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	05/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00457194 and IN00458664. Complaint IN00457194 - No deficiencies related to the allegations are cited. Complaint IN00458664 - No deficiencies related to the allegations are cited Survey dates: May 6, 7 & 8, 2025 Facility number: 002392 Residential Census: 209 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/12/25.	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 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, record review, and interview, the facility failed to ensure a resident	R 0216	**R-216** Deficient Practice: Failure to Observe Administration of	05/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rikki Ford	Executive Director	05/24/2025

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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	was assessed for the ability to self-administer medications for 1 of 5 residents observed during medication pass. (Residents 12 and 15) Findings include: 1. On 5/7/25 at 9:05 a.m. QMA 1 was observed preparing Resident 12's medications, which included chlorhexidine gluconate mouthwash. She brought the medications to Resident 12's room and put the mouthwash in the resident's bathroom. She told the resident she left her mouthwash in the bathroom "how she liked it", and proceeded to give the resident her remaining medications. She then exited the resident's room. She had not administered the mouthwash to the resident or observed the resident take the mouthwash. The record for Resident 12 was reviewed on 5/7/25 at 11:29 a.m. Diagnoses included, but were not limited to, schizophrenia and hypertension. The Physician's Order Summary, dated 5/2025, indicated chlorhexidine gluconate solution 0.12% mouthwash, swish with 15 ml (milliliters) for 30 seconds after brushing twice daily then spit. Do not eat or drink for 30 minutes after. There was a lack of any physician's order or assessment for self-administration of medications. During an interview on 5/7/25 at 11:27 a.m., the Administrator and the Resident Care Coordinator were made aware the medication was left with the resident. No further information was provided. 2. On 5/8/25 at 8:55 a.m., LPN 1 was observed preparing Resident 15's medications, which		Mouthwash (Resident 12, 5/7/25) • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident 12 was assessed with no adverse effects noted from the delayed or unobserved administration of chlorhexidine gluconate mouthwash. QMA 1 was immediately counseled and re-educated on the importance of observing medication and treatment administration per physician orders, including non-oral medications such as mouthwash when prescribed. Resident 12's care plan and physician orders were reviewed and clarified to specify whether mouthwash is to be administered or self-administered. • 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:On 5/9/25 through 5/23/25, the Director of Nursing and/ or designee reviewed the current physician orders and medication administration records (MARs) for all residents. Any inconsistencies between orders and administration practices were addressed. For residents capable of self-administration, physician orders were updated accordingly, and documentation was completed in their care plans. • What measures will be put into	

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	included fluticasone nasal spray. She was unable to find the fluticasone nasal spray in the medication cart. She indicated the medication was "probably in his room." She asked the resident where the nasal spray was located and he indicated it was on the kitchen table in his apartment. LPN 1 then went to the resident's apartment to get the medication. She returned to the medication cart with the fluticasone nasal spray and administered it to the resident. The record for Resident 15 was reviewed on 5/8/25 at 9:30 a.m. The Physician's Order Summary, dated 5/2025, indicated fluticasone 50 mcg (micrograms), 1 spray each nostril. There was a lack of any physician's order or assessment for self-administration or storage of medications. During an interview on 5/8/25 at 9:07 a.m., LPN 1 indicated the resident was not supposed to self-administer any medications. During an interview on 5/8/25 at 11:05 a.m., the Resident Care Coordinator was made aware the medication had been left in the resident's room. No further information was provided.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur: From 5/20/25 through 5/25/25 all QMAs and nursing staff will receive mandatory re-education on the facility's medication administration policy, with emphasis on: Observing administration of all medications and treatments unless explicitly ordered for self-administration. Proper documentation of medication and treatment administration. The facility's medication administration policy will be reviewed and updated to clarify procedures for treatments like mouthwash. • 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 Director of Nursing and/or designee will conduct weekly medication administration audits for 16 weeks. Results will be reviewed in the facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings. If compliance is achieved consistently, audits will then occur monthly for 3 months. Any ongoing deficiencies will trigger additional staff training and corrective measures. • By what date the systemic changes will be completed:All corrective actions and systemic changes will be	

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			completed by May 31, 2025. R216 Deficient Practice: Improper Storage and Unauthorized Self-Administration of Medication (Resident 15, 5/8/25) • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 15 was assessed with no adverse effects noted from the administration of fluticasone nasal spray. The medication was immediately removed from the resident's apartment and returned to the secured medication storage area. The resident's physician was notified, and the current orders were reviewed by the Director of Nursing. No order was found for self-administration or in-room storage. LPN 1 received immediate re-education on proper medication storage, handling, and the prohibition of unauthorized retrieval of medications from resident living areas. • 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:	

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			On 5/20/25 through 5/23/25, the Director of Nursing (DON) and/or designee will complete a facility-wide audit of all resident medications and storage practices. Resident rooms will be checked to ensure no medications are stored outside the designated medication storage areas unless there is a current physician order and self-administration assessment in place. Any medications found stored in resident rooms without proper authorization will be removed, and physicians will be contacted to determine whether a self-administration order is appropriate. Appropriate assessments and documentation will be completed at that time. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All licensed nursing staff will receive mandatory in-service education from 5/20/25 through 5/25/25 on medication storage policies, self-administration protocols, and safe medication administration practices.	

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			A policy reminder will be distributed from 5/20/25 through 5/25/25 to reinforce that staff are not to leave medications unsecured in resident living areas unless an order and assessment for self-administration is on file. As of 5/20/2025, a facility protocol has been implemented requiring that any missing medications be reported to the charge nurse and/or DON immediately rather than retrieving medications from resident areas. • 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 Director of Nursing and/or designee will conduct random weekly audits of resident medication storage practices for 16 weeks to ensure compliance. Findings will be discussed during monthly Quality Assurance and Performance Improvement (QAPI) meetings. After 16 weeks of	

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			compliance, audits will continue on a monthly basis for three months. Noncompliance will result in immediate correction, retraining and progressive disciplinary action as appropriate. • By what date the systemic changes will be completed: All corrective actions and systemic changes will be completed by May 30, 2025.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were signed and completed and/or updated with changes for 4 of 12 records reviewed. (Residents 5, 8, 3, and 14) Findings include: 1. Record review for Resident 5 was completed on 5/7/25 at 11:04 a.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and osteoporosis. A Service Plan, dated 2/18/25, was not signed by the resident or responsible party. The Nurse's Notes, dated 2/2025, lacked documentation the Service Plan had been	R 0217	**R217-** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident 3, 5, 8's service plan, has been reviewed and updated. All residents and responsible parties were contacted, and all service plans were reviewed with them and signed as required. Documentation of the review was entered into the nurse's notes. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	05/30/2025

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	reviewed with the resident or responsible party. During an interview on 5/7/25 at 11:44 a.m., the Resident Care Coordinator indicated she was not aware the Service Plan had to be signed every time it was completed. 2. Record review for Resident 8 was completed on 5/6/25 at 1:00 p.m. Diagnoses included, but were not limited to, hypertension, depression, and arthritis. A Service Plan, dated 11/14/24, was not signed by the resident or responsible party. The Nurse's Notes, dated 11/2024, lacked documentation the Service Plan had been reviewed with the resident or responsible party. During an interview on 5/7/25 at 11:44 a.m., the Resident Care Coordinator indicated she was not aware the Service Plan had to be signed every time it was completed. 3. The record for Resident 3 was reviewed on 5/6/25 at 2:18 p.m. Diagnoses included, but were not limited to, alcohol use with withdrawal delirium and bipolar depression. The 5/5/23 Admission Assessment indicated the resident had bipolar depressive disorder. A Service Plan, dated 12/6/24, indicated the resident did not have current or a history of depression, anxiety, or mood disorders. The Service Plan did not indicate the resident was receiving psychiatric services, and was not signed by the resident or their representative. During an interview on 5/6/25 at 3:26 p.m., the		will be taken:On 5/22/25 through 5/30/25, the Director of Nursing (DON) and Resident Care Coordinator will audit all current resident service plans to ensure they contain the appropriate resident or responsible party signatures and documentation of plan review. Any service plans found without signatures or documentation of review will be corrected by contacting the resident or responsible party, reviewing the plan, obtaining signatures, and documenting the interaction in the clinical record. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The service plan policy will be reviewed with the facility's clinical management team to clarify that all initial and updated plans must be reviewed with the resident and/or responsible party and signed at each revision. A signature and documentation checklist will be added to the service plan binder to reflect review process. Staff responsible for completing and updating service plans, including the Director of Nursing and/or designee, will receive re-education on the documentation and signature requirements for service plans. Admission and quarterly review processes will now include a mandatory audit step to verify all	

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	resident indicated she was receiving psychiatric services for bipolar depression. During an interview on 5/7/25 at 3:30 p.m., the Resident Care Coordinator indicated the resident was receiving psychiatric services for bipolar depression and she did not know why it was not on the Service Plan. Sometimes the residents signed the Service Plans and sometimes they did not. 4. Resident 14's record was reviewed on 5/7/25 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and high blood pressure. The Service Plan, dated 12/20/24, indicated the resident was oriented to person, place, and time. He was independent with eating, bathing, dressing, grooming, and toileting. He required assistance with medication administration. The Service Plan indicated there was a phone conference with the family on 5/7/25. The record lacked documentation a conference was held before 5/7/25 or documentation of the facility reviewing the Service Plan with the resident. During an interview on 5/8/25 at 2:50 p.m., the Director of Nursing (DON) indicated the resident refused to sign it. She had called the resident's sister on 5/7/25 to inform her of a new concern and so they signed on her behalf. There was no documentation of the family or resident being provided information about the Service Plan any sooner than 5/7/25, and it must have been overlooked.		necessary signatures and documentation are complete before finalizing the record. • 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 and/ or designee will conduct monthly audits of all new or revised service plans for a period of 6 months to ensure all required signatures and review documentation are present. Audit findings will be reported and reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) meetings. If issues are identified, retraining and additional follow-up audits will be conducted until consistent compliance is achieved. • By what date the systemic changes will be completed:All corrective actions and systemic changes will be completed by May 30, 2025.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency			

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	Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident 13) Finding includes: On 5/7/25 at 9:30 a.m., QMA 1 was observed preparing Resident 13's medications. She prepared the resident's pills and administered them to the resident. She then signed out the resident's medications on the Medication Administration Record. She signed off calcium carbonate 500 mg (milligram) fruit chew as given but had not administered it to the resident. During an interview on 5/7/25 at 9:40 a.m., QMA 1 was made aware she had signed out the calcium carbonate but had not administered it. She indicated, "oh yeah, she might refuse it." QMA 1 then prepared the medication and administered it to the resident. Record review for Resident 13 was completed on 5/7/25 at 11:38 a.m. The Physician's Order Summary, dated 5/2025, indicated calcium carbonate 500 mg fruit chew 1 tab by mouth twice daily. During an interview on 5/7/25 at 11:27 a.m., the Administrator and the Resident Care Coordinator were made aware of the omitted medication. No further information was provided.	R 0247	**R247** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 13 received the missed dose of calcium carbonate shortly after the error was identified. The resident was assessed, and no adverse effects were noted. QMA 1 was immediately counseled on the importance of administering medications before documenting them on the Medication Administration Record (MAR) and the facility's Medication Administration policy was reviewed at that time. • 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: On 5/9/25 the Director of Nursing (DON) and/ or designee completed an audit of the MARs of all residents who received medications from QMA 1 during the three days prior to and following the incident. Although the facility acknowledges additional discrepancies between medication administration and	05/31/2025

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			documentation could have occurred, none were discovered at that time, and affected residents will be assessed. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: On 5/23/25 and 5/24/25, All QMAs and licensed staff will receive mandatory re-education on the facility's medication administration policy, with emphasis on: Refraining from administering medications prior to documenting in the MAR. Accurate and timely documentation of all medications administered or refused. A "Med Pass Integrity Checklist" will be implemented monthly for all nurses and QMAs to ensure proper sequencing and accuracy.	

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			Director of Nursing and/or designee will conduct real-time observations of med passes weekly for 4 weeks to reinforce adherence to proper protocol. Then monthly for 6 months. • 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 and/or designee will conduct weekly MAR audits for 16 weeks focusing on administration and documentation accuracy. 10 Random med pass observations will also be conducted monthly by DON and/or designee for 6 months. Results will be reviewed in monthly QAPI (Quality Assurance and Performance Improvement) meetings. After 6 months of compliance, MAR audits will continue monthly for three additional months. Ongoing issues will result in progressive disciplinary action and targeted retraining. • By what date the systemic changes will be completed:	

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			All corrective actions and systemic changes will be completed by May 31, 2025.	
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe. This had the potential to affect 5 residents who resided in the facility and received a pureed diet. Finding includes: On 5/7/25 at 11:07 a.m. Cook 1 was observed preparing a pureed modified diet. She was observed gathering items and bringing them to the preparation area. She donned gloves without performing hand hygiene beforehand. She then proceeded to add 20 meatballs to a blender. She used a dessert cup to scoop out an unmeasured amount of beef broth and then added it to the blender and began mixing. She stopped blending and added another unmeasured amount of beef broth to the blender and began mixing again. She continued to do this process three times. She stopped blending and then poured an	R 0270	**R270** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The pureed meatballs prepared on 5/7/25 were immediately discarded upon identification of improper preparation procedures. The facility dietary manager immediately educated the dietary employee utilizing a documentation tool and the meal was prepared again. • How the facility will identify other residents having the	06/07/2025

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	unmeasured amount of food thickener to the blender and blended again. She reached into the container of food thickener and scooped up food thickener using her gloved hands and added the unmeasured amount of thickener to the blender and continued blending. She poured her final mixture into a bowl and removed her gloves. She donned another pair of gloves, without performing hand hygiene, and continued to cover and put away the pureed meatballs. During an interview on 5/7/25 at 11:15 p.m., the Dietary Manager indicated she had no further information to provide. The "Production Recipe for Pureed Thick Meatballs," received from the Dietary Manager as current, indicated "Ingredients & Instructions ...Meatballs 20, 2 each, Water 2.5 cups, Beef Base 2.5 teaspoons, Food Thickener 2/3 cup....Wash hands... 1. Place cooked meatballs in food processor. 2. Add water plus base and process until smooth in texture. 3. Add a food thickener and process briefly until mixed. Scrape down sides with spatula and reprocess. 4. Pour into steam table pan coated with cooking spray. 5. Cover tightly and heat in conventional over at 350 degrees Fahrenheit until temperature reaches 165 degrees Fahrenheit."		potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving mechanically altered or pureed diets meals were reviewed to ensure correct preparation procedures by dietary director . On 5/9/25, food production records and meal service logs were audited for the previous 3 days, to identify any similar instances. No additional concerns were found. On 5/9/25, dietary staff were interviewed and closely observed to determine if improper food handling practices were occurring elsewhere. No other deficient practices were discovered at that time. As a precaution, all modified diet meals prepared on 5/10/25 through 5/15/25 were evaluated for compliance with recipe standards and consistency guidelines. No additional concerns discovered. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: On 5/10/25 through 5/15/2025 a documented in-service was conducted by the dietary director	

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	05/08/2025

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			regarding the following: Hand hygiene protocols (especially before and after glove use) Proper glove use and change procedures The importance of accurate measuring for all therapeutic diets Safe handling and dispensing of bulk ingredients such as food thickeners Reinforcement of standardized recipes and measuring procedures for all modified diets. Procedural updates to include a mandatory use of labeled scoops or measuring devices in thickener and broth containers. Signs posted near handwashing	

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		A. BUILDING 00 B. WING	05/08/2025

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			and prep areas to remind staff of critical hygiene steps before donning gloves. • 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 facility's dietary director and/or designee will initiate and conduct random observation audits of food preparation practices three times weekly for 16 weeks, then weekly for two months. A monthly documented skills check on proper measuring and food handling will be performed for all dietary staff for 6 months. Audit results will be reported to the QA Committee monthly, and trends will be reviewed to determine if further interventions are needed. Any non-compliance identified will	

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		A. BUILDING 00 B. WING	05/08/2025

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			result in immediate re-education and documented follow-up. • By what date the systemic changes will be completed: All corrective actions, staff training, and systemic updates will be completed by June 7, 2025.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to ensure food was prepared under sanitary conditions related to improper hand hygiene and touching ingredients with dirty gloves during the preparation of a puree modified diet. This had the potential to affect all 5 residents who received a pureed modified diet. Finding includes: On 5/7/25 at 11:07 a.m. Cook 1 was observed preparing a puree modified diet. She was observed gathering items and bringing them to the preparation area. She donned gloves without performing hand hygiene. She proceeded to add 20 meatballs to a blender. She used a dessert cup to scoop out an unmeasured amount of beef broth and then added it to the blender and began mixing. She stopped blending and added another unmeasured amount of beef broth to the blender and began mixing again. She continued to do this	R 0273	R273 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Although there were no identified negative outcomes for the 5 residents receiving the pureed diet, all pureed food prepared during the observed incident on 5/7/25 was immediately discarded. The cook involved was immediately re-educated on proper hand hygiene and glove usage in accordance with facility policy and the Food Code.	06/03/2025

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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	process three times. She stopped blending and then poured an unmeasured amount of food thickener into the blender and blended again. She reached into the container of food thickener and scooped up food thickener using her gloved hands and added the unmeasured amount of thickener to the blender and continued blending. She poured her final pureed mixture of meatballs into a bowl and removed her gloves. She donned another pair of gloves, without performing hand hygiene, and continued to cover and put away the pureed meatballs. During an interview on 5/7/25 at 11:15 p.m., the Dietary Manager indicated she had no further information to provide. A current facility policy titled, "Handwashing," indicated "...Gloves and Sanitizers: According to the Food Code: Gloves, if used, single use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discard when damaged or soiled, or when interruptions occur in the operation. Gloves and sanitizers are not meant to be used as a replacement for handwashing. They are only effective if proper handwashing is completed. When someone wears gloves they should remove and throw away the gloves after completing any of the above mentioned tasks and then wash their hands, and put on a new pair of gloves before starting their next task."		The food preparation area and equipment used were cleaned and sanitized immediately following the incident. • 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: On 5/8/25 a review of all residents currently receiving a pureed diet was completed to identify others potentially affected. The dietary staff were interviewed and observed during the preparation of modified diets to assess compliance with hand hygiene protocols. No additional incidents were identified, but re-education was provided to all dietary staff to ensure consistent and safe food handling. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All dietary staff received	

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		A. BUILDING 00 B. WING	05/08/2025

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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			mandatory in-service training on proper hand hygiene and glove usage on 5/10/2025 through 5/15/2025 Visual reminders (signage) regarding proper glove use and handwashing procedures were posted in all kitchen and prep areas. A “Hand Hygiene & Glove Use Protocol” was re-implemented, requiring staff to wash hands before donning gloves and between tasks, with supervisory spot-checks during meal preparation. • 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 Dietary Manager or designee will conduct random observations of food prep activities daily for 30 days, then weekly for 90 days. Observations will be documented using a standardized compliance checklist. Any identified noncompliance will result in immediate corrective action and re-education.	

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			Audit results will be reviewed monthly during the QAPI meetings for ongoing monitoring and adjustments as needed. • By what date the systemic changes will be completed: All corrective actions and systemic changes will be completed by June 3, 2025	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to incomplete or a lack of orders for home health, wound care, and glucose monitoring and wound care orders not implemented for 3 of 10 resident records reviewed. (Residents 7, 10, and 4) Findings include: 1. The record for Resident 7 was reviewed on 5/7/25 at 3:43 p.m. Diagnoses included, but were not limited to, congestive heart failure, acute kidney failure, and diabetes. The 3/9/25 Service Plan indicated blood sugar checks on Mondays and Thursdays and home health services for wound care. The record lacked any physician's orders for blood sugar checks, home health services, and	R 0349	**R349** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 4: On 5/10/25, Orders were reviewed and clarified in collaboration with hospice. The treatment orders were updated to clearly reflect frequency and responsible parties. Wound treatments have been initiated per clarified orders and properly documented. Service care plan was updated at that time.	06/07/2025

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		A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	wound care since the resident was admitted on 3/5/25. During an interview on 5/8/25 at 12:05 p.m., the Assisted Living Unit Manager indicated they resumed the home health, wound care, and blood sugar checks the resident had from a previous admission, but she did not write an order for them this admission. 2. The record for Resident 10 was reviewed on 5/7/25 at 11:40 a.m. Diagnoses included, but were not limited to, depression, dementia and diabetes. A 4/3/25 Physician's Order indicated to clean the resident's heel wound with saline, apply nystatin (an anti-fungal), and cover with dry dressing. The order lacked a frequency for the wound care. During an interview on 5/8/25 at 12:15 p.m., the Assisted Living Unit Manager indicated she should have put the frequency of the wound care in the order. 3. Resident 4's record was reviewed on 5/6/25 at 2:21 p.m. Diagnoses included, but were not limited to, dementia. The Service Plan, dated 12/16/24, indicated the resident was receiving hospice services. The resident had a wound to the left side of the head and treatments were being completed by hospice and staff nurses. A Hospice Nurse Progress Note Comprehensive Assessment, dated 4/10/25, indicated the resident had a wound to the left scalp measuring 3.5 centimeters (cm) long by 3.3 cm wide. It was a chronic open wound that was red/pink in color with a scant amount of drainage. He also had a left buttock stage 2 pressure wound measuring 2 cm		Resident 7: New physician orders were obtained for blood glucose monitoring, wound care, and home health services. Services have been initiated, and documentation now reflects current treatments. Service care plan was updated at that time Resident 10: Wound care treatment orders were reviewed and reissued to include accurate details. Nursing staff will be re-educated from 5/20/25 through 5/25/25 to ensure timely documentation and implementation of treatments. • 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: From 5/19/25 through 5/24/25, the clinical records of all current residents receiving wound care, glucose monitoring, or home health/hospice services will be audited by the Director of Nursing (DON) or designee utilizing an audit tool.	

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		A. BUILDING 00 B. WING	05/08/2025

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	long by 3 cm wide. It was red/pink in color with a scant amount of drainage. The treatment was completed for the scalp wound. The physician was notified of the new stage 2 wound to the left buttock and a new order was received to cleanse with wound wash, pat dry, and apply a dry dressing every 3 days and as needed if soiled. The hospice staff were to do the treatment on hospice visit days and facility staff were to do the dressing changes on non-hospice visit days. The facility nurse was educated to call the hospice company with any questions/concerns or changes in patient status. The Hospice Combined Disciplinary Plan of Care, dated 4/16/25, indicated "Physician Order Profile... Create Date: 4/10/25 Status: current. Treatment: Wound to left buttock - cleanse with wound wash, pat dry, apply dry dressing every three days and as needed if soiled. Hospice nurse to do on hospice visit days. Facility staff to do on non-hospice visit days...Create Date: 10/3/24 Status: Current. Treatment: Left Scalp open wound - cleanse with wound wash pat dry, apply dry dressing every 3 days and as needed if soiled. Hospice nurse to do on hospice visit days, facility staff to do on non-hospice visit days...Nurse Visit Frequency - start date 10/2/24 - Hospice nurse visits 2 times weekly." The April 2025 Physician Order Summary indicated the resident had a wound to the left buttocks. Treatment orders indicated to clean the area with wound wash, pat dry, and apply dry dressing every 3 days as needed if soiled. The hospice nurse was to complete on hospice visit days and facility staff was to reinforce. The resident had a wound to the left scalp. Treatment orders indicated to clean the area with wound wash, pat dry, apply a collagen sheet, and cover		Any missing, incomplete, or outdated orders will be clarified with the physician or care provider. Service care [plans will be revised at that time. Staff auditing will ensure that treatment administration records (TARs) and service plans match current physician orders. This will be verified utilizing an audit tool. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Mandatory staff training for all licensed nursing staff and care coordinators will be conducted from 5/19/25 through 5/24/25 on: Accurate and timely transcription of physician orders	

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		A. BUILDING 00 B. WING	05/08/2025

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	with hydrocolloid. Complete per hospice staff 3 times a week and as needed. Facility staff nurse to reinforce only. The April 2025 Treatment Administration Record was blank from 4/1/25-4/30/25 for both the treatment to the left scalp and left buttock. During an interview on 5/7/25 at 11:50 a.m., the Resident Care Coordinator indicated that the facility staff never did the wound treatments. Hospice nurses came into the facility to do the treatments. During an interview on 5/8/25 at 2:50 p.m. the Director of Nursing and the Memory Care Unit Manager indicated neither of them had the orders clarified or updated, as the facility staff do not perform wound care in their facility. They did not realize the hospice nurses were only visiting twice weekly as the hospice nurses did not check in with them when they visited.		Required documentation on MAR/TAR and service plans Coordination with hospice and home health providers, including verifying visit frequencies and responsibilities New Admission/Re-admission Checklist will include: Verification of all standing and new orders Communication with hospice/home health to confirm and document services Clinical Record Review Tool will be implemented to verify that service plans, physician orders, and treatment documentation are aligned and updated regularly. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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		A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			program will be put into place: The DON and/or designee will conduct monthly audits for 6 months utilizing an audit tool of all resident charts, with emphasis on those receiving wound care, glucose monitoring, or third-party services (hospice/home health). Audit findings will be presented during the monthly QA/QI committee meetings. Any identified gaps will trigger immediate corrective action, re-education, and follow-up review. Ongoing compliance will be conducted by DON and/or designee using a monthly QA tracking log and corrective actions will be documented. • By what date the systemic changes will be completed: All corrective actions, staff re-education, and implementation of auditing procedures will be	

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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			completed by June 7, 2025.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the Emergency Binder had complete resident information for 5 of 10 resident records reviewed. (Residents 2, 5, 7, 8, 10) Findings include: The resident Emergency Binder was reviewed on 5/8/25 at 12:00 p.m. a. Resident 2 was missing physician contact information. b. Resident 5 was missing physician contact information. c. Resident 7 was missing allergies. d. Resident 8 was listed to be in apartment number D-60. The resident roster indicated the resident was currently living in 254. e. Resident 10 was missing physician contact information. During an interview on 5/8/25 at 2:50 p.m., the Director of Nursing was made aware of the	R 0356	**R356** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Emergency Binder was immediately updated to include complete and accurate information for: Resident 2, 5, and 10: Physician contact information was obtained and entered. Resident 7: Allergy information was confirmed through clinical records and added to the Emergency Binder. Resident 8: The correct	05/31/2025

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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	missing items. No additional information was provided.		apartment number (254) was verified and updated. The updated binder was reviewed and signed off by the Medical Records Liaison and Administrator on 5/22/25 to confirm accuracy. • 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: A full documented audit of the Emergency Binder for all current residents was initiated utilizing an audit tool on 5/9/25 and will be completed by 5/21/25. Any missing or outdated information (e.g., physician contact, allergies, current apartment numbers) will be updated using current clinical records and resident rosters. On 5/21/25, the facility will cross-check Emergency Binder against the resident roster to	

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		A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			ensure consistency and completeness. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Emergency Binder will be reviewed and updated monthly by the Medical Records Liaison and/or designee utilizing an audit tool. On 5/19/25 the New Admission and Discharge Checklist was modified to include steps for adding or removing residents from the Emergency Binder and ensuring information is complete. On 5/15/25 the facility's Medical Records Liaison received additional training on required emergency documentation including resident demographics, allergies, physician contact, and apartment location.	

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		A. BUILDING 00 B. WING	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			• 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: A monthly Emergency Binder Audit will be completed by the Medical Records Liaison and/ or designee and results will be documented utilizing an audit tool Audit results will be reviewed during the monthly QA/QI Committee meetings and tracked to ensure continued compliance. Any discrepancies found during audits will be corrected within 24 hours by the facility's Medical Records Liaison and/or designee. • By what date the systemic changes will be completed: All corrective actions and implementation of systemic changes will be completed by May 31, 2025.	

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	05/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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