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	01/23/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00416936, IN00417082, IN00417715, IN00417984, IN00418886, IN00418935, IN00419284, IN00419841, and IN00422911. Complaint IN00416936 - State deficiency related to the allegations is cited at R0144. Complaint IN00417082 - State deficiency related to the allegations is cited at R0349. Complaint IN00417715 - No deficiencies related to the allegations are cited. Complaint IN00417984 - State deficiency related to the allegations is cited at R0041. Complaint IN00418886 - No deficiencies related to the allegations are cited. Complaint IN00418935 - State deficiency related to the allegations is cited at R0036. Complaint IN00419284 - No deficiencies related to the allegations are cited. Complaint IN00419841 - No deficiencies related to the allegations are cited. Complaint IN00422911 - No deficiencies related to the allegations are cited. Survey dates: January 22 and 23, 2024 Facility number: 002392	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	02/13/2024

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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	Residential Census: 226 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/29/24.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to promptly notify a resident's family member of a significant change in condition related to COVID-19, for 1 of 13 sampled residents. (Resident F) Finding includes: During an interview on 1/22/24 at 2 p.m., Resident F indicated she had tested positive for COVID-19 last October 2023. The resident indicated she was told she had to stay in her room, however, she could have visitors. The record for Resident F was reviewed on 1/22/24 at 1:30 p.m. A Nurses' Note, dated 10/3/23 at 7:00 p.m., indicated the resident tested positive for COVID. There were no signs or symptoms of shortness of breath or distress. The Physician was made aware.	R 0036	R036 1. The corrective actions accomplished for the resident was the family was contacted to discuss resident 's COVID positive status and address any pending concerns. A review of the resident’s medical records indicated that on the Residents family was later notified via telephone. 2. The facility identified other residents having the potential to be affected by conducting a chart review of all residents’ charts from 2/2/2024 through 2/9/2024 by Administrator, Director of Nursing, ADON and clinical unit manager. No other residents were found to be affected at that time.	02/17/2024

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	The next entry in Nurses' Notes, was on 10/4/23 at 11:00 p.m., which indicated the resident was not in distress and her vital signs were checked. There was no documentation the resident's family, who had durable Power of Attorney, was notified she had tested positive for COVID-19. During an interview on 1/22/24 at 4:00 p.m. the Director of Nursing indicated there was no documentation the resident's family was notified she had tested positive for COVID-19, but the facility should notify family with COVID-19 positive status. This citation relates to Complaint IN00418935.		3. The measures put into place to ensure the deficient practice does not recur is: 3a. all alert charting will be reviewed by Director of Nursing, ADON, clinical unit manager and/or designee 4 days per week using an audit tool to ensure proper notification. 3b. On 2/6/2024 all nursing staff were in-serviced regarding notification and change of condition policy. 3c. All newly employed nurses will be in-serviced at time of hire regarding notifying and documenting when there is a change in condition utilizing an acknowledgement form. 4c. Each resident's chart will have a document inserted under the nurses notes tab, reminding all nurses to notify all parties when there is a change of condition. 4. The corrective actions will be monitored by the Director of Nursing, ADON, clinical unit manager and/or designee four times per week for 6 months the weekly for 3 months. 5. Completion date will be 2/17/2024	
R 0041	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency			

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Bldg. 00	(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 their own grievance policy for a family member with complaints, related to being promptly notified when medications were in need of being refilled, for 1 of 13 sampled residents (Resident C) Finding includes: Resident C's record was reviewed on 1/22/24 at 10:11 a.m. Diagnoses included, but were not limited to, kidney disease, hypertension (low blood pressure), dementia, and prostate cancer. A Nurse's Note, dated 9/18/24 at 3:50 p.m., indicated the QMA and the Unit Manager called the resident's daughter to communicate medications that needed to be refilled. The daughter responded she was on her way to the facility. The current and revised 6/2020 "Grievance/Concern Policy and Procedure" policy, provided by the Administrator on 1/24/24 at 3:45 p.m., indicated ..."It is the policy of this facility to throughout investigate all resident and family grievances/concerns regarding his/her treatment, medical care, behavior of other residents, staff members, theft of property, ect., without fear or mistreatment or reprisal in any	R 0041	R041 1. The corrective action that was accomplished for resident C is: the Director of Nursing documented the grievance using the facility's grievance form. Further investigation revealed that the grievance was previously resolved. 2. The facility identified other residents having the potential to be affected by the deficient practice by: (2a) an interview was conducted by the Administrator, and Director of Nursing on 2/04/2024 to discuss and review any undocumented grievances. No other residents were noted to be affected at that time. (2b) On 2/5/2024 the Director of Nursing reviewed all correspondences for past 90 days to ensure all past grievances were documented and the facility's grievance policy was utilized.	02/19/2024

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	form..." During an interview on 1/23/24 at 11:39 a.m., the Director of Nursing indicated she couldn't provide any further documentation the resident's daughter was notified of his need for medication refills. The nurses or QMA's have contacted the daughter when refills were required. During an interview on 1/23/24 at 3:36 p.m., the Administrator indicated a grievance should've been filed for the family's concern over not being notified timely when medications were in need of a refill. This citation relates to Complaint IN00417984.		(2c) on 2/05/2024, the Director of Nursing, ADON and Human Resources Dept completed an educational in-servicing regarding the facility's grievance process to ensure understanding. (2d)on 2/28/2024 all current employees, residents and family members will receive a documented reminder of the facility's grievance policy as well as a grievance form to document any pending or future grievances. 3. All grievances will be reviewed weekly by the Board of Directors to ensure the facilitation of the facility's grievance process. The review and compliance determination will be monitored utilizing a quality assurance monitoring tool. 4. The grievance process will be monitored by the Board of Directors weekly for 6 months, then monthly for 3 months. 5. The date of systemic changes will be 2/19/2024.	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of			

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	daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure a CNA's certificate was current and not expired while she worked at the facility. (CNA 3) Finding includes: The employee files were reviewed on 1/22/24 at 4:30 p.m. CNA 3 was hired on 10/4/23, with an out of state certificate that had an expiration of 1/2023. The last day the CNA worked at the facility was on 1/22/24. During an interview on 1/23/24 at 2:00 p.m., the Human Resource Director indicated the CNA's certificate had expired and she was unaware.	R 0118	R118- 1 The corrective actions that were accomplished for residents found to be affected by the deficient practice is the employee was contacted and removed from any and all-scheduled workdays. Employee has also been terminated for not obtaining an updated License. 2 The facility identified other residents having the potential to be affected by the same deficient practice by reviewing all nursing departments employee licenses from 2/1/2024 through 2/4/2024. All licenses were verified under the professional licensing agency website to verify all licensed employees were active and compliant with standards. 3 The measures that will be put in place and the systemic that the facility will make to ensure that the deficient practices does not recure includes: 3a. on 2/1/2024 Employee Excel Force Electronic System was	02/05/2024

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			revised to generate a report that automatically notifies the facility by receiving an email notification 30 days prior to license expiration. 3b. in addition, each license will be reviewed monthly by the accounting director and/or designee using an audit tool to monitor the efficacy of the revised system. 4 The corrective actions will be monitored by the human resource department, accounting director and/or designee by analyzing populated reports monthly for 12 months, then quarterly indefinitely. 5 The date systemic changes will be put into place is 2/5/2024.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid			

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	personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure an employee's health screen was signed by a licensed nurse or a Physician for 2 of 5 employee files reviewed. (Dietary Staff 1 and CNA 2) Findings include: The employee files were reviewed on 1/22/24 at 4:30 p.m.. The following employees lacked documentation of a signature from a licensed nurse or the Physician	R 0121	R121 1 The corrective actions that were accomplished for residents found to be affected by the deficient practice is the files were corrected and reviewed and approved by the facility's licensed Nurse. 2 On 2/1/2024 through 2/5/2024, Human Resources reviewed all Departments Health	02/05/2024

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	on their health screens: a. Dietary Staff 1, hired on 12/13/23. b. CNA 2, hired on 1/4/24. During an interview on 1/23/24 at 3:00 p.m., the Human Resource Director indicated after the employee completed their health screen questionnaire, she gave them to the Administrator to sign because she was also a licensed nurse, however, she had not given her these screens.		Screening Forms by auditing all employee files utilizing a checklist to ensure all health information was reviewed and signed in acknowledgement by a licensed nurse. No other concerns were found at that time. 3 The measures that will be put in place to ensure that the deficient practices do not recur includes: (3a). on 2/1/2024- a mandatory in-service was conducted by the Administrator to review Rule 5 with Human Resources Director to ensure acknowledgement and understanding of regulations as it relates to health screenings being reviewed and signed by a licensed nurse or physician. (3b). on 2/5/2024 a doublecheck checklist system was initiated to ensure both Human Resource and Administrative assistant verifies that all documentations are reviewed, signed and dated by the correct personnel. This system will be monitored by utilizing a revised checklist and will be attached to all employees' files indefinitely to ensure compliance. (3c). A copy of the checklist and employee file will be forwarded to the Administrator for final reviewing.	

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			4 The corrective actions will be monitored by the Human Resource Department and/or designee. A minimum of 15 files will be reviewed weekly utilizing a monitoring tool for 16 weeks, then monthly for 3 months. The revised checklist system will continue indefinitely. 5 The date systemic changes will be put into place is 2/5/2024.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair, related to marred walls, holes in walls, peeling paint and drywall, call lights lacking pull cords, torn and frayed carpet, and leaky faucets on 3 of 3 units. (Independent Living, Assisted Living, and Memory Care) Findings include: During the Environmental Tour on 1/23/24 at 1:33 p.m., with the Maintenance Supervisor, the following was observed: 1. Independent Living	R 0144	R144 1 The corrective action that was accomplished for residents found to be allegedly affected by deficient practice is: (1a) new alert device installed in room 137. (1b) bathroom faucets and hardware were adjusted mechanically, and parts were assessed for malfunctioning. Any applicable parts were replaced at that time to ensure no drips or leaks.	02/19/2024

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	a. The faucet located on the bathroom sink in Room 137 was leaking. There was no pull cord for the bathroom call light. One resident resided in this room. b. There was a hole near the base of the wall by the entrance door in Room 168. There was no toilet paper holder in the bathroom. One resident resided in this room. c. There was a hole in the wall behind the entrance door in Room 258. The carpet was torn and frayed and nails were protruding from the metal tacking strip. The corner of the wall by the closet was gouged and marred. One resident resided in this room. 2. Assisted Living The door frame to Room C31 was marred and had chipped paint. The bathroom door frame was marred and had chipped paint. The soap dispenser located on the wall in the bathroom had sections of peeling dry wall on the sides and bottom of the dispenser. One resident resided in this room. 3. Memory Care Unit The base of the wall at the entrance of Room 424 had areas of peeling paint. The bathroom door frame was marred and had chipped paint. One resident resided in this room. During an interview on 1/23/24 at 2:10 p.m., the Maintenance Supervisor indicated all of the above were in need of repair. This citation relates to Complaint IN00416936.		(1c) As it relates to frayed carpet, the facility reviewed past work orders for this apartment of concern and noted that this resident previously received new carpet however, her motorized scooter continuously indents and frays carpet. It was also noted that this resident has a cat who shreds and frays the carpet. Records indicated the carpet was also repaired by Hometown Flooring after the new installation. However, on 2/5/24 a new carpet was installed again. (1d) On 1/28/2024 through 2/7/2024, all areas noted to have areas of concern to walls were repaired including apartments 137, 168, 258, C31, 424. 2. On 2/2/2024 through 2/4/2024, the maintenance director completed an environmental audit of the community including assessing faucets, showers, and walls to ensure no other residents were affected by the alleged deficient practice. 3. The measures put in place to ensure the deficient practice does not recur is: 3a. On 2/9/2024 all maintenance employees completed an environmental in-service training to be educated on the facility's revised policy related to reporting and repairing environmental concerns. 3b. In addition, on 2/9/2024 through 2/12/2024, all residents	

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			and employees received educational documents related to the facility's revised maintenance repair policy and the reporting process to ensure the consistency of the repair process. 3c. The facility has implemented a revised daily cyclical maintenance system that involves the inspection of 13 apartments per day, 5 days per week to ensure all apartments and areas are inspected monthly. This revised system also requires all areas of concern to be repaired at the time of inspection. 4. Efficacy of the corrective actions will be monitored utilizing an audit tool to document the apartments and areas monitored as well as the details of the required repairs. The systemic changes will be monitored by the maintenance director, assistant maintenance director and/or designee and will be completed 5 days per week indefinitely. 5. Date of completion will be 2/19/2024.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter			

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	and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was clean and in good repair, related to missing cabinet doors, a rubber gasket coming apart from the sink, dirty pipes, grease and debris on the floor under the garbage disposal, and walls and the ceiling with chipped paint for 2 of 2 kitchens. (The Main Kitchen and Assistive Living Kitchen) Findings include: 1. During the Main Kitchen sanitation tour on 1/22/24 at 9:05 a.m., with Dietary Supervisor 1, the following was observed: a. The cabinet doors were missing. b. The rubber gasket was coming apart from the sink in the dish room. c. There was grease and debris on and under the garbage disposal. During an interview at that time, Dietary Supervisor 1 indicated that things were going to be fixed. 2. During the Assisted Living Kitchen sanitation tour on 1/22/24 at 10:12 a.m., with Dietary Supervisor 2, the following was observed: a. The walls and ceiling were observed with chipped paint. b. The pipes under the dish machine had an accumulation of lime build up. During an interview at that time, Dietary	R 0154	R154 1.The corrective actions accomplished for residents/areas to have been affected by the deficient practice is: 1a. On 2/09/2024 new kitchen cabinets were ordered to replace previous cabinets with missing doors. 1b.the rubber gasket under the sink was replaced and the pipes were cleaned. The debris under the garbage disposal and dish machine was cleaned. 1c. Calumet Cleaning services are scheduled to complete a steam cleaning of both kitchens on 2/13/2024 at 6:00 pm. 1d. On 2/9/2024 through 2/12/2024, both kitchens were repainted. 2. Although the facility recognizes that residents may have the potential to be affected by this deficient practice, on 2/09/2024, the community reviewed grievances from the past 6 months, reviewed resident council reports from the past 6 months, and closely inspected all areas in both kitchens however, no residents were found to have been affected. 3. The measures put into place to ensure the deficient practice does not recur is: (3a)On 1/24/24 and 1/25/24, all	02/16/2024

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	Supervisor 2 indicated that "things were going to get better."		dietary employees attended an educational in-services to review sanitation expectations and requirements. (3b) on 2/9/2024 through 2/12/2024, all dietary employees received educational documents related to the facility's revised maintenance repair policy and the reporting process to ensure the consistency of the repair process. (3c) on 2/10/2024, the community revised its current kitchen sanitation scheduled to include the inspection of walls, areas under the dish machine and the garbage disposal. The inspection and compliance will be monitored daily utilizing a checklist. 4. The corrective actions will be monitored by the dietary director, dietary supervisor and/or designee. Audits will be conducted daily indefinitely. 5. Date of completion will be 2/16/2024	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living.			

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	(3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a self-administration of medication evaluation was completed for 1 of 13 residents reviewed. (Resident 1) Finding includes: On 1/22/24 at 1:28 p.m., Resident 1 was observed lying in bed watching a movie. There was a blue inhaler sitting on her nightstand. On her dresser was a tube of antihistamine ointment. During an interview on 1/22/24 at 1:31 p.m., the resident indicated she used the inhaler and cream whenever she needed it. Resident 1's record was reviewed on 1/22/24 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar, schizophrenia, low back pain, hypertension (low blood pressure), and neuropathy (numbness). A Physician's Order, dated 1/2/23, indicated to inhale 2 puffs of Albuterol Aerosol (inhaler) every two hours as needed for shortness of breath. The record lacked any documentation a self-administration of medication evaluation had been completed for the resident to ensure she could safely administer her own medications. There was no Physician's Order for Diphenhydramine (antihistamine) HCl and Zinc	R 0216	216 The corrective actions that will be accomplished was on 1/23/24 the medication was removed from the resident's apartment. On 1/25/24 a self-administer test was completed. The resident was deemed competent to self-administer the inhaler and biofreeze. Attending physician was contacted, orders received to self-administer medications. The measures put into place to0 ensure deficient practice does not recur is; On 2/6/24, an environmental audit was completed of each apartment to ensure no medications, oral or topical were in residents' apartments without self-administer physician order. On 1/23/24 ADON completed a one-on-one education with all staff and residents to review the community's self-administration policy to include education regarding all residents must notify refrain from purchasing medications independently and failing to notify staff to ensure the physician is	02/16/2024

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	ointment, and no Physician's Order to self administer medications. A Policy, titled, "Resident Self-Management of Medications", indicated, ..."If the Physician has checked "yes" to indicate the resident is capable of self administration, the Wellness Director should conduct a Medication Self Administration Assessment..." During an interview on 1/23/24 at 11:45 a.m., the Director of Nursing indicated the resident does not have an order to self-administer medications and she should not have had medications at her bedside.		notified to give order to self-administer and complete a self-administer assessment. The facility will complete environmental audits of 40 rooms weekly, using an audit tool to ensure medications are not stored in residents' rooms who do not have an order to self-administer weekly. The corrections actions will be monitored by DON/ADON and/or designee. The date of systemic changes will be 2/16/24	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy			

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	of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to update a resident's Service Plan when there were changes in medications and treatments for 1 of 13 Service Plans reviewed. (Resident G) Finding includes: During an interview on 1/22/24 at 2:15 p.m., Resident G indicated she was very ill last fall, and could not eat any food, had lost weight, and was diagnosed with gastroparesis (paralysis of the stomach). She no longer had to take Insulin and her blood pressure was very good. She has no open areas on her body including her buttocks and legs. The resident indicated staff never asked her for an updated medication list or any information when she comes back from the doctor's office. The resident stated, "the nurse just came in here and told me to sign my Service Plan. I told her I wanted to read it first, she said back to me, you can, just sign this now, and I will bring it back to you." The record for Resident G was reviewed on 1/22/24 at 11:40 a.m. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, hypotension, anxiety, anemia, and constipation.	R 0217	217 The corrective actions that will be accomplished was on 1/25/24, Resident G service care plan was updated. Medications and treatment orders were updated. On 1/27/24 the physician completed a physician review and competed a medication revision and updated orders. The corrective actions that were put in place to identify if other residents were affected was on 1/27/24 DON and unit manager reviewed all service care plan and made sure were revised to reflect all residents current care needs. The measures put into place to prevent reoccurrence is : On 1/23 all nursing staff was educated regarding ensuring service care plans are up to date and reflects residents' level of care. The facility has developed a checklist form which the DON, ADON and unit	01/27/2024

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	Physician's Orders, dated 6/22/21, and on the current 1/2024 Physician's Order Statement (POS), indicated right lower leg, cleanse with Hibiclens to open area and apply Band-Aid daily. Physician's Orders, dated 4/24/34, and on the 1/2024 POS, indicated Calmoseptine to buttocks twice a day. Physician's Orders, dated 5/30/23, and on the 1/2024 POS, indicated apply a 2 by 2 hydrocolloid to the right buttock wound daily. A Nurses' Note, dated 10/9/23, indicated the resident was found on floor in her room. There was no injury. The resident's son and Physician were notified. The Service Plan, updated 1/9/24 and signed by the resident, indicated the resident had no falls in the last 90 days. There were handwritten notes on the front of the Service Plan indicating the resident had treatments of hydrocolloid and Calmoseptine to the buttocks every day and to cleanse the right lower leg with Hibiclens. The resident also received Lantus Insulin and Ozempic. During an interview on 1/22/24 at 3:30 p.m., the Director of Nursing indicated the resident's Service Plan was outdated and those treatments needed to come off the POS. The resident attended her own appointments and the nurses needed to get the information from the resident, so the medication list could be updated. She was unaware the resident only was taking 5 of her medications. During an interview on 1/22/24 at 4:00 p.m., Unit Manager 1 indicated the resident's Service Plan		manager will use to monitor all residents care needs and service care plans monthly during recapulations using an audit tool. All residents service care will be reviewed monthly by DON , ADON and clinical management team. I addition 15 service care plans will be randomly audited weekly for 24 weeks, The date of systemic changes are 1/27/24	

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	was not up to date. .			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was prepared and stored under sanitary conditions, related to uncovered food, and food that was not dated, for 2 of 2 kitchens observed. (The Main Kitchen and Assisted Living Kitchen). Findings include: 1. During the Main Kitchen sanitation tour on 1/22/24 at 9:05 a.m., with Dietary Supervisor 1, the following was observed: There were 2 loaves of bread and an uncovered cup of juice in the freezer that were not dated. During an interview at that time, Dietary Supervisor 1 indicated that things were going to be fixed. 2. During the Assisted Living Kitchen sanitation tour on 1/22/24 at 10:12 a.m., with Dietary Supervisor 2, the following was observed: a. There were containers of juice and milk in the refrigerator that were not dated. b. There was food wrapped in a paper towel in the microwave that was not labeled or dated.	R 0273	The correction actions put into place were: an audit was completed to ensure that all pertinent items were dated. Any items discovered undated were immediately discarded on 1/25/2024. The dining supervisor completed an audit of all food areas including equipment and refrigerators, to ensure all items were properly labeled. No residents were noted to be affected at that time. The measures put into place to ensure the deficient practice does not recur is: Dining Director and/or designee will complete daily checks of all kitchen areas to ensure all food items are properly labeled. These audits will be conducted daily for 12 weeks, then twice weekly for 8 weeks, then weekly indefinitely. The audits will be completed using a documentation audit tool created	02/12/2024

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	During an interview at that time, Dietary Supervisor 2 indicated that "things were going to get better".		to monitor compliance and will be completed by the Dining Director and/or designee. The date of systemic changes was 2/12/2024	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure medications were available for a resident with the diagnosis of a fecal impaction for 1 of 13 sampled residents. (Resident K) Finding includes: The record for Resident K was reviewed on 1/22/24 at 3:38 p.m. Diagnoses included, but were not limited to, dementia, congestive heart failure (CHF), stroke, and chronic kidney disease. Nurses' Notes, dated 11/16/23 at 8:50 a.m., indicated the resident was observed lying on their right side. The resident was complaining of neck and right leg pain. 911 was called and the resident was sent to the emergency room for evaluation. The resident returned to the facility at 6:19 p.m., and documentation in the Nurses' Notes indicated the resident had impacted stool in their intestine and constipation. A new order was received for Miralax (a laxative) 17 grams/1 scoop daily in the morning for 3 days. The resident's daughter was updated on their status and the new medication	R 0297	R297 The corrective action completed for Resident K was the facility ensure all medications were available for resident K. The facility reviewed resident's K bowel and bladder book investigate any additional concerns. None were noted at that time. The facility identified all residents having the potential to be affected by deficient practice by completing an audit of all medication carts on 1/31/24 to ensure all medications were available for all resi9dents. The measures put into place to ensure the deficient practice does not recur is: MAR to CART audits weekly for 12 weekly then monthly for 6 months. On 1/23/24, all	02/07/2024

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	order at 7:13 p.m. Nurses' Notes, dated 11/17/23 at 12:40 a.m. and 6:00 p.m., had no documentation indicating if the Miralax had been delivered or the pharmacy had been contacted. Nurses' Notes, dated 11/18/23 at 2:10 a.m., indicated the resident's Miralax had been delivered and would be given as ordered. An entry at 4:00 p.m., indicated the Miralax was administered that morning and no bowel movement was noted during the shift. The November 2023 Medication Administration Record (MAR), indicated the resident received the Miralax on 11/18, 11/19, and 11/20/23. During an interview on 1/23/24 at 3:30 p.m., the Administrator indicated documentation should have been completed related to the pharmacy being contacted for the Miralax. She also indicated the facility did not have Miralax available for emergency use, and next time a situation like that arose, the Miralax would be obtained from a local pharmacy, since it can be bought over the counter.		nurses attended an educational in-service regarding medication availability to ensure al residents medications are available. The corrective action will be monitored by DON, ADON and clinical team using an audit tool. Th date of the systemic changes will be 2/7/24	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			

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	Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented\, related to the lack of documentation before and after a hospitalization, monitoring of bowel movements, when a resident left the facility out on pass, and after an altercation between a resident and staff, for 5 of 13 sampled residents. (Residents E, K, G, J, and D) Findings include: 1. The record for Resident E was reviewed on 1/22/24 at 11:02 a.m. Diagnoses included, but were not limited to, type 2 diabetes, congestive heart failure (CHF), and hypertension. Nurses' Notes, dated 12/15/23 at 11:50 a.m., indicated the resident had returned to the facility from the emergency room. There was no documentation indicating why the resident was sent to the emergency room. During an interview on 1/22/24 at 2:00 p.m., the Director of Nursing indicated documentation should have been completed related to the resident being sent to the hospital. 2. The record for Resident K was reviewed on 1/22/24 at 3:38 p.m. Diagnoses included, but were not limited to, dementia, congestive heart failure (CHF), stroke, and chronic kidney disease. Nurses' Notes, dated 11/16/23 at 8:50 a.m., indicated the resident was observed lying on their right side. The resident was complaining of neck and right leg pain. 911 was called and the resident was sent to the emergency room for evaluation. The resident returned to the facility at 6:19 p.m., and documentation in the Nurses' Notes indicated the resident had impacted stool in their intestine	R 0349	349 Resident E- The corrective actions put into place Resident E is resident declined interview with DON to discuss the reason she went to the hospital. DON completed an entry on 1/24/24 to address Resident's 12/15/23 hospital stay. On 2/1/24, all nurses' notes were reviewed for the past 90 days by the Director of Nursing, ADON and clinical unit manager using an audit tool to ensure no other residents were affected by the alleged deficient practice. This audit was documented to ensure quality assurance. The measures that will be put into place to prevent this deficient practice from reoccurring is: (3a) a document was created and distributed to all residents and families requesting that nursing staff is notified prior to initiating hospital transfers to ensure the nursing staff has knowledge of transfer to ensure the facility's documentation practices and policies are followed.	02/16/2024

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	and constipation. A new order was received for Miralax (a laxative) 17 grams/1 scoop daily in the morning for 3 days. The resident's daughter was updated on their status and the new medication order at 7:13 p.m. Nurses' Notes, dated 11/17/23 at 12:40 a.m. and 6:00 p.m., had no documentation indicating if the resident had a bowel movement since returning to the facility. There was also no documented assessment of bowel sounds. Nurses' Notes, dated 11/18/23 at 2:10 a.m., indicated the resident's Miralax had been delivered and would be given as ordered. An entry at 4:00 p.m., indicated the Miralax was administered that morning and no bowel movement was noted during the shift. Nurses' Notes, dated 11/19/23 at 9:55 a.m., indicated the Miralax had been administered as ordered with no adverse side effects and staff would continue to monitor. There was no documentation in the Nurses' Notes indicating if the resident had a bowel movement or of bowel sounds. The next documented entry in the Nurses' Notes was on 11/24/23. The Bowel and Bladder Log, dated 11/2023, indicated the resident was documented as having a soft bowel movement every day on the day and night shift. During an interview on 1/23/24 at 3:30 p.m., the Administrator indicated follow up documentation related to the resident's bowel status should have been completed. She also indicated the accuracy of the documentation on the bowel and bladder log would need to be reviewed due to the resident's diagnoses of fecal impaction and		(3b) Monthly reminder statement will be included in all residents' monthly invoices as a reminder to notify staff immediately in the event of a hospital admission, transfer or change in care/medications. (3c) A document was created and included in the community's admission packet requesting that all residents and family members notify staff immediately of hospital admissions, transfers or changes in care/ medications. The corrective actions will be monitored and reviewed by Director of Nursing, ADON, clinical unit manager using an audit tool reviewing all alert charting 4 days per week for 6 months then weekly for 3 months. The date of systemic changes: 2/20/2024 349 Resident K	

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	constipation. 3. During an interview on 1/22/24 at 2:15 p.m., Resident G indicated she had her gall bladder removed last year. The record for Resident G was reviewed on 1/22/24 at 11:40 a.m. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, hypotension, anxiety, anemia, and constipation. Nurses' Notes, dated 6/19/23 at 10:00 p.m., indicated the resident told staff she had an appointment tomorrow for gall bladder surgery. The next documented Nursing Note was on 6/20/23 at 8 p.m., which indicated the resident was getting around on the power scooter and told staff she had some pain, but was able to tolerate it. Nurses' Notes, dated 6/21/23 at 9:00 p.m., indicated the resident complained of some abdominal pain and had 1 episode of diarrhea. Nursing staff changed the bandage on the resident's abdomen after she took a shower. The next documented Nursing Note was on 6/23/23, which indicated there were steri-strips to the residents's abdomen, and her vital signs were checked. There was no documentation when the resident left for surgery or an assessment of the resident when she returned after gall bladder surgery. During an interview on 1/22/24 at 3:30 p.m., the Director of Nursing indicated nursing staff were to document when a resident left the facility and when they came back, just like for an appointment. There was no assessment of the resident when		The corrective action completed for Resident K is: a head-to-toe assessment was completed on 2/5/2024 to ensure proper assessment and identify any concerns. No concerns were noted at that time. On 2/8/2024 a review of all nurse's notes was completed by the Administrator, Director of Nursing Assistant Director of Nursing, clinical unit manager and/or designee to ensure all changes of conditions notated reflected a detailed assessment. Any items requiring interventions were addressed at that time. The measures put into place to ensure that the systemic changes do not recur is: (3a) On 2/7/2024 an all-staff in-service was completed with all nursing staff to be educated on assessments and documentation. (3b) all nurses' notes were reviewed by Director of Nursing, ADON, clinical unit manager.	

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	she came back from her gallbladder surgery. 4. The record for Resident J was reviewed on 1/22/24 at 3:45 p.m. Diagnoses included, but were not limited to, depression, high blood pressure, neuropathy, and schizophrenia. Nurses' Notes, dated 12/29/23 at 2:00 p.m., indicated the resident's daughter phoned the facility to let staff know the resident was admitted to the hospital after having a seizure. There was no documentation the resident went out on pass with her daughter. During an interview on 1/22/24 at 3:30 p.m., Unit Manager 1 indicated the resident went out on pass with her daughter for the holidays, and there was no documentation in the chart regarding that information. During an interview at the same time as above, the Director of Nursing indicated nursing staff should have documented when the resident left with her daughter. 5. During an interview on 1/23/24 at 1:17 p.m., LPN 1 indicated she went to check on Resident D in her room due to being inebriated. After knocking on her door and entering the room, the resident was on a video call with a male friend. The resident started recording her on the video and she had asked the resident not to video her and she left the room. The LPN indicated she had informed the Director of Nursing of the altercation. The record for Resident D was reviewed on 1/22/24 at 1:37 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, bipolar, depressive disorder, anxiety, gastrostomy, and alcohol use with withdrawal.		and designee to review nurses' notes, assessments and documentation. (3c) the Director of Nursing, ADON, clinical unit manager and/or designee will be reviewing all alert charting 4 times per week for 16 weeks, then weekly for 3 months including residents with change of condition to ensure adequate assessments are completed. The corrective actions will be monitored by Director of Nursing, ADON, clinical unit manager and/or designee utilizing an audit tool reflecting all pertinent charts. Frequency and duration listed above. The date of systemic changes 2/21/2024 Resident G The corrective action completed for Resident G was: (1a) On 2/8/2024 an interview and assessment were completed with Resident G to obtain any updated information related to residents' medical history and current needs to ensure accurate records, documentation and assessments.	

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	There was no documentation related to the incident in the resident's clinical record. During an interview on 1/22/24 at 1:28 p.m., the Director of Nursing indicated the resident was unable to be interviewed due to being in the hospital. During an interview on 1/23/24 at 10:45 a.m., the Administrator indicated she was unaware of any altercation with LPN 1 and the resident. The resident would usually let her know if she had any issues. During an interview on 1/23/24 at 11:58 a.m. the Director of Nursing indicated she had not received any reports from the resident or LPN 1 regarding the incident. During an interview on 1/23/24 at 1:04 p.m., LPN 2 indicated the resident had never reported an argument or any other incident with a staff member. The resident left the facility often with her male friend. The current 12/1/2010 "Abuse Prevention and Reporting Policy and Procedure" policy, provided by Director of Nursing on 1/23/24 at 2:19 p.m., indicated The Administrator and/or Resident Care Coordinator will provide with the investigation by obtaining initial statements of information related to reporting Initial Report to proper authorities. This citation relates to Complaint IN00417082.		On 2/09/2024 the Director of Nursing, ADON, clinical unit manager and or designee completed an audit of all residents' medical records to assess lack of assessments and documentation. The measures put into place to ensure the deficient practices does not recur is: (3a) On 2/5/2024 through 2/12/2024 a documented educational in-service will be conducted to educate staff as it relates to the community's revised assessment and documentation policy. In-servicing will continue monthly for 6 months. (3b) all new employees will also receiving the educational in-servicing during the new hire period. (3c) all nurses' notes will be reviewed by the Director of Nursing, ADON and clinical unit manager and /or designee. 4 times per week for 16 weeks then weekly for 3 months. The corrective actions will be monitored by the Director of	

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			Nursing, ADON, clinical unit manager and or designee. The date of systemic changes 2/20/2024. Resident J The corrective actions accomplished for Resident J is : (1a) A meeting was held with the Resident, Legal Guardian and by the Director of Nursing/ADON to discuss the facility's policy and procedures as it relates to resident's leaving the facility out on pass. (1b) On 2/6/2024 an educational in-service was conducted with all nurses to review the facility's policy and documentation procedures as it relates to resident's leaving the facility out on pass. On 2/09/2024 through 2/12/2024 all residents' medical records were reviewed for the past 90 days by the Director of Nursing, ADON, clinical unit manager and Administrator to ensure no other Residents were not affected by the deficient practice. Any concerns notated were addressed during the clinical record audit.	

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			The measures put into place to ensure the deficient practice does not recur is: (3a) monthly in-services will be conducted reviewing the community's policy as it relates to the facility's policy and procedures regarding documentation policy and procedures. These in-services will be conducted by the director of Nursing for 6 months, then quarterly for 6 months. (3b) The facility's policy regarding documentation will be included in all new hire orientation packets to ensure consistent compliance. (3c) The Director of Nursing, ADON, clinical unit manager and/or designee will conduct an audit of the facility's sign out sheets and residents' charts to ensure all residents medical records reflect residents going out on pass. The measures put into place to	

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			ensure the deficient practice does not recur will be monitored by the Director of Nursing, ADON, clinical unit manager and/or designee four times weekly for 16 weeks utilizing a compliance monitoring document. If compliance is maintained, audits will be decreased to 20 audits monthly for 3 months. The date of completion is 2/24/2024. Resident D The corrective actions accomplished for Resident D is: (1a) LPN 1 is no longer employed with facility. (1b) On 2/6/2024 administrator met with Resident D to discuss incident with LPN1 to complete a grievance and an investigation. On 2/12/2024 through 02/16/2024 a review of the community's abuse and neglect policy was reviewed	

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			with all residents to ensure that no other residents were affected by the deficient practice. The measures put into place to ensure the deficient practice does not recur is: (3a) On 2/09/2024, the Director of Nursing was in-serviced by the Administrator to ensure that the facility's abuse, neglect and reporting policy is followed in the event of a reported verbal altercation. (3b) On 2/12/2024 through 2/16/2024 a review of the community's abuse and neglect policy was completed with all staff members. (3c) All staff members will complete an educational in-service monthly for 6 months and and new employees will receive a documented educational in-service upon hire to ensure that the deficient practice does not recur. The measures put into place will be monitored by the human resources department and/or designee. Compliance will be monitored utilizing a monitoring tool that will be completed	

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			monthly to ensure compliance. The date of systemic changes is 2/24/2024.	