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	03/10/2023

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 IN00394470, IN00397091, IN00397140, IN00398308, and IN00401392. Complaint IN00394470 - State deficiency related to the allegations is cited at R0240. Complaint IN00397091 - State deficiencies related to the allegations are cited at R0036 & R0217. Complaint IN00397140 - No deficiencies related to the allegations are cited. Complaint IN00398308 - State deficiency related to the allegations is cited at R0185. Complaint IN00401392 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: March 9 & 10, 2023 Facility number: 002392 Residential Census: 222 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/14/23.	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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rikki Ford | Executive Director | 03/27/2023

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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	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 ensure a Resident's Physician and Responsible Party were notified of a fall, for 1 of 4 residents reviewed for family and physician notification. (Resident F) Finding includes: Resident F's record was reviewed on 3/9/23 at 12:34 p.m. The diagnoses included, but were not limited to, advanced dementia. A Nurse's Progress Note, dated 12/16/22 at 4:30 p.m., indicated she attempted to sit on the rolling walker seat and the walker rolled away from her and she fell to the floor. There was no documentation that indicated the Physician and Responsible Party had been notified of the fall. During an interview on 3/9/23 at 4:34 p.m., the Director of Nursing acknowledged the Physician and Responsible Party had not been notified of the fall. An undated Change of Condition policy, received as current from the Executive Director on 3/10/23 at 10:33 a.m., indicated the Physician and Responsible Party were to be notified of a change in condition. This state residential finding relates to Complaint	R 0036	Please note: The Clinical Management Team consists of the Director of Nursing, The Assistant Director of Nursing, and the facility's unit managers. CITATION R036 associated with COMPLAINT IN00397091- The corrective action accomplished for citation R036 is Resident's F's family and physician was contacted on March 11, 2023, to be informed of the resident's fall. The facility identified other residents' being affected by the deficient practice by completing a visual audit of all resident's nurses' notes for the year 2023 to ensure proper notification was completed. This audit was completed utilizing an audit tool to monitor conciseness. In addition, on 3/15/23, the community inserted signage in each resident's chart under the Nurse's Notes section instructing staff to report all changes in condition to Resident's physicians and family. The systemic changes the facility put into place to ensure deficient practice does not recur is: On 3/29/23, an educational in-service for all nurses will be	04/11/2023

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	IN00397091.		conducted to provide a re-education regarding the facility policy related to Residents Rights, proper notification to family members and physicians. All pertinent staff will be signing in acknowledgement of this policy. Also, the facility recruited 4 unit managers and interim Director of Nursing to monitor all incident reports, and nurses notes to ensure proper notification. The systemic changes will be monitored by the facility's clinical management team and/or designee. The monitoring will consist of nursing notes audits related to changes in condition and be reviewed 4 times per week for 20 weeks, then 2 times per week for 20 weeks. In the event a concern arises, nurses notes will be revert to audit completions 4 times per week for 12 months. The date the systemic changes will be completed is 4/11/2023.	
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items			

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	upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.			
	Based on observation, record review, and interview, the facility failed to ensure staff were aware of the call lights activated in the resident apartments, related to staff not having walkie talkies that informed them when an apartment call	R 0185	CITATION R185 associated with COMPLAINT IN00398308 The corrective action	04/11/2023

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	light was activated, for 1 of 3 Units in the facility. (Memory Care Unit) Finding includes: During an interview on 3/9/23 at 12:20 p.m., LPN 1 indicated some of the residents on the Memory Care Unit had pendants and there were pull cords for the call lights in the apartments and the bathrooms in the apartments. She indicated the staff carry walkie talkies and the activation of the call light was announced over the walkie talkie. CNA 1 and CNA 2 were interviewed on 3/9/23 at 12:21 p.m. The CNAs indicated they had not picked up a walkie talkie from the front desk when their shift began. On 3/9/23 at 12:24 p.m., Resident H approved the call light to be activated. The call light in the apartment's bathroom and living area was activated. There were no visible lights on the outside of the apartment nor at the Nurses' Station that alerted the staff the call light was activated. On 3/9/23 at 12:28 p.m., LPN 2 entered the Medication Room and had a walkie talkie. A automatic voice announced a call light had been activated in Resident H's apartment. LPN 2 had not responded to the announcement. During an interview on 3/9/23 at 12:31 p.m., LPN 1 indicated the CNAs should have had a walkie talkie. At 3/9/23 at 12:33 p.m., LPN 1's walkie talkie had been announcing the call light activation in Resident H's apartment. LPN 1 did not respond to the announcement.		accomplished for citation R185 is: The Director of Nursing completed facility rounds on 3/10/2023 and 3/11/2023 to ensure all staff were carrying walkie talkies. It was recognized during rounds that even though residents had the potential to be affected by the deficient practice, no residents were found to have been affected by the deficient practice. In addition, the Administrator created a facility policy dated 3/11/2023 indicating all clinical staff must carry a walkie talkie during work shift. On 3/11/2023 through 3/14/2023, all staff were educated regarding walkie use and facility's policy regarding walkies. The measures put into place to ensure compliance with walkie talkie compliance is: The facility purchased 10 additional walkies to ensure	

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	At 3/9/23 at 12:45 p.m., the CNAs now had walkie talkies and responded to Resident H's call light. During an interview on 3/9/23 at 3:45 p.m., the Director of Nursing indicated the staff were to have a walkie talkie when they worked and they were to pick up the walkie talkie at the front desk when they started their shift. During an interview on 3/10/23 at 8:37 a.m., RN 1 indicated she had not picked up a walkie talkie at the beginning of the shift. During an interview on 3/10/23 at 8:41 a.m., CNA 3 indicated she had not picked up a walkie talkie at the beginning of the shift. This state residential finding relates to Complaint IN00398308.		availability. The facility's clinical management team and/or designee will complete rounds 5 times per week, utilizing an audit tool, to monitor staff's compliance with walkies. Any employee found to be non-compliant will receive coaching and/or further disciplinary action leading up to termination. The systemic changes will be effective by 4/11/23.	
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			

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	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 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 observation, record review, and interview, the facility failed to ensure a Service Plan was updated and revised related to behaviors, falls and a language barrier, for 1 of 4 residents reviewed for Service Plans. (Resident F) Finding includes: During an observation on 3/9/23 at 1:13 p.m., Resident F was propelling her wheelchair throughout the Unit. She had a doll in her hands and was speaking to the doll in Spanish. CNA 1 indicated at the time of the observation, the resident spoke and understood Spanish and understood very little English. Resident F's record was reviewed on 3/9/23 at 12:34 p.m. The diagnoses included, but were not limited to, advanced dementia. The Nurses' Progress Notes indicated falls had occurred on 11/17/22 at 9 a.m., 12/16/22 at 4:30 p.m. after she attempted to sit on a rolling walker and it rolled away, 12/25/22 at 7:10 p.m. after she	R 0217	CITATION R217 associated with COMPLAINT IN00397091 The corrective action completed for Resident F with a language barrier is as follows:On 3/10/23, Resident F's service care plan was updated to reflect the language barrier. The facility completed a review of all resident's service care plans on 3/20/2023 through 3/24/2023 to determine if other residents were affected by the deficient practice. Although the facility recognizes other resident's had the potential to be affected, none were noted to be affected at that time. To prevent the deficient practice from recurring, the facility has included a document in the admission agreement that will reflect language barriers prior to admission. The document will be forwarded to our clinical department to be included in the	04/10/2023

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	had slid from her walker seat to the floor, and on 3/7/23 at 7:40 p.m. she had been found on the floor in the apartment. The Nurses' Progress Notes, dated 11/19/22 at 2 a.m. and 11/30/22 at 9:38 a.m., indicated she had been resistant to care. A Service Plan, dated 12/8/22, indicated the resident had falls and no current behaviors. The intervention for falls indicated to keep the apartment free from clutter. The Service plan had not included the resident's behaviors or language barrier. The Director of Nursing indicated on 3/9/23 at 4:34 p.m., the Service Plan needed to be updated for the language barrier. This state residential finding relates to Complaint IN00397091.		initial service care plan and will continue to be included in the resident's health record and service care plan. In addition, the facility will initiate service care plan audits in comparison with behavior logs and nurse's notes to ensure all service care plans concisely reflects resident's care needs and behaviors. These audits will be conducted utilizing an audit tool designed for monitoring and will be completed by the clinical management team, Director of Nursing and/or designee weekly for 52 weeks. The clinical management team, medical records liaison and/or designee will monitor compliance by completing weekly audits for 52 weeks utilizing an audit tool. The date systemic changes will be completed: 4/10/2023.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to ensure a medication patch was located on a resident as ordered by the Physician for 1 of 2 residents reviewed for medication patches. (Resident G) Finding includes: During an observation on 3/10/23 at 7:57 a.m., Resident G was sitting on the side of the bed. LPN 3 lifted the hair up and acknowledged there was	R 0240	CITATION R240 associated with complaint IN00394470 The corrective action accomplished for Resident G is as follows: the medication patch was applied to posterior ear as prescribed.	04/12/2023

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	no medication patch behind either ear. Resident G's record was reviewed on 3/10/23 at 8:55 a.m. The diagnoses included, but were not limited to, dementia. A Physician's Order, dated 2/25/23, indicated a Scopolamine (used for increased secretions) patch 1 milligram per 3 day was to be applied behind the ear and to rotate the ear it was applied to, every 72 hours for secretions. The Medication Administration Record, dated 3/2023, indicated the patch had been applied on 3/7/23. During an interview on 3/10/23 at 9:40 a.m., the Director of Nursing indicated the resident could have taken the patch off herself and she was due to have a new patch applied on 3/10/23. She was unsure when the the patch had been removed. This state residential finding relates to Complaint IN00394470.		To determine if other residents were affected by the alleged deficient practice, an audit was conducted on 3/11/23 to ensure all residents medication patches were applied and noted dermally as prescribed by the attending physician. No residents were noted to be affected at that time. To prevent deficient practice from recurring, all applicable resident's medication administration records were updated to reflect required signature acknowledgement of medication patch application and placement requesting acknowledgement from nurses confirming placement each shift. Also, on 3/23/2023, a request was submitted to In-Touch Pharmaceuticals to request this acknowledgment be included in future recapulations. The correction actions will be monitored by the clinical management team and/or designee monthly utilizing an audit tool in comparison with the recapulations printed by In Touch Pharmaceuticals.	

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			The date of systemic changes: 4/12/2023	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, record review, and interview, the facility failed to ensure doses for only 1 scheduled medication administration pass were pre-set, related to medications prepared for more than one medication pass time and pre-set for a time the QMA who pre-set the medication was not scheduled to work, for 1 of 2 floors on the Memory Care Unit. (First Floor) Finding includes: During an observation and interview on 3/9/23 at 11:37 a.m., QMA 1 indicated she had pre-set her medications up for the midday medication pass and the evening medication pass. There were medication cups inside the Medication Cart with resident names written on the cups. QMA 1 indicated pre-setting the medications was not the policy of the facility. She indicated her shift was over at 6:30 p.m. and usually the residents were ready for their bedtime medications before her shift was over, so she gave the bedtime medications before she left, except for a couple residents who wanted their medications given at 8 p.m. She pre-set these medications also and whoever was scheduled after her would administer the medications to those residents. Review of the First Floor Memory Care Unit	R 0244	CITATION R244 The corrective actions accomplished for deficiency is as follows: QMA 1 was educated regarding the deficient practices. A clinical staff educational in-services is scheduled to be conducted 3/28/2023 through 3/31/2023 to review the facilities policies as it relates to ISDH guideless regarding pre-setting medications. On 3/9/2023 and 3/10/23 the facility's Director of Nursing completed an audit of all medication carts to determine if residents were harmed or negatively affected by the deficient practice. The facility recognizes the potential for harm as it relates to the deficient practice however, no residents were found to be affected or harmed at that time. To prevent the deficient practice from recurring, the facility will be conducting monthly in-services for 6 months to educate/re-educate staff regarding pre-setting medications. In addition, all	04/15/2023

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	Medication Administration Records, dated 3/2023 on 3/10/23 at 7:46 a.m., indicated there were seven residents who received midday and evening medications and had more than one medication pass pre-set up for administration. During an interview on 3/9/23 at 3:45 p.m., the Director of Nursing indicated medications for one than one medication pass were not to be pre-set and the QMA was not to set up medications for someone else to administer. The undated Medication Administration Time Policy, received from the Executive Director on 3/9/23 at 10:06 a.m., indicated the midday medication pass was from 11 a.m. through 2 p.m., the evening medication pass was from 2 p.m. to 6 p.m., and the bedtime medication pass was from 7 p.m. through 10 p.m. The undated Medication Administration policy, received from the Executive Director on 3/10/23 at 10:06 a.m., indicated the preparation for more than one scheduled administration was not permitted.		nurses and QMA's will complete documented medication administration in servicing 4/1/2023 through 4/10/2023. These in-services will be conducted and monitored by the clinical management team and/or designee upon hire and every 3 months for 12 months. The date systemic changes will be completed is 4/15/2023	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			

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	Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented related to touching pills with bare hands for 1 of 5 residents observed during medication administration. (RN 1, Residents J and K) Findings include: During an observation on 3/10/23 at 8:05 a.m., RN 1 prepared Resident J's morning medications. The six medications were in pill bottles and RN 1 used her bare fingers to remove the pills from the bottles or poured the medication in the palm of her bare hands and then placed the medications in the medication cup. RN 1 then administered the medications to the resident. On 3/10/23 at 8:35 a.m., RN 1 prepared Resident K's medication. The memantine (Alzheimer's disease medication) 5 milligrams tablet was dropped on the Medication Cart. RN 1 picked up the medication with her bare hands, placed the tablet in the medication cup, and administered the medications to the resident. During an interview on 3/10/23 at 8:54 a.m., RN 1 indicated she should not have touched the medications with her bare hands.	R 0407	CITATION R407 The corrective actions that will be accomplished for the deficient practice is: RN 1 a documented coaching and education regarding handwashing, infection control and proper medication administration. The facility's clinical management team conducted medication observation educations on 3/23/2023 and 3/24/2023 with all applicable clinicians to determine if other residents could have been affected by this deficient practice. None were noted to be affected at that time. The facility has scheduled an educational in-servicing with nurses, QMA's CNAs regarding handwashing and infection control to be conducted on 4/10/2023 through 4/14/2023. To prevent the deficient practices from recurring, all facility nurses will complete medication	04/17/2023

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	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			administration monitoring utilizing a monitoring tool every other month for 12 months. This will also be completed and documented upon hire. This will be conducted and monitored by the clinical management team and/or designee. The date of systemic changes: 4/17/2023.	