family brought in a video of a nurse in the resident's room. The video revealed a nurse using profanity in the presence of the resident. There was no physical abuse and no injury was noted to the resident. An investigation was	R 0053	The corrective actions put into place is: The staff nurse was immediately suspended and terminated to prevent any further encounters with residents. A complete head to toe assessment of resident B was completed to ensure no physical abuse occurred. The resident was also interviewed to ensure Resident B was not injured and felt safe. The facility identified other residents having the potential to be affected by the deficient practice by completing one on one interviews with all residents to ensure no physical, verbal, sexual, mental abuse occurred. The measures put into place to ensure the deficient practice does not recur is: an all staff in-service will be conducted on 11/9/2022 to educate staff regarding Resident	11/17/2022

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	immediately initiated. The allegation of verbal abuse, dated 9/19/22, indicated a staff member used a curse word in front of a resident. The employee was suspended and later terminated. The Administrator called the Community Liaison on 9/19/22 at 1:15 p.m., and requested she meet with the resident's son. She met with the son on the third floor in the library at 2:00 p.m. He then showed her the video of the nurse making threats stating "I'm not getting beat up by a F****** [word not able to be understood] and if you kick me I swear to God, I'll call the cops on you." There was a second employee in the room encouraging the resident to get in the bed. Once they left the room, the resident calmly got into the bed. The Community Liaison then contacted the Administrator and told her what was in the video and asked the son to give permission to send the video to the Administrator and he said he would do that. CNA 1, who was in the room at the time of the incident, emailed a statement to the facility. The CNA statement indicated the resident was "beating up" the nurse and herself as they were trying to get her into bed. The resident cursed at the staff as well. LPN 1 got frustrated and said "F*** it" she was not going to put up with this anymore. The CNA wrote in her statement the nurse was not used to working with residents like Resident B and the resident was not really herself that night. A statement from LPN 1 indicated she was scratched and kicked in the stomach, legs and arms. The LPN indicated she did not swear at the resident but may have said a cuss word out of frustration from "getting beat up."		Rights. Also, all residents will receive a Residents' Rights informational education regarding their rights as a resident which will occur between November 7, 2022 and November 12, 2022 utilizing a census tool to ensure all residents receive the information In addition, the facility will complete monthly staff educational in-servicing regarding the facility's abuse policy utilizing a tracking tool bi-monthly for 6 months then semi-annually for 24 months. Facility to complete an abuse audit weekly including speaking with 20 family members and 8 employees weekly for 6 months that includes inquiring about staff observatory or reported concerns of abuse as well as family member reports of any concerns to ensure there have been no unreported allegations of abuse. The corrective actions will be monitored utilizing a monitoring tool by the Administrator and/or designee. The date of the systemic changes will be 11/17/2022	

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	CNA 1 did not inform any staff of the allegation of verbal abuse until asked about it the next day. Interview with the Director of Nursing via phone on 10/18/22 at 11:00 a.m., indicated the resident's daughter called her that morning and left a message indicating her loved one had been verbally abused and it was caught on the camera. CNA 1 did not report any allegation of the verbal abuse. Interview with the Administrator on 10/18/22 at 12:35 p.m., indicated CNA 1 actually defended LPN 1 indicating she was a good nurse, however, she did not report the incident to anyone. This State Residential Finding relates to Complaint IN00391642.			