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	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOWNE PARK ASSISTED LIVING	503 S MURPHY AVE BRAZIL, IN 47834

(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 the Investigation of Complaint IN00445086. Complaint IN00445086 - State deficiencies related to the allegations are cited at R0044 and R045. Survey date: October 31 to November 1, 2024 Facility number: 014623 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 14, 2024.	R 0000	**This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.**	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency Based on record review and interview, the facility failed to document discharge information for 2 of 3 residents reviewed for discharge (Residents C and K). Findings Include: 1. On 11/1/24 at 9:28 a.m., during a phone interview with the Power of Attorney (POA) of Resident C, she indicated the resident was discharged from the facility to a hospital. She was informed she would not be allowed to return because she had eloped from the facility. The POA was not notified of the discharge till hours later. She indicated the resident was discharged back to the facility and was given one to one	R 0044	**Ro44 Residents Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C and Resident K no longer reside at the facility. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Any resident that resides in the facility has the potential to be	12/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hannah Wilson	Administrator	11/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	supervision. She was informed the facility had decided to transfer the resident to another facility, but she had not been included in this decision. She was advised since the resident had eloped she must be placed in a facility with a secure unit. The POA removed the resident the next day and placed her in a long-term care facility. She indicated at the time of the discharge she was not provided any discharge information including a list of medications and directions for care. On 11/1/24 at 10:15 a.m., the medical record of Resident C was reviewed. Admission diagnosis included but were not limited to disorientation, bi-polar disorder (a mental illness that causes unusual shifts in a person's mood), HTN (high blood pressure), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The resident was discharged on 10/19/24. Review of the nurse progress notes indicated the resident was seen by the Nurse Practitioner (NP) on 10/7/24. She indicated she discussed increased confusion with the resident's POA. On 10/10/24 the resident eloped from the facility. She was found walking down the street in front of the facility. She was sent to the hospital for an evaluation at 7:10 p.m., the medical record indicated the POA was notified at 7:25 p.m., The resident was discharged to the hospital and returned to the facility on 10/11/24. She was seen by a physician on the day of re-admission and referred to a long-term care facility (LTC). The medical record lacked documentation of a meeting with resident and POA to discuss discharge. The record lacked documentation of the resident being discharged home with the POA or of any discharge instructions being sent with the resident and POA.		affected by the alleged deficient practice. An audit has been conducted to ensure that all documentation was completed for discharges. No other concerns noted. **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 corporate clinical team reeducated Administrator and DON on discharge policy and documentation. DON/ designees reeducated licensed staff on discharge policy and documentation. **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?** Administrator or designee will audit discharge documentation for all discharges monthly for 6 months until 100 percent substantial compliance is achieved. Results of audits will be reviewed during monthly quality assurance meetings. **By what date the systemic changes will be completed?** 12/04/2024	

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	On 10/31/24 at 2:55 p.m., during an interview, the Administrator indicated she or the DON would notify the case manager at the hospital if a resident was not going to return to the facility. They did an assessment to determine the needs of the resident. If the resident was a danger to themselves or others they would not be allowed to return. A review of the facility residential care agreement indicated. "Section E, paragraph G ...Residents physical, mental or emotional condition or behavior is such that a resident is or is likely to become an endangerment to him or herself or others, in the sole judgement of the facility, then facility may terminate this agreement upon thirty (30) days prior to written notice to resident. Section V. Termination ...B termination by facility ... except when the resident's health or safety, or the health and safety of others is endangered the facility will give not less than thirty (30) days' notice of termination ...." 2. On 11/1/24 at 1:50 p.m., the medical record of Resident K was reviewed. The resident was admitted to the facility for a respite stay on 10/10/24. Admission diagnosis included but were not limited to, seizure, pain, HTN (high blood pressure) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). The resident was discharged home with family on 10/28/24. The record lacked documentation of discharge instructions being sent with the resident upon discharge. The record indicated medications were sent but did not indicate what medications were sent.			

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	On 11/1/24 at 12:05 p.m., during an interview, the Administrator indicated the facility did not have a specific policy for discharge. She indicated they followed the state regulations. She was not aware the record did not contain any discharge information. On 10/31/24 at 2:37 p.m., during an interview, the Director of Nursing (DON) indicated if a resident was planning to discharge she would contact the resident's regular pharmacy and send orders to them for medications to be filled. She would verify home healthcare needs and contact appropriate services. The day of discharge she would print the resident's orders out and send them along with medications. She documented this information and gave it to the resident but indicated she did not keep a copy of the information which was sent with the resident. If a resident was not allowed to return to the facility after discharge. She would have a conference with administration. In deciding this they would look at the safety of the residents and consider the safety of the other residents. If they are returning with more nursing care needs which are beyond what they could provide they did not allow the resident to return to the facility. On 11/1/2024 at 1:33 p.m., the Administrator provided a copy of the Residential State Rules, and indicated it was the policy currently being used by the facility ...The administrator highlighted rule 0354 Clinical Records-Noncompliance ...." This citation relates to Complaint IN00445086.			
R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency			

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	Based on record review and interviews, the facility failed to notify the POA of the transfer or discharge and the reasons for the move, in writing or by conference meeting and facility failed to provide discharge instructions to the family members responsible for two of three residents reviewed for facility discharge for 2 of 3 residents reviewed for discharge (Residents C and K). Findings Include: 1. On 11/1/24 at 9:28 a.m., during a phone interview with the Power of Attorney (POA) of Resident C, she indicated the resident was discharged from the facility to a hospital. She indicated she was informed she would not be allowed to return because she had eloped from the facility. She indicated she was not notified of the discharge till hours later. She indicated the resident was discharged back to the facility and was given one to one supervision. She was informed the facility had decided to transfer the resident to another facility, but she had not been included in this decision. She was advised since the resident had eloped she must be placed in a facility with a secure unit. She removed the resident the next day and placed her in a long-term care facility. She indicated at the time of the discharge she was not provided any discharge information including a list of medications and directions for care. On 11/1/24 at 10:15 a.m., the medical record of resident C was reviewed. The resident was admitted to the facility on 3/4/22. Admission diagnosis included but were not limited to disorientation, bi-polar disorder (formerly called manic-depressive illness or manic depression, is a mental illness that causes unusual shifts in a	R 0045	**R045 Residents Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C and Resident K no longer reside at the facility. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. Conducted audit of discharges in the last 30 days to ensure notification and discharge instructions were provided **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 corporate clinical team reeducated Administrator and DON on discharge notifications and providing discharge instructions. DON/ designees have reeducated licensed nursing staff on discharge notifications and providing discharge instructions. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	12/04/2024

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	person's mood), HTN (high blood pressure), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The resident was discharged on 10/19/24. Review of the nurse progress notes indicated the resident was seen by the Nurse Practitioner (NP) on 10/7/24. She indicated she discussed increased confusion with the resident's POA. On 10/10/24, the resident eloped from the facility. She was found walking down the street in front of the facility. She was sent to the hospital for an evaluation at 7:10 p.m. The medical record indicated the POA was notified at 7:25 p.m., The resident was discharged to the hospital and returned to the facility on 10/11/24. She was seen by a physician on the day of re-admission and referred to a long-term care facility (LTC). The medical record lacked documentation of a meeting with resident and POA to discuss discharge. The record lacked documentation of the resident being discharged home with the POA or of any discharge instructions being sent with the resident and POA. On 10/31/24 at 2:55 p.m., during an interview with the Administrator she indicated she or the DON would notify the case manager at the hospital if a resident was not going to return to the facility. They did an assessment to determine the needs of the resident. If the resident was a danger to themselves or others they would not be allowed to return. A review of the facility residential care agreement indicated. "Section E, paragraph G ...Residents physical, mental or emotional condition or behavior is such that a resident is or is likely to become an endangerment to him or herself or others, in the sole judgement of the facility, then		**recur, i.e., what quality assurance program will be put into place?** The administrator or designee will audit discharge notifications and discharge instructions for all discharges monthly for 6 months until 100 percent substantial compliance is achieved. Results of audits will be reviewed during monthly quality assurance meetings. **By what date the systemic changes will be completed?** 12/04/2024	

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	facility may terminate this agreement upon thirty (30) days prior to written notice to resident. Section V. Termination ...B termination by facility ... except when the resident's health or safety, or the health and safety of others is endangered the facility will give not less than thirty (30) days' notice of termination ...." 2. On 11/1/24 at 1:50 p.m., the medical record of Resident K was reviewed. The resident was admitted to the facility for a respite stay on 10/10/24. Admission diagnosis included but were not limited to, seizure, pain, HTN (high blood pressure) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). The resident was discharged home with family on 10/28/24. The record lacked documentation of discharge instructions being sent with the resident upon discharge. The record indicated medications were sent but did not indicate what medications were sent. On 11/1/24 at 12:05 p.m., during an interview, the Administrator indicated the facility did not have a specific policy for discharge. She indicated they followed the regulations. She was not aware the record did not contain any discharge information. On 10/31/24 at 2:37 p.m., during an interview, the Director of Nursing (DON) indicated if a resident was planning to discharge she would contact the resident's regular pharmacy and send orders to them for medications to be filled. She would verify home healthcare needs and contact appropriate services. The day of discharge she would print the resident's orders out and send them along with medications. She documented this information and gave it to the resident but			

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	indicated she did not keep a copy of the information which was sent with the resident. If a resident was not allowed to return to the facility after discharge. She would have a conference with administration. In deciding this they would look at the safety of the residents and consider the safety of the other residents. If they are returning with more nursing care needs which are beyond what they could provide they did not allow the resident to return to the facility. On 11/1/2024 at 1:33 p.m., the Administrator provided a copy of the Residential State Rules, and indicated it was the policy currently being used by the facility ...The administrator highlighted rule 0354 Clinical Records-Noncompliance ...." This citation relates to Complaint IN00445086.			