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	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TERRACE AT TOWNE CENTRE THE	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. Survey dates: December 16 and 17, 2019. Facility number: 002392 Residential Census: 160 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/18/19.	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Towne Centre as to the accuracy of the surveyors' findings or the 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 that 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**	

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

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			or affiliated companies.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.			

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	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure personnel records were complete related to annual three hour dementia-specific training for 2 of 5 personnel files reviewed. (Housekeepers 1 and 2) Findings include: The Employee Files were reviewed on 12/17/19 at 8:42 a.m., the following was not included: 1. Housekeeper 1, hired on 10/16/12, did not complete 3 hours of dementia-specific training for the year 2018. 2. Housekeeper 2, hired on 3/12/13, did not complete 3 hours of dementia-specific training for the year 2018. Interview with the Human Resource Director on 12/17/19 at 11:43 a.m., indicated the above employees did not complete the required annual dementia-specific training.	R 0120	1.Housekeeper 1 and Housekeeper 2 completed the 3-hour dementia-specific training on or before December 31, 2019. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.On December 20, 2019, the Community's Human Resources Director and designee completed an audit of all employees requiring training, including dementia training, to identify other possible employees with the required lack of training. Any employee found to have not completed the required training were required to do so on or before December 21, 2019. The Community's Human Resources Director and designee conducted a second audit on January 3, 2020, to ensure all training was completed. On January 15, 2020, all staff will be in-serviced on completing all required training. 4.The Community's Human Resources Director and designee will randomly audit 10 employee files per month for 7 months to ensure compliance in required training. 5.Corrective date: January 20, 2020	01/20/2020

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review and interview, the facility failed to ensure evaluations were completed related to the self administration of medications for 1 of 5 residents observed during medication pass. (Resident 14) Finding includes: On 12/16/19 at 11:45 a.m., QMA 1 was observed preparing Resident 14's medications. The QMA entered the resident's room to administer her the medications. At that time, there was an open bottle of Systane eye drops observed on the resident's night stand. There was no label on the bottle. The QMA indicated the resident did not have an order or assessment to self administer her own medications. The record for Resident 14 was reviewed on 12/17/19 at 10:00 a.m. Diagnoses included, but were not limited to, depression, high blood	R 0216	1.On December 17, 2019, Resident 14 was assessed for self-administration of medication. Resident 14 and the POA were reminded about notifying staff of over-the-counter medications. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.The Director of Nursing and designee(s) completed an audit of resident's apartments to ensure that all residents that self-administer medication had a current assessment for self-administration of medication. Appropriate staff will be in-serviced on reporting over the counter medications to the Director of Nursing and designee. 4.The Director of Nursing and	01/20/2020

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	pressure, and osteoarthritis. The 6/20/19 Service Plan indicated the resident had occasional disorientation to person, place, time and situation. The resident required frequent redirection and reminders. There was no self administration of medications evaluation. The resident had been transferred to the Memory Care Unit on 11/12/19. There was no Physician Order prior to 12/16/19 for Systane eye drops. A Nurses' Note, dated 12/16/19 at 9:00 p.m., indicated the family was made aware of a new order for the Systane eye drops. Interview with the Memory Care Director on 12/16/19 on 12:00 p.m., indicated the resident did not have an order or an evaluation/assessment to self administer her own medications.		designee(s) will randomly audit residents' apartments to ensure …. In addition, on December 30, 2019, all Residents and their responsible parties were provided with a notice requesting that all medication brought into the Community be delivered to the Community's charge nurse on duty to ensure that there is a current order and assessment are in place to self-administer medication. 5.Corrective date: January 20, 2020	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure blood pressure medications were signed out as ordered or held per parameters for 1 of 10 records reviewed. (Resident 5) Finding includes: The record for Resident 5 was reviewed on	R 0247	1.Resident 5 blood pressure medication are being signed out or held per parameter orders. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.On December 19, 2019, the	01/20/2020

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	12/16/19 at 1:32 p.m. Diagnoses included, but were not limited to, diabetes, hyperlipidemia (high cholesterol), and hypertension. A Physician's Order, dated 2/27/19, indicated Midodrine (a medication to treat low blood pressure) 10 milligrams (mg) three times daily for orthostatic hypotension (low blood pressure). May hold when systolic level (top number) is greater than 160. The 12/2019 Medication Administration Record (MAR), indicated there were no initials of the person who administered or held the medication on the dates of 12/1/19 thru 12/16/19 for any of the administration times. There were blood pressure results listed on the MAR instead. The resident's systolic blood pressure was above 160 and should have been held on the following dates and times: -12/3/19 at 5:00 p.m., blood pressure 179/69. -12/7/19 at 1:00 p.m., blood pressure 174/101. -12/13/19 at 5:00 p.m., blood pressure 171/81. The current policy for medication and treatment records, received on 12/17/19 at 10:33 a.m., indicated the medication and treatment records, "shall be documented, indicating the time... the name or initials of the person administering the drug or treatment ...." Interview with the resident on 12/17/19 at 9:11 a.m., indicated he had been fatigued and believed it was related to his medications. He spoke to the Director of Nursing regarding his health and decreased energy level concerns. Interview with the Director of Nursing on 12/17/19		Director of Nursing and designee audited all residents' medications to ensure administration as ordered by physician. All appropriate staff will be in-serviced on proper documentation of medication administration 4.The Director of Nursing and designee will conduct a weekly audit of all monthly medication administration records for 12 weeks then monthly for 7 months to monitor proper documentation and medication administration. 5.Corrective date: January 20, 2020	

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	at 10:33 a.m., indicated there should have been documentation to indicate the administration or holding of the medication as ordered.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to the high temperature dishwasher not reaching 180 degrees Fahrenheit during the rinse cycle and an accumulation of food and debris on the floors and inside of the refrigerators for 2 of 2 kitchens. (The Main and Assisted Living Kitchens) Findings include: 1. On 12/16/19 at 9:20 a.m., during the Initial Kitchen Tour with the Dietary Manager, the following was observed: a. An accumulation of food and debris was on the floor in the Assisted Living kitchen. b. An accumulation of debris and marker markings were inside the refrigerator in the Assisted Living kitchen. c. An accumulation of food and debris was on the floor in the Main Kitchen. d. An accumulation of debris and marker markings were inside of the refrigerators in the Main Kitchen.	R 0273	1.On December 17, 2019, the accumulation of food and debris on the floor in the assisted living kitchen was cleaned. The accumulation of food and debris on the floor in the main kitchen was cleaned. On January 1, 2020, a third-party vendor deep cleaned the floors in the main kitchen and assisted living. On January 2, 2020, the refrigerator in the main kitchen and assisted living were replaced. A third-party vendor serviced the dishwasher in the main kitchen temperature which was corrected to reach 180 degrees F. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.On December 27, 2019, dietary staff were in-serviced on kitchen sanitation, dishwasher temperature and food storage. In addition, the kitchen floors will be cleaned after each meal and the cleanings will be added to the	01/27/2020

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	e. The high temperature dishwasher in the Main Kitchen was observed to peak at 160 degrees F during the rinse cycle and did not reach a temperature of 180 degrees F . Interview with the Dietary Manager at the time, indicated the floors were cleaned after each meal by the dishwashers and needed to be cleaned. She also indicated, the refrigerators needed to be cleaned.		daily cleaning schedule and will be deep cleaned weekly. The interior of the refrigerators will be cleaned daily by dietary staff. Dietary staff will audit and document the dishwasher temperature and will report temperature under 180 degree F to the Dietary Director or designee. 4.The Dietary Director or designee will monitor the cleaning schedules for 7 months to ensure compliance with kitchen sanitation, dishwasher temperature and food storage. Corrective date: January 27, 2020	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review, and interview, the facility failed to ensure proper infection control related to lack of hand washing after glove removal during a glucometer (machine to test blood sugar levels) use and insulin injection for 1 of 1 glucometer uses observed. (Resident 13) Finding includes: On 12/16/19 at 12:00 p.m., LPN 1 was observed preparing supplies to complete a blood glucose test for Resident 13. She entered the resident's room, used hand sanitizer to both hands, and donned clean gloves. The nurse proceeded to collect the blood sample. The resident's blood sugar was 232 and he required a scheduled dose	R 0414	1.LPN 1 was in-serviced on proper infection control related to lack of hand washing after glove removal. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3.On December 26, 2019, staff were in-serviced on universal precautions, infection control and hand hygiene. All nursing staff were required to demonstrate proper hand washing techniques. 4.The Director of Nursing or designee will conduct five (5)	01/20/2020

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	of 12 units of insulin. With the same pair of gloves, the nurse primed and drew up the insulin and administered it into the resident's abdomen. She removed one of her gloves and placed all of the supplies into the glove. She removed the other glove and placed the used lancet and needle into the glove and left the room. The LPN returned to her medication cart which was in the medication room and disposed of the used supplies. She signed the medication administration sheet and left the room. She did not sanitize her hands after removing her gloves. Interview with the LPN at the time, indicated she should have sanitized her hands after removing her gloves. Interview with the Memory Care Director on 12/16/19 at 12:25 p.m., indicated the LPN should have sanitized her hands after glove removal. The current and undated "Hand Hygiene Policy," provided by the Human Resource Director, indicated hands should be washed after gloves were removed when there had been contact with blood.		random hand washing audits on a monthly basis for 7 months to ensure proper technique. 5.Corrective date: January 20, 2020	