DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE ASSISTED LIVING LLC	7252 ARTHUR BLVD MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00351473. Complaint IN00351473 - Substantiated. State Residential Findings related to the allegation are cited at R0052. Survey date: April 13, 2021 Facility number: 002392 Residential Census: 144 This State Residential finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/14/21.	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 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse;			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	(3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.			
	Based on observation, record review, and interview, the facility failed to ensure proper supervision was provided to prevent the elopement of a memory care resident whose whereabouts were unknown for an extended period of time before notifying local Police. The resident was located 6 miles from the facility several hours after he was last seen. (Resident D) Finding includes: On 4/13/21 at 9:38 a.m., the location of Resident D's room was observed. He resided on a secured memory care unit and his room was approximately 4-5 feet from a secured exit door to the outside. The record for Resident D was reviewed on 4/13/21 at 9:20 a.m. The resident was admitted to the facility on 1/29/2021. Diagnoses included, but were not limited to, dementia, alcohol abuse, altered mental status, visual hallucinations and anemia. The resident resided on the secured Memory Care unit. A Service Plan indicated Resident D had moderate orientation impairment with occasional disorientation to person, place and time. No Service Plans related to exit seeking or wandering were in place. During tour of the Memory Care Unit 4/13/21 at 9:10 a.m., the Director of Nursing (DON) indicated Resident D had eloped from his room on the unit. She did not know how the resident	R 0052	The corrective actions accomplished for Resident D were- orders were retrieved from Resident's attending physician to apply a wander guard device to residents left ankle and check for placement and proper functioning twice daily. On 4/14/21 the facility completed Elopement Risk assessments on all residents who resided in the MC secured unit to identify other residents having the potential to be affected by the deficient practice. The facility recognizes that other residents could have been affected however, none were found to be affected at that time. Upon completion of the Elopement Risk Assessments conducted on 4/14/21, per attending physicians' orders, for all other residents identified as a wanderer or elopement risk received a wander guard device to ensure safety. All families and/or responsible parties were all notified of the updated orders. In addition, by 5/3/21, all clinical staff will be educated regarding 2-hour wellness checks for residents who reside in the Memory Care secured unit. By April 27, 2021, all staff, including nursing, activities,	05/10/2021

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	had left the building. An investigation was initiated. Resident D was last seen by the night shift nurse on 4/10/21 during morning rounds and medication pass at 5:30 a.m. Staff began looking for him inside and outside of the property. The resident was found approximately 6 miles away from the facility by a nurse who was out driving around attempting to locate the resident. The resident was sent to the hospital after he was found and had not returned to the facility. He was located along a busy 4 lane road in an adjacent city near a high traffic interstate. Follow up interview with the DON on 4/13/21 at 9:25 a.m. indicated Resident D was last seen around 5:30 a.m. on 4/10/2021. Staff searched on and off the grounds and he was not located. The facility called her and she came to the facility. Residents on the Memory Care unit are to be checked every 2 hours. The entire staff began looking for the resident and the family was called. No staff were able to find the resident at this time. The DON indicated the facility protocol is to ensure all buildings including Independent Living and all the grounds are searched before notifying the police. The police were not called until 10:28 a.m. that morning. An "Actual Elopement Report" was completed on 4/10/21. The Executive Director and Director of Nursing were notified. Resident D was noted to be missing for breakfast at 8:15 a.m.. Staff initiated elopement procedures. He was last seen at 5:00 or 5:30 a.m. that morning. Attempts to contact the family were made. Local hospitals were called. The facility search was expanded. A Merrillville Police Department Incident		laundry, housekeeping, dietary, maintenance and business office will have been educated and trained on the proper response to the facility's revised Memory Care elopement policy which includes door alarms and initial resident search expectations when door alarms are activated, or a possible elopement has occurred. The systemic changes that were put into place is: The facility created a "Memory Care Specific" Elopement Policy that requires facility staff to immediately call 911 in the event a resident is unable to be located in the secure Memory Care unit. The facility will monitor the staff's compliance by conducting weekly Elopement drills to ensure the appropriate responsiveness and compliance which began on 4/15/21. On 4/19/21 the facility doors with wander guard sensors were audited by the facility maintenance director and will continue weekly for 16 weeks then monthly for 6 months to ensure proper functioning. In addition, beginning 4/23/21 the Director of Nursing and/or designee will audit and document staff members response to facility door alarms and initial resident search expectations when door alarms are activated. Audits will be conducted 4 times weekly for 4 weeks. Thereafter, weekly for 12 weeks. Results will be shared with	

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	Report, dated 4/10/21, indicated they were first contacted at 10:26 a.m. for a missing person. Police spoke with the Director of Nursing at that time and were informed the resident left the facility without her knowledge or permission. A punch code was needed to exit the area. A trained canine unit was employed. Assistance from the Lake County Aviation unit was also requested. When interviewed on 4/10/21 at 1:40 p.m., RN 1 indicated he was assigned to the Memory Care Unit for the day shift on 4/10/21. His shift began at 7:15 a.m. He did not see the resident upon rounds around 8:15 a.m. and he was not in his room. Staff later notified him the they could not find Resident D. Employees then began looking throughout the building to locate him. He indicated residents were to be checked every 2 hours. The "Missing Resident Policy and Procedure" was reviewed on 4/13/21 at 9:15 a.m. No date was noted on the Policy. The Director of Nursing verified the policy was current. Staff were to notify the Health Care Coordinator and Facility Administration, then do the following: - Check the Sign-Out Sheets - Check to see if Activities Department is out on an Activity. - Thoroughly check the Resident's apartment (bathroom, closet, under bed). - Check all apartments on the resident's wing, - Check all apartment on the other wings. - Check all common areas (Dining Room, Library, public restrooms, private dining room and activity room. - Determine time and location resident was last seen. - Check outside on the grounds and front		the executive director weekly and discussed weekly during the facility's QA Committee meeting. Plan of Correction completion May 10th, 2021	

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	entrance - Notify the Physician. - Notify the Family - Notify the Police When interviewed on 4/13/21 at 11:00 a.m., the Director of Nursing indicated the resident was on the secured Memory Care unit. The policy was followed. This State Residential finding relates to Complaint IN00351473.			