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		A. BUILDING 00 B. WING	08/14/2024

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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 Complaint IN00437888, IN00438307, IN00438703, IN00439710, IN00439842, IN00439945, IN00439960, IN00440596, & IN00440781. Complaint IN00437888 - State deficiencies related to the allegations are cited at R0179. Complaint IN00438307 - State deficiencies related to the allegations are cited at R0041. Complaint IN00438703 - No deficiencies related to the allegations are cited. Complaint IN00439710 - No deficiencies related to the allegations are cited. Complaint IN00439842 - No deficiencies related to the allegations are cited. Complaint IN00439945 - State deficiencies related to the allegations are cited at R0179. Complaint IN00439960 - No deficiencies related to the allegations are cited. Complaint IN00440596 - State deficiencies related to the allegations are cited at R0217 and R0240. Complaint IN00440781 - State deficiencies related to the allegations are cited at R0052. Survey date: August 13 and 14, 2024 Facility number: 002392 Residential Census: 206	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	Ford	09/06/2024

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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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/19/24.			
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency Based on record review and interview, the facility failed to implement their own grievance policy for a resident with complaints of theft or missing items for 1 of 3 residents reviewed for grievances. (Resident G) Finding includes: During an interview on 8/13/24 at 10:00 a.m., Resident G indicated she had many missing items that have been gone since her move to the first floor. She was in the process of making a new list to give to the facility liaison. The record for Resident G was reviewed on 8/14/24 at 8:35 a.m. Diagnoses included, but were not limited to, anemia (low iron), type 2 diabetes and high blood pressure. A Service Plan, dated 6/6/24, indicated the resident was cognitively intact for daily decision making. During an interview on 8/14/24 at 3:20 p.m., the facility Liaison indicated she had written down items the resident had told her were missing on a post it note. She did not remember the exact date but thought it was in the middle of July 2024. The post it note, undated, indicated "1 leg rest, a projector, a lock set and 2 pops" were missing from her room. The Liaison indicated the projector	R 0041	R041 1. The corrective action that was accomplished for resident C is: the facility documented the grievance using the facility's grievance form. The original complaint from the affected resident stated the 2 can sodas, a projector and a leg rest was missing from the apartment. The resident had security cameras in her apartment however, stated that there is a device that she believes the staff is using to block the WiFi to disengage cameras. No evidence was found during the investigation to support a WiFI interruption device is used . 2. The facility identified other residents having the potential to be affected by the deficient practice by: (2a) a records and correspondence review was conducted by the Administrator, and Liaison on 8/20/24 to review and discuss and review any undocumented grievances. No	09/20/2024

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	was found and they gave her new leg rests. She tried to follow up with the resident several times but the resident was not available or would not answer her door. There was no official grievance form completed for the missing items. The current 6/2020, "Grievance/Concern Policy and Procedure, provided by the Liaison 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 form..." This citation relates to Complaint IN00438307		other residents were noted to be affected at that time. (2b) On 8/18/24 the Liaison reviewed all correspondences for past 90 days to ensure all past grievances were documented and the facility's grievance policy was utilized. (2c) On 8/18/24, the Administrator, Human Resources Dept and Liaison completed an educational in-servicing regarding the facility's grievance process to ensure understanding. (2d)on 9/5/2024 all current employees, and residents will receive a documented review and 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 and documented by the Community Liaison, Administrator, and or designee weekly for 6 months	

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			5. The date of systemic changes will be 9/20/2024.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, record review, and interview, the facility failed to ensure a resident was free from neglect, related to adequate supervision not provided for a resident with dementia residing on the locked Memory Care Unit (MCU), who had a history of exit-seeking behaviors and was not wearing a WanderGuard (electronic wander alarm system) bracelet, for 1 of 3 residents reviewed for facility reported incidents. (Resident B) This resulted in the resident exiting the building without the knowledge of the staff, was witnessed falling by bystanders, and was found by the guard shack near a busy road and sustained a fracture. Finding includes: An IDOH Facility Reportable was filed on an incident that occurred on 8/3/24 at 4:15 p.m. The report indicated the Director of Nursing (DON) was informed that a resident was outside near the guard shack, and they were ambulating independently. The resident appeared to have walked out of the door with visitors. A nurse went and performed a head-to-toe assessment, and it was noted the resident was not wearing a WanderGuard. The nurse observed swelling to the resident's left hand and wrist. Emergency services were called, and the family and physicians were notified. The resident returned to the facility on the same day (8/3/24) with her son	R 0052	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. R052- (A) The corrective action is a second wander guard was placed in the event the resident removes one. (B) Per the family request, resident relocated to second floor MC in efforts to prevent future elopements (C) Signage posted to alert outside vendors, and visitors regarding ensuring that the doors are fully closed when leaving. (D) ATN Technology was contacted on 8/13/24 to assess and service the front entrance door. (E) DON/Human Resources/Administrator completed an educational counseling with unit manager regarding proper documentation on 8/15/24. From 9/3/24 through 9/6/24, all nursing employees will complete an educational in-service regarding documentation. How the facility will identify other	09/15/2024

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	via car, with a post mold brace to the left hand due to a sustained nondisplaced fracture of the left ulnar styloid process (fracture at the end of the forearm). Preventative measures were to continue to check the wander guard placement, continue 15-minute safety checks, and physician orders were received to increase WanderGuard checks. The facility's investigation, dated 8/5/24, indicated many staff members were interviewed, and the resident eloped without the staff's knowledge. Written statements were as follows: - A written interview from CNA 2, dated 8/3/24, indicated she saw the resident wandering the memory care unit halls per usual, around 2:00 p.m. she was in B Hall. The resident was redirected to A hall where the A hall CNA took over. - A written interview from CNA 1, dated 8/3/24, indicated she last saw resident B at 3:30 p.m. to 3:35 p.m., walking towards the MCU A/B nursing station. At around 4:00 p.m., she was informed resident B was out of the building on the nearby road intersection. - A written interview from the Assistant Director of Nursing (ADON), dated 8/3/24, indicated she had last seen Resident B in the hall by the common area at 3:35 p.m., she started to pass medication and at about 4:15 p.m., a QMA notified her that Resident B was found walking on the nearby road intersection and was now in an ambulance. - A written interview from LPN 1, dated 8/3/24, indicated she was the last staff to see Resident B and another resident walking together down A hall. They walked to the end of the hall and tried to exit through the exit door. They then walked back up the hall to the commons area. The time was before pharmacy made a delivery, which was around 4:10 p.m. to 4:15 p.m. - A written interview from RN 2, dated 8/3/24,		residents having the potential to be affected by the same deficient practice and what corrective action will be in place. (A) On 8/15/2024 and 8/16/2024 an all-staff mandatory meeting was conducted to discuss any concerns or unreported behaviors related to wandering and elopement. (B) On 8/19/2024 all service care plans and nurses notes for past 90 days were reviewed to determine if any other residents had the potential to be affected. None noted at that time. (C) DON completed a review of all medication books and treatment books from 8/15/24 through 8/20/24. No documentation deficiencies were noted at that time. What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not occur. (A) Nursing staff will receive an educational in-service on 8/15/2024 and 8/16/2024 to provide education regarding Elopement requirements. (B) Elopement book created to update monthly using an audit tool. (C) Staff will monitor door checks with wander guards every shift. (D) Monthly in services and elopement drills to increase education on elopements and	

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	indicated at 4:22 p.m. the resident was observed on her knees holding onto the fence. RN 2 ran to the resident and at that time the resident was able to stand and ambulate on her own. The resident was assessed and noted swelling to her left wrist. There was no obvious injury anywhere else on her body. An ambulance was on the scene and EMTs (Emergency Medical Technicians) placed the resident in the ambulance. Other staff members then arrived on the scene. - A written interview from the Memory Care (MC) Unit Manager, dated 8/3/24, indicated they were told the resident was walking down the nearby busy road by a QMA. When the MC Unit Manager went down to the scene, the resident was being loaded into the ambulance. Resident B smiled and waved when she saw the staff member, and the ambulance pulled away at 4:24 p.m. The facility investigation did not include any documentation to indicate interventions were implemented to prevent elopement or how the resident responded when exhibiting exit-seeking behavior. The record for Resident B was reviewed on 8/13/24 at 10:55 a.m. Diagnoses included but were not limited to, anxiety, arthritis, heart disease, depression, dementia, and asthma. Resident B resided on the locked Memory Care unit. A Service Plan, dated 7/15/24, indicated the resident had cognitive impairment and had wandering behaviors. Interventions were to keep behavior logs, encourage the resident to participate in activities, apply a WanderGuard bracelet and monitor placement each shift, encourage the resident to keep in place and perform 15-minute checks if wander guard was removed.		residents at risk for elopement (E) DON and/or designees will monitor medication and treatment records using a monitoring tool bi-weekly for 6 months to ensure proper documentation. How the corrective action (s) will be monitored to ensure the deficient practice will not occur, ie., what quality assurance will be put into place. DON or designee will utilize an audit tool monthly for 6 months. Staff will monitor and document the proper functioning of the doors and wander guards and placement each shift indefinitely. By what date the systemic changes will be completed. Completion date 09/15/2024	

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The facility's Elopement Binder indicated Resident B was an elopement risk.

A hospital x-ray report indicated the resident was examined on 8/3/24 at 5:15 p.m. The left wrist was x-rayed and showed a non-displaced fracture through the ulnar styloid process.

A Physician's Order, dated 8/3/24, indicated to increase wander guard checks.

A Post Fall Investigation form, dated 8/3/24, indicated staff could have intercepted the resident prior to her attempt to leave the facility. The report was signed by LPN 1, the DON, and the Administrator.

On 8/13/24 at 10:19 a.m., Resident B was observed sitting in a recliner chair in the MC lounge room doing exercises. The resident was wearing a wrist brace on her left hand.

During an interview on 8/13/24 at 10:22 a.m., RN 1 indicated she would not know which residents had a WanderGuard in place. They were purchased by the residents' family, and she did not specifically check for wander guard placement when she assessed a resident. If the resident had a WanderGuard on, it would be positioned on their ankle or their wrist.

On 8/13/24 at 10:26 a.m., RN 1 performed an observation upon request to check if the resident was wearing a WanderGuard. Resident B did not have a WanderGuard on her wrists or ankles. The resident was wearing a brace to her left wrist.

During an interview on 8/13/24 at 10:31 a.m., the MC Unit Manager indicated Resident B had

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	consistently removed the WanderGuard. The resident's daughter took the WanderGuard home on 8/12/24 and was trying to get the WanderGuard placed into a necklace or a bracelet. The current intervention for the resident was to perform 15-minute checks. On 8/13/24, Resident B was observed continuously from at 10:33 a.m. until 10:50 a.m. to ensure the 15-minute checks were completed. There was no nursing employee of the facility that entered the lounge to perform a 15-minute check during that time. During an interview on 8/13/24 at 10:56 a.m., the MC Unit Manager indicated she had signed the resident's safety check log on 8/13/24 from 4:45 a.m. to 7:00 a.m. because the midnight staff had forgotten to sign off on the 15-minute checks during that time frame. She did not perform those checks, and she was not working the midnight shift. During an interview on 8/13/24 at 1:28 p.m., the DON indicated Resident B's WanderGuard was now replaced on her right arm. The DON was not made aware that the resident was not wearing a WanderGuard or that the resident's daughter had taken the WanderGuard home. Staff should be checking for placement and functioning of the WanderGuards. The DON could not provide any documentation Resident B's WanderGuard was checked prior to or after her elopement. During an interview on 8/13/24 at 1:38 p.m., the DON indicated the investigation showed LPN 1 had watched Resident B leave and didn't attempt to stop her because she blended in with visitors. LPN 1 didn't know she was a resident.			

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	During an interview on 8/13/24 at 3:21 p.m., the MC Unit Manager indicated Resident B had attempted to elope again out of the front doors of the Memory Care 2 building on 8/10/24. Resident B had followed the mail lady out. The resident was wearing her WanderGuard at the time and the alarm went off. This was witnessed and a staff member immediately followed the resident and immediately brought her back into the facility. On 8/13/24 at 3:40 p.m., CNA 3 directed Resident B to the front door per request to demonstrate how the WanderGuard system would become activated. CNA 3 indicated the front doors to the Memory Care Unit 2 did not open without a code. Resident B was observed touching the front doors and the alarm was not activated. The resident was now wearing a WanderGuard on her right hand. During an interview on 8/13/24 at 3:41 p.m., the DON indicated the front door in Memory Care 2 needed to be serviced again. They had been having difficulty with the alarm working and it would need to be serviced. The front door should have alarmed once Resident B was near the door wearing her WanderGuard. During an interview on 8/13/24 at 3:47 p.m., QMA 1 indicated she walked by and performed the 15-minute checks on the resident at 10:30 a.m. and 10:45 a.m. on 8/13/24 since she was easily viewed from the doorway. On 8/14/24 at 11:05 a.m., the Administrator indicated she had not signed off previously on any order to service the Memory Care Unit 2 front doors. She would call to have the doors serviced today.			

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	The current, "Elopement Assessment" policy, provided by the Director of Nursing on 8/25/14 at 3:20 p.m., indicated ... "Potential interventions to manage the wander/elopement risk may include exit door alarms, admission to a secured unit, medication review by a physician/pharmacist, identification alert bracelet, private sitter, use of electronic wander management system, diversionary techniques ...." No policy was provided related to elopement prevention or WanderGuard use and monitoring. This citation relates to Complaint IN00440781.			
R 0179 Bldg. 00	410 IAC 16.2-5-1.6(c) Physical Plant Standards - Deficiency Based on observation, interview, and record review, the facility failed to maintain comfortable and safe temperature levels for 9 residents participating in an activity in the activity room. (Memory Care 2 Activity Room) Finding includes: An environmental tour was completed with the Maintenance Director on 8/13/24 at 1:54 p.m. The facility was observed to feel warm throughout the common areas. The air temperature outside was 83 degrees Fahrenheit (F). The activity room in the Memory Care 2 Unit had 9 residents who were participating in an activity. The room felt warm. A few of the residents, when asked, indicated they thought it was "hot" in there. Activity Aide 1 also indicated she thought it was hot in there. There were no fans observed in the activity room.	R 0179	R-0179 The corrective action accomplished was the windows in the affected area was immediately closed which caused the room temperature to range within comfortable and safe temperature levels. The facility completed intermittent environmental temperature audits throughout the building 8/14/24-8/20/24 to determine if any other areas or resident were noted to be affected. None were noted to be affected at that time. The measure put into place to prevent reoccurence is, (a) all staff will be in-serviced by 9/10/24, ensuring staff has an	09/20/2024

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	The Maintenance Director checked the room temperature in the activity room and the temperature registered 82 degrees F. The Maintenance Director indicated the air conditioning was not working on the unit and a company was there to fix it. They were unable to fix it that day, and would have to be back. He indicated the temperatures should be under 81 degrees F and they should have had fans in the activity room. During and interview on 8/13/24 at 2:55 p.m., the Administrator indicated the temperature in the activity room was too warm. The staff should have been using fans while the residents were in the room. She indicated the air conditioning units were not working properly. They had 3 companies come in June 2024 to complete an estimate to fix them. The facility was not allowed to proceed with hiring a company until they received all 3 bids. They did not receive the 3rd bid until 7/24/24. The facility decided to go with one of the other companies that submitted their bid in June. That company had to order parts and was not able to start the work until 8/12/24. Every resident had their own air conditioning units in their apartments and they were working. The air conditioning units that were not working were in the common areas of the facility. In the Memory Care 2 Unit, on 8/14/24 at 11:59 a.m., a resident's family member was observed telling a staff member "this heat is unacceptable". A facility policy titled, "Daily Temperature Monitoring", and received as current from the Administrator on 8/14/24, indicated, "...The acceptable temperature range for all monitored areas is between 71 F and 81 F..."		understanding of maintaining comfortable temperatures, utilizing facility fans and refraining from practices that may cause elevated out of range environmental temperatures. (b) Mechanical Concepts was present onsite during the state survey visit to address air conditioning repairs. They are currently in the process of completing the necessary repairs to ensure the systems are fully operational. (c) The facility's maintenance team will monitor facility temperatures daily and will make any necessary adjustments to ensure levels are within 71-81 degree range. The facility's environmental temperatures will be monitored by the facility's maintenance director and/or designee daily and documented using a monitoring tool enhanced with cooling/heating interventions daily indefinitely. The date of systemic changes will be 9/20/24	

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	This citation relates to complaints IN00437888 and IN00439945. 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			
R 0217 Bldg. 00	Based on record review and interview, the facility failed to update a resident's service plan when there were changes in physical and mental statuses for 1 of 12 residents whose services plans were reviewed. (Resident F) Finding includes: The record for Resident F was reviewed on 8/13/24 at 11:13 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis of one side of the body) and heart disease. A Service Plan, dated 6/4/24, indicated the resident was oriented to person, place and time. The resident's skin was intact with no open wounds, and needed minimal to stand by assist for transfers and positioning. The resident consumed a regular diet. The Hospice Nurses' Notes, dated 7/20, 7/22, 7/24, 7/26, 7/27, and 7/29/24, indicated the resident was dependent on staff for transfers, dressing, bathing, and personal hygiene, and had pressure ulcers. The resident was oriented to person but unable to understand and participate in care. A Nurses' Note, dated 7/20/24 at 6:30 p.m., indicated the resident's POA (Power of Attorney) was at the facility and observed her father more confused. A Nurses' Note, dated 7/24/24 at 1:00 p.m., indicated the resident wanted to get up and was	R 0217	217 The corrective actions that will be accomplished for Resident G: resident was discharged from facility. The corrective actions that were put in place to identify if other residents were affected was on 8/15/24- 8/21/24 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 _____ 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 revised checklist form which the DON, and unit 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. In addition 15 service care plans will	09/25/2024

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		A. BUILDING 00 B. WING	08/14/2024

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	assisted but was very weak and unable to bear weight. A Nurses' Note, dated 7/25/24 at 1:00 a.m., indicated the resident appeared weaker than before. During an interview on 8/14/24 at 10:00 a.m., the Director of Nursing indicated she was unaware the service plan was not updated to reflect the resident's current status. This citation relates to Complaint IN00440596.		be randomly audited weekly for 24 weeks, The date of systemic changes are 9/25/24	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based record review and interview, the facility failed to ensure a resident with a history of falls received adequate supervision related to being left alone in the room which resulted in another fall, for 1 of 3 residents reviewed for falls (Resident F). The facility also failed to provide only residential care related to performing pressure ulcer treatments for 1 of 3 residents reviewed for pressure ulcers (Resident F). Finding includes: During an interview on 8/13/24 at 2:10 p.m., Resident F's POA indicated she was extremely upset her father had fallen out of the wheelchair on 7/29/24. She had purchased a camera and was able to watch and hear conversations in the resident's room. On 7/29/24, both CNAs could be heard saying "How are we were going to get him out of bed and put him in the wheelchair." The POA indicated she did not know why they even got him out of bed, due to him being so weak and more confused. After he had started to decline,	R 0240	R-240 What corrective action (s) will be accomplished for those residents found to have been affected by deficient practice. Resident no longer resides in facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. DON will educational in-service with staff regarding falls, fall risks, appropriate treatments in a residential setting and fall interventions from 9/6/24 through 9/10/24 Resident’s medical charts/SCP and fall reports were reviewed by DON prior to survey exit. No other residents were found to be affected at that time or in the last 3 months. DON and or designee	09/15/2024

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	she reached out to nursing homes to move him into one, however, after a conversation with the Administrator, she convinced her to keep the resident at the facility. The Administrator told her they had a memory care unit and it had the least amount of residents and more staff. Soon after he was moved, he got very confused and weaker. The record for Resident F was reviewed on 8/13/24 at 11:13 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis of one side of the body) and heart disease. A Nurses' Note, dated 6/15/24 at 3:00 p.m., indicated the resident's daughter had informed staff her father was a fall risk, but stayed in his room most of the time. A Nurses' Note, dated 6/20/24 at 6:30 p.m., indicated the hospice nurse told staff the resident had a pressure ulcer between his right and left buttocks and a treatment was ordered. A Nurses' Note, dated 6/23/24 at 11:30 p.m., indicated the resident was found on the floor in his room beside the bed. A Hospice Note, dated 7/20/24, indicated the resident had 2 pressure ulcers to the right and left buttock. The treatment was to wash the wounds with soap and water, pat dry, apply medi honey (a debriding agent) and cover with a 4 by 4 foam dressing. Hospice staff was to perform the treatment 2 times a week and the facility staff was to perform 3 times a week. A Nurses' Note, dated 7/21/24 at 5:50 p.m., indicated the resident was observed lying on the floor on his butt next to the recliner chair. The resident was delusional and thought he could		will review and monitor other residents who are at risk for falls to ensure interventions are in place. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. DON completed in services with all nursing staff on policies and procedures of our fall policy and interventions. DON implemented an additional communication book to ensure all staff are knowledgeable of resident's changes. A list of fall interventions was created, and staff educated regarding utilizing interventions in efforts to prevent falls. In addition- on 9/10/24 all wound orders were clarified to ensure residential compliance. Also, the DON scheduled a nursing in-service to be conducted on 9/12/24 to educate nurses regarding the residential scope as it relates to wound treatments. The DON and/or designee will; complete monthly in-servicing regarding wound treatments and the residential scope monthly for 6 months utilizing an audit tool as it relates to wound care. The DON and/or designee will monitor wound order completions twice weekly for 6 months. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, ie.	

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	ambulate by himself. A Nurses' Note, dated 7/26/24 at 3:45 p.m., indicated the resident was observed lying on the floor beside the bed. The resident sustained an abrasion to the right knee. A Nurses' Note, dated 7/27/24 at 3:50 p.m., indicated the resident was observed on the floor with his upper torso under the bed and his legs in the opposite direction. A Nurses' Note, dated 7/29/24 at 10:00 a.m., indicated the resident was in bed resting. A Nurses' Note, dated 7/29/24 at 11:30 a.m., indicated "Received a call from POA, upset and yelling dad in room on floor. Reached over to pick oxygen tubing from floor and fell forward face down according to recording. Daughter very upset because she informs writer that they didn't ask her father but told him that they were getting him up. Informed daughter that he asked to get up earlier, but was informed that he will be gotten up after other aide came back from break due to needing 2 assist. New abrasion to forehead red in color, no active bleeding...." A Nurses' Note, dated 7/30/24 at 4:45 a.m., indicated staff had informed the nurse the resident's bandage had fallen off of his pressure ulcers. The treatment was completed and a new bandage was applied. A Service Plan, dated 6/4/24, indicated the resident was oriented to person, place and time. The resident's skin was intact with no open wounds, and needed minimal to stand by assist for transfers and positioning. The resident consumed a regular diet. The Service Plan		What quality assurance program will be put into place. Corrective actions will be monitored to ensure the alleged deficient practice will not occur. Each fall investigation will be reviewed and documented by DON or Designee using an audit tool to ensure proper interventions are in place to prevent falls. The DON or designee will audit the fall incident reports, treatment books as well as service care plans weekly indefinitely to ensure compliance. By what date the systemic changes will be completed. Completion date 9/15/2024	

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	indicated after the fall on 6/23/24, the fall intervention was to encourage staff to round more frequently. The interventions after the fall on 7/21/24 indicated to encourage the resident to press the pendant for assistance. The intervention after the fall on 7/26/24 was to ensure the bed was in the lowest position. The Hospice Nurses' Notes, dated 7/20, 7/22, 7/24, 7/26, 7/27, and 7/29/24, indicated the resident was dependent on staff for transfers, dressing, bathing, and personal hygiene, and had pressure ulcers. The resident was oriented to person but unable to understand and participate in care. A Grievance/Concern Form, dated 7/30/24, indicated the resident's daughter expressed concern regarding recent falls. A written statement, dated 7/30/24 from CNA 4, indicated "...the housekeeper told the DON (Director of Nursing) and the DON told me he wanted to get up. [Name of resident] fell out of his wheelchair in his bedroom...." During an interview on 8/13/24 at 3:28 p.m., the Memory Care Unit Manager indicated in her opinion, it was safe for the resident to be left alone in his room if staff were doing their 2 hour checks. During an interview on 8/13/24 at 3:45 p.m., the Director of Nursing indicated the housekeeper told her the resident indicated he wanted to get up, so she told the CNA to get the resident out of bed. The resident should have been taken out of his room and positioned by the nurses' station for safety reasons. When the resident first moved back to the memory care unit, the POA wanted the resident to stay in his room. Before the resident			

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	was moved back to the memory care unit, the daughter wanted to transfer the resident out to a higher level of care. During an interview on 8/14/24 at 10:29 a.m., CNA 4 indicated the resident was confused and needed a 2 person assist for all transfers. She was not aware the resident had previous falls and was found on the floor inside his room on 7/26 and 7/27/24. CNA 4 was told by the Director of Nursing the resident wanted to get out of bed because the housekeeper had informed her. CNA 4 indicated she went into the resident's room to change him and get him dressed and then waited for the other CNA to come back from break. They placed the resident into the wheelchair because someone had moved his television into the bedroom and his recliner chair was in the living room. If she was made aware the resident had previous falls in his room, she would have taken him out to the nurses' station for safety During an interview on 8/14/24 at 10:37 a.m., CNA 5 indicated Resident F was confused and needed a 2 person assist for transfers. The resident's recliner chair was in the living room, however, the television set was in the bedroom, so they left him in the bedroom sitting in the wheelchair. The wheelchair was able to recline, however, they did not recline the wheelchair before leaving the room. She was unaware the resident had previous falls in his room, or she would have placed him by the nurses' station for safety reasons. During an interview on 8/14/24 at 11:00 a.m., the Administrator indicated she had a conversation with the resident's daughter regarding the facility having a memory care unit because she wanted her father moved there. She was not involved in the decision of the resident not being transferred			

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	to a nursing home in June 2024. During an interview on 8/14/24 at 10:00 a.m., the Director of Nursing indicated nursing staff were not allowed to perform the treatment for the pressure ulcers. She was unaware the service plan was not updated with the resident's activities of daily living status, pressure ulcers, and cognition. This citation relates to Complaint IN00440596.			