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	04/13/2022

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 Complaints IN00376055, IN00376807, IN00376785, IN00377071, and IN00377089. Complaint IN00376055 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376807 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376785 - Substantiated. State deficiencies related to the allegations are cited at R0036, R0090, R0091, and R0240. Complaint IN00377071 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00377089 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 12 & 13, 2022 Facility number: 002392 Residential Census: 222 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/18/22.	R 0000	"This plan of correction is submitted as required under State and Federal Law. The submission of the Plan of Correction does not constitute an admission on conclusions drawn therefrom- Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	
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

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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 Responsible Party, Physician, and Hospice Services were notified of a fall for 1 of 3 residents reviewed for Responsible Party and Physician notifications. (Resident C) Finding includes: Resident C's record was reviewed on 4/12/22 at 3:13 p.m. The diagnoses included, but were not limited to, dementia. A Nurse's Progress Note, dated 3/16/22 at 8:45 p.m., indicated the DON (Director of Nursing) was notified by the resident's family the resident had fallen on 3/13/22, they had not been notified until 3/16/22, and the resident had fractured the right knee. There were no Nurses' Progress Notes in the record that indicated the resident had fallen on 3/13/22. There were no Nurses' Progress Notes that indicated the Responsible Party, Physician, and Hospice Services were notified of the fall. A statement received from CNA 1, dated 3/17/22 at 8:21 a.m., indicated the nurse had been notified of the fall. A statement from QMA 1, dated 3/17/22 at 9:23	R 0036	R036 It is the practice of the facility to ensure that notification is and will be timely to both physicians and families when there is a change of condition. On 4/15/2022 an audit of all residents' nurses' notes in the chart was completed by DON to ensure all appropriate parties were notified of changes of condition. Although the facility recognize others could have been affected by the deficient practice, no residents were noted to be affected at that time. An educational in-service is scheduled for 5/9/2022 to review The Facility's Policy and Procedure for Physician Notification/Change in Condition for Resident(s) with the Potential to be Affected: with all licensed staff addressing circumstances that require notification of the resident's physician, legal representative, or family member. The Director of Nursing Services, or designee, will conduct a random audit of ten (5) residents health records weekly for four (20) consecutive weeks. These residents will be reviewed to ensure that any declines in	05/11/2022

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	a.m., indicated on 3/13/22, CNA 1 came to the first floor and notified Nurse 1 the resident had fallen. A statement from Nurse 1 (no longer employed at the facility), dated 3/13/22 at 12:30 p.m., though identified by the ADON (Assistant Director of Nursing) and DON as not written on 3/13/22 and had not been in the record, indicated the resident was in the common area. The CNA had stated the resident complained of knee pain. The resident was sitting in a chair with her legs elevated. No swelling, redness, or increased warmth to the bilateral extremities was noted. No facial grimaces, moaning, or guarding was present. On 4/12/22 at 2:17 p.m., interview with CNA 1 indicated the nurse went to see the resident and asked her if she was dizzy. The ADON was interviewed on 4/12/22 at 2:25 p.m., and indicated Nurse 1 had informed her CNA 1 had told her the resident fell and she assisted her off the floor before she notified her. This state residential finding relates to Complaint IN00376785.		condition have been identified, properly evaluated and communicated to the appropriate people and the documentation is present in the record. Findings of this audit will be documented using an audit tool. The Director of Nursing is responsible to ensure that notification will be timely to both physicians and families when there is a change of condition. Date of systemic changes 5/11/2022	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made			

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	by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the	R 0090	R090	05/11/2022

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	facility failed to follow the Indiana Department of Health (IDOH) Incident Reporting Policy for unusual occurrences, related to reporting a fall with injury in a timely manner and reporting a fall with injury with accurate information, for 2 of 3 residents reviewed for unusual occurrences. (Residents B & C) Findings include: 1) Resident B's record was reviewed on 4/13/22 at 9:05 a.m. The diagnoses included, but were not limited to, dementia. The Service Plan, dated 4/5/22, indicated indicated she was dependent for all activities of daily living and received Hospice services. A Nurse's Progress Note, dated 3/16/22 at 7:16 a.m., indicated the resident was on the floor, complained of severe pain to the bilateral hips, and was unable to move the left leg. Orders were received to transfer the resident to the Emergency Room for an evaluation and treatment. An x-ray report, dated 3/16/22 at 10:01 a.m., indicated there was a fracture of the left femoral neck. The incident was reported to the IDOH on 3/18/22. The Director of Nursing (DON) was interviewed on 4/12/22 at 2:49 p.m., and indicated she thought she had 48 hours to report the unusual occurrence to the IDOH. 2) Resident C's record was reviewed on 4/12/22 at 3:13 p.m. The diagnoses included, but were not		Staff member who identifies a resident with an unusual occurrence will notify the Director of Nursing and/or designee immediately. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. Executive Director has educated DON and Administrator regarding mandatory reporting requirements providing reeducation regarding the required 24-hour ISDH reporting guidelines. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will receive an educational in-service on 5/9/2022 to provide education regarding following Prevention of Abuse and Mandatory Reporting Requirement. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The DON/ED and/or designee will audit all Incident/Unusual Occurrence Reports to assure timely notification of the Administrator/designee, the state and other agencies as appropriate utilizing an audit tool weekly for 20 weeks then monthly for 6 months.	

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	limited to, dementia. A Nurse's Progress Note, dated 3/16/22 at 8:45 p.m., indicated the DON received a call from the resident's family and was informed the resident had fallen on 3/13/22 and they were unaware of the fall until 3/16/22. They reported to the DON the resident had fractured the right knee. CNA 1 was interviewed by the DON and indicated the resident had fallen on 3/13/22. The note indicated CNA 1 had reported the resident had, "persistently" tried to get herself off the floor. CNA 1 assisted the resident off the floor before the nurse was notified of the fall. An IDOH Reportable Incident, dated 3/17/22, indicated the resident had fallen on 3/13/22 and the fall was not reported to the DON, the staff on the Unit, nor the family on 3/13/22. The resident now had a fractured right knee. The resident was "persistent", in attempting to get up off the floor and CNA 1 assisted her to the chair, prior to the nurse being informed the resident had fallen. A statement received from CNA 1, dated 3/17/22 at 8:21 a.m., indicated, "...fell Sunday around 2 p.m....stomach flat on floor. I went over turned her over and picked her up and sat her on the chair...I asked her if she was dizzy she said alittle (sic) bit. so I grabbed her some water and told the nurse..." On 4/12/22 at 2:17 p.m., CNA 1 was interviewed per cell phone placed on speaker, with the DON present. CNA 1 indicated she had found the resident on the floor. She indicated she, "picked her up" and asked if she was dizzy. The resident was not attempting to get herself off the floor. "I just was not thinking and I got her up."		Date of systemic changes 5/11/2022.	

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	The DON was interviewed right after the cell phone call and indicated she thought CNA 1 had told her the resident had been attempting to get herself off the floor. The facility's Unusual Occurrence Reporting Policy, dated 6/15/18 and received as current from the DON, indicated all unusual occurrences were to be reported immediately or within 24 hours to the IDOH. This state residential finding relates to Complaint IN00376785.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to implement the Fall Management policy, related to, a care of a resident post fall, for 1 of 3 residents reviewed for implementation of the Fall Management policy. (Resident C) Finding includes: Resident C's record was reviewed on 4/12/22 at 3:13 p.m. The diagnoses included, but were not limited to, dementia. A Nurse's Progress Note, dated 3/16/22 at 8:45	R 0091	R0911. Corrective action for resident to have been affected: Resident was immediately assessed. All appropriate interventions were initiated. On 5/9/2022 all clinical staff will be re-inserviced regarding the facility's fall policy. The facility completed a one-on one education with all nursing staff to inquire about other falls that occurred as well as a review of all falls for past 3 months were completed to ensure proper	05/13/2022

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	p.m., indicated the DON (Director of Nursing) was notified by the resident's family the resident had fallen on 3/13/22, they had not been notified until 3/16/22, and the resident had fractured the right knee. There were no Nurses' Progress Notes in the record that indicated the resident had fallen on 3/13/22. A statement received from CNA 1, dated 3/17/22 at 8:21 a.m., indicated, "...fell Sunday around 2 p.m....stomach flat on floor. I went over turned her over and picked her up and sat her on the chair...I asked her if she was dizzy she said alittle (sic) bit. so I grabbed her some water and told the nurse..." A statement from QMA 1, dated 3/17/22 at 9:23 a.m., indicated on 3/13/22, CNA 1 came to the first floor and notified Nurse 1 the resident had fallen. A statement from Nurse 1 (no longer employed at the facility), dated 3/13/22 at 12:30 p.m., though identified by the ADON (Assistant Director of Nursing) and DON as not written on 3/13/22 and had not been in the record, indicated the resident was in the common area. The CNA had stated the resident complained of knee pain. The resident was sitting in a chair with her legs elevated. No swelling, redness, or increased warmth to the bilateral extremities was noted. No facial grimaces, moaning, or guarding was present. On 4/12/22 at 2:17 p.m., CNA 1 was interviewed per cell phone placed on speaker, with the DON present. CNA 1 indicated she had found the resident on the floor. She indicated she, "picked		procedures were followed. None were found to be affected at that time. The DON and/or designee will review all falls 5 days per week to ensure the facility's procedures are followed to prevent the deficient practice from recurring utilizing an audit tool. The corrective actions will be monitored and documented utilizing an audit tool. The fall audit tool will be completed weekly for 6 months then monthly for 6 months. The effective date of changes is 5/13/2022	

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	her up" and asked if she was dizzy. The resident was not attempting to get herself off the floor. "I just was not thinking and I got her up." She indicated the Nurse went to the resident and asked her if she was dizzy. The ADON was interviewed on 4/12/22 at 2:25 p.m., and indicated Nurse 1 had informed her in a phone call, that if "she didn't see anyone on the floor then she could not say anyone fell." She had informed her CNA 1 had told her the resident fell and she assisted her off the floor before she notified her. The Fall Management policy, dated 7/2016 and received from the DON as current, indicated after the fall, the resident was to be assessed for injury, the DON or the Executive Director was to be notified, and the Hospice services were to be notified. If the resident had no apparent injuries and denied pain, the staff could then assist the resident off the floor. The Physician and resident Responsible Party was to be notified. The fall would be placed on the, "Alert Charting" for 72 hour follow up. The fall and assessment was to documented in the record and an incident report was to be completed. This state residential finding relates to Complaint IN00376785.			
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 record review and interview, the facility failed to ensure a resident who had fallen	R 0240	R240 1. Corrective action for the residents found to have been affected by the alleged deficient	05/15/2022

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	received necessary services after the fall for 1 of 3 residents reviewed for personal care. (Resident C) Finding includes: Review of the Nurses' Progress Notes, indicated the following: On 3/13/22 at 2 a.m., there were no complaints of pain. On 3/13/22 at 2 p.m., she was resting in the common area without distress present. Continued on antibiotics for an urinary tract infection, and would continue to to observe for changes. On 3/14/22 at 6:15 a.m., complained of pain to the right knee, with redness, warmth, and limited passive range of motion to the right knee. A x-ray was ordered and the family and the Hospice service was made aware. On 3/14/22 at 5 p.m., the Hospice Nurse notified the facility and canceled the right knee x-ray, per orders from the Physician. On 3/15/22 at 1 p.m., the Hospice nurse visited, and noted the resident ambulating with the rolling walker with a steady gait. On 3/15/22 at 8:50 p.m., she complained of pain to the bilateral knees and was having difficulties ambulating. On 3/16/22 at 1 p.m., the Hospice Nurse assessed the knee pain and orders received to increase the muscle relaxer. The Responsible Party was notified.		practice: Resident no longer resides in facility; 2. Corrective action taken for those residents having the potential to be affected by the same alleged deficient practice: Residents medical charts were reviewed and were audited by DON prior to survey exit. No other residents were found to be affected at that time and no negative outcomes were noted from the alleged deficient practice. 3. Measures/systemic changes put into place to ensure the alleged deficient practice does not re occur: Licensed nurses have been in serviced prior to date of compliance by the DON/DESIGNEE on the policy and procedures regarding implementing necessary services, documentation, and assessments. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/DESIGNEE will audit 10 resident's nurses notes weekly for 20 weeks then monthly for 5 months to ensure compliance. Date of systemic changes is 5/15/2022	

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	On 3/16/22 at 4:37 p.m., an x-ray was ordered of the right knee due to the pain. The Responsible Party was notified. On 3/16/22 at 8:45 p.m., the DON indicated she had received a call from the Responsible Party, who stated he had been informed by one of the staff members that his mother had fallen on 3/13/22 and no one had notified him. He also reported the resident had a fractured right knee. CNA 1 was notified and indicated on 3/13/22 the resident had been observed on the floor and she assisted the resident off the floor, then she notified the nurse. There had been no assessment nor notification of the fall on 3/13/22. There had been no follow up documentation after the fall, until 3/14/22 at 6:15 a.m. The DON (Director of Nursing) was interviewed on 4/12/22 at 2:10 p.m. and indicated the Responsible Party was very upset they had not been notified of the fall. Nurse 2 had found the right leg swollen and requested an x-ray. The Hospice Nurse had spoken with the family and they had not wanted the x-ray. No one was aware that the fall had occurred. The Responsible Party and Hospice Nurse had indicated if they had been aware a fall had occurred, they would have approved the first x-ray ordered. Once they were informed a fall had occurred, then the x-ray was approved. When she had spoken to Nurse 1 (no longer employed at the facility), she denied knowledge of the fall. CNA 1 was interviewed by cell phone on 4/12/22 at 2:17 p.m. and indicated she assisted the resident up after the fall prior to telling the			

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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
	nurse. The nurse was then informed of the fall and went to see the resident and asked her if she was dizzy. CNA 1 indicated she had been off work for a few days and upon returning to work, she stopped in the resident's room to check on her and the Responsible Party was in the room. He was concerned about the resident's ambulation. She informed the Responsible Party that the cause could have been due to the fall on 3/13/22. The Assistant Director of Nursing (ADON) was interviewed on 4/12/22 at 2:25 p.m., she indicated she was unaware of the fall until 3/16/22. There had been no documentation nor report from Nurse 1 about the fall. When she notified Nurse 1, she was informed CNA 1 had reported the fall to Nurse 1. The Hospice Nurse was interviewed on 4/12/22 at 3:03 p.m. and indicated the Hospice service was unaware of the fall. The resident had been having knee pain and the Responsible Party had not wanted her to be transferred to the Hospital. When they were informed there had been a fall, they notified the Responsible Party and suggested the x-ray be completed so the cause of the pain could be determined. He agreed to the mobile x-ray as long as a transfer to the hospital was not needed. Once the fracture was diagnosed, they were able to treat the fracture and the pain. This state residential finding relates to Complaint IN00376785.			