STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155475	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towne House Retirement Community	2209 St Joe Center Rd Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45794 Based on interview and record review, the facility failed to ensure a person-centered, individualized Baseline Care Plan was developed with instructions needed to provide effective care for 1 of 1 resident reviewed with a catherter. (Resident 116) Findings include: Resident 116's record was reviewed on 5/28/24 at 2:35 PM. Diagnoses included an open reduction internal fixation (surgery to repair) of a fracture to the left femur, coronary artery disease, atrial fibrillation, (irregular heartbeat) anemia due to chronic blood loss, enlarged prostate gland and urinary retention. A physician order dated 5/20/24 indicated Resident 116 was to be administered acetaminophen (pain reliever) every 6 hours as needed for a pain rating of 1 to 5 on a 1 to 10 scale. A physician order dated 5/20/24 indicated Resident 116 was to be administered oxycodone (narcotic pain reliever) every 6 hours as needed for a pain rating of 6 to 10 on a 1 to 10 scale. A physician order dated 5/20/24 indicated Resident 116 was to be administered cyclobenzaprine (muscle relaxer) every 12 hours as needed for muscle spasms. A physician order dated 5/20/24 indicated Resident 116 was to be administered nitroglycerin every 5 minutes as needed for chest pain for a maximum of 3 doses. A physician order dated 5/20/24 indicated Resident 116 was to be administered apixaban (blood thinner) twice daily for atrial fibrillation. Resident 116's Baseline Care Plan dated 5/20/24 indicated Resident 116's Brief Interview for Mental Status (BIMS) score was 15 (cognitively intact), had an indwelling urinary catheter in place to drain urine, had been prescribed narcotic pain medications, anticoagulants, (blood thinner) and diuretics (water pill), and had post-surgical pain to their left hip. There was no documentation in the Baseline Care Plan section to evaluate pain on a 1 to 10 scale. The Baseline Care Plan did not indicate Resident 116 had skin issues. There was no documentation in the Baseline Care Plan's skin integrity section. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 5/21/24 indicated Resident 116 was to have the indwelling urinary catheter removed. A physician order dated 5/21/24 indicated Resident 116 was to have a straight catheter procedure performed (urinary catheter inserted into the bladder and removed immediately after the release of urine) every 8 hours as needed for urinary retention. Resident 116's Care Plan focus dated 5/22/24 indicated the resident was at risk for infection. The target goal was to be free from signs and symptoms of infection through 8/18/24. Interventions included antibiotics, infection prevention education, standard precautions, encourage fluids and evaluation of wounds. The Care Plan was not individualized to Resident 116's infection risks related to their surgical incision or the straight catheter procedure. Resident 116's Care Plan focus dated 5/22/24 indicated the resident was on a regular diet and had a surgical skin impairment to the left hip. The target goal was to maintain adequate nutritional status through 8/18/24. Interventions included medications, observing for malnutrition, monitoring weight, serving diet as ordered, monitoring and recording intake at every meal. The Care Plan dated 5/22/24 did not include a focus, a target goal or interventions for the following care concerns: 1. unusual bleeding 2. chest pain 3. urinary retention 4. diuretic use 5. urinary drainage via straight catheter 6. infection risk from straight catheter 7. muscle spasms 8. surgical incision care 9. infection risk from surgical incision 10. pain assessment 11. effects of narcotic pain medication. In an interview on 5/29/24 at 3:02 PM, the Executive Director (ED) indicated the facility had completed Resident 116's Baseline Care Plan within 24 hours as required. The ED indicated the facility had 21 days after a resident's admission to complete an official Care Plan. The ED reviewed the Baseline Care Plan and the current Care Plan. The ED indicated neither the Baseline Care Plan, nor the current Care Plan were individualized to Resident 116. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/29/24 at 4:09 PM the Director of Nursing (DON) reviewed Resident 116's Baseline Care Plan and current Care Plan. The DON indicated neither the Baseline Care Plan, nor the current Care Plan were individualized to Resident 116. The DON indicated Resident 116's Baseline Care Plan did not include a pain scale rating or a surgical incision, straight catheter procedure or their specific infection risk. The DON indicated neither the Baseline nor current Care Plan included the minimum healthcare information necessary to provide individualized care to Resident 116. A current facility policy dated 4/06 and revised 10/19 provided by the DON on 5/30/24 at 12:20 PM indicated the care plan is a compilation of services to be furnished to each resident with the goal to reach or maintain the resident's highest possible physical, mental, and psychosocial well-being. The policy indicated an individualized plan of care would be initiated upon admission. The policy indicated the individualized care plan would identify each resident's needs related to health, disease, condition, impairments, physical function, mental status, nutrition, psychosocial health, safety, and discharge potential. The policy indicated modifications and additions to the care plan would be updated as the resident's needs changed. The policy indicated the resident's individualized care plan would be continual, reviewed quarterly or as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on interview and record review, the facility failed to ensure physician orders were current for the provision of wound care to a surgical incision for 1 of 1 resident reviewed (Resident 116). Findings include: Resident 116's record was reviewed on 5/28/24 at 2:35 PM. Diagnoses included an open reduction internal fixation (surgery to repair) of a fracture to the left femur. Resident 116's Baseline Care Plan dated 5/20/24 indicated Resident 116's Brief Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident 116's Baseline Care Plan dated 5/20/24 did not indicate Resident 116 had skin issues. There was no documentation in the Baseline Care Plan skin integrity section. Resident 116's current, completed, and discontinued physician orders dated 5/20/24 through 5/29/24 did not include wound care instructions for the surgical incision of their left hip. Resident 116's current Care Plan dated 5/22/24 did not include a focus, a target goal, or interventions for wound care to the resident's left hip surgical incision. A hospital Discharge Summary dated 5/20/24 at 11:19 AM indicated Resident 116's left hip surgical incision's dressing was to be reinforced or changed daily as needed. The surgical incision was to be assessed for complications daily. The staples were to be removed in 2 weeks. A Skin and Wound Evaluation dated 5/21/24 at 10:51 AM indicated Resident 116 had a surgical wound to the front of their left thigh. The wound was present on admission to the facility on [DATE]. The wound was 1. 7 centimeters (cm) long and 0.4 cm wide. The wound had 3 staples. The dressing was intact. A Skin and Wound Evaluation dated 5/21/24 at 10:52 AM indicated Resident 116 had a surgical wound to the left side of their left thigh. The wound was present on admission to the facility on [DATE]. The wound was 2.7 cm long and 0.4 cm wide. The wound had 4 staples. The dressing was intact. A Skin and Wound Evaluation dated 5/21/24 at 10:54 AM indicated Resident 116 had a surgical wound to the front of their left hip. The wound was present on admission to the facility on [DATE]. The wound was 3.8 cm long and 0.5 cm wide. The wound had 6 staples. The wound dressing was intact. A progress note dated 5/21/24 at 2:34 PM indicated Resident 116's surgical sites had been evaluated. The staples were intact and healing well. A progress note dated 5/21/24 at 5:25 PM indicated Resident 116 had experienced a fall in their room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 5/22/24 at 11:52 AM indicated Resident 116 had increased bruising and swelling around their surgical incision. The dressing had been saturated with bloody drainage. A Skin and Wound Evaluation dated 5/28/24 at 7:48 AM indicated Resident 116 had a surgical wound to the left side of their left thigh. The wound was present on admission to the facility on [DATE]. The wound was 2.3 cm long and 0.3 cm wide. The wound had 4 staples. The staples were removed by the Nurse Practitioner. The wound did not have a dressing. A Skin and Wound Evaluation dated 5/28/24 at 7:49 AM indicated Resident 116 had a surgical wound to the front of their left thigh. The wound was present on admission to the facility on [DATE]. The wound was 1.4 cm long and 0.2 cm wide. The wound had 3 staples. The staples were removed by the Nurse Practitioner. A Skin and Wound Evaluation dated 5/28/24 at 7:50 AM indicated Resident 116 had a surgical wound to the front of their left hip. The wound was present on admission to the facility on [DATE]. The wound was 3.5 cm long and 0.4 cm wide. The wound had 6 staples. The dressing was intact. The wound was cleansed with soap and water. The staples were removed by the Nurse Practitioner. A Nurse Practitioner progress note dated 5/28/24 at 9:45 AM indicated Resident 116 had experienced a fall in their room on 5/21/24 that caused bleeding from their upper most hip incision. The staples were removed. Adhesive strips (steri-strips) were applied to the upper most incision and the middle incision. In an interview on 5/30/24 at 12:25 PM the Director of Nursing (DON) indicated hospital discharge surgical incision care instructions should have been included on Resident 116's physician orders upon admission to the facility. A current facility policy dated 2/06 and revised 3/24 provided by the DON on 5/30/24 at 12:53 PM indicated physician orders for dressing changes would be verified to ensure dressing changes followed state regulations, federal regulations, and national guidelines. 3.1-37

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on interview and record review the facility failed to ensure safe transfer assistance for 1 of 5 residents reviewed (Resident 115). Findings include: During an interview on 5/28/24, a family member of Resident 115 indicated he was concerned Resident 115 had a fall while transferring in the middle of the night the previous weekend, resulting in a skin tear to her arm, bruising and pain. He indicated her pain resulted in a setback in her progress in therapy. He indicated only one staff member was assisting her at the time of the fall. During an interview on 5/30/24 at 1:40 PM, Resident 115 indicated she was transferring from her bed to her wheelchair when one of her feet caught on the other causing her to lose her balance and fall backward to her buttocks, tearing the skin on her elbow on the table as she fell . She indicated only one staff member was in the room at the time of the transfer. Resident 115's record was reviewed on 5/28/24 at 12:28 PM. Diagnoses included displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, generalized, and unsteadiness on feet. Resident 115's current admission Minimum Data Set (MDS), dated [DATE], indicated her Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). The MDS indicated the resident was dependent for transfers from a bed to a chair. Progress notes dated 5/25/24 at 4:42 AM indicated a staff member was assisting Resident 115 to transfer from her bed to a wheelchair when her leg gave out. Resident 115 sustained a skin tear on her left elbow from the table as she tried to stop the fall. Resident 115's current care plan regarding limited physical mobility, dated 5/17/24, indicated the resident had a problem of limited mobility related to weakness, recent left femur surgery and pain with a goal date of 8/4/24. Interventions included referring to the green therapy binder for current assistance needs. An instructional document in the green therapy binder dated 5/17/24 and last updated 5/24/24, provided by Licensed Practical Nurse 10 indicated Resident 115 required maximum assistance of two staff for transfers. In an interview on 5/30/24 at 12:37 PM, the Director of Nursing (DON) indicated one staff member was assisting Resident 115 at the time of her fall on 5/25/24. She indicated two staff should have been assisting with the transfer. In an interview on 5/30/24 at 12:46 PM, Physical Therapist 11 and Physical Therapy Assistant 12 indicated Resident 115 had not been cleared at any time to transfer with one assist since her admission to the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy titled General Policy- Falls Policy, last revised 7/22 provided by the DON indicated the facility should implement appropriate measures to ensure safety. 3.1-45(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained, opened food items were labeled and dated in the kitchen. 12 of 12 residents residing in the facility consumed food prepared in the kitchen. Findings include: 1. During an observation and interview in the main kitchen on [DATE] at 9:20 AM, a package of cheese slices and two packets of cheese cubes were observed with no label or date visible on the package on a shelf in the walk-in cooler. The Dietary Manager (DM indicated the packages should have been labeled and dated when opened. A container of ground beef with an expiration date of ,d+[DATE] and a container of diced tomatoes with an expiration date of ,d+[DATE] were observed on the shelf in the walk-in cooler. The DM indicated the ground beef was expired and should have been discarded. Multicolored specks of debris, too many to count, a dry piece of pepperoni, and several dime-sized red, dried spots near the container labeled marinara sauce were observed on the work surface area on the front of the pizza station. A container of cut up peppers was not covered with a lid or label. The DM indicated the pizza station had not been used yet that day and should have been cleaned after each use. In the reach in cooler, a bag of cut up lettuce, undated, had yellowish liquid visible at the bottom of the package. The DM indicated it should be discarded. The reach in cooler also had a tray of cups of salsa, ketchup, sour cream, poppy seed dressing, and horseradish dated ,d+[DATE] and ,d+[DATE]. The DM indicated the cups should be discarded. In an observation and interview on [DATE] at 9:44 AM, the Executive Chef used a test strip to test a bucket of sanitizer water being used to clean work surfaces in the kitchen. He indicated the solution tested at about 150 parts per million (ppm) of QUAT solution. He indicated the solution should test between 200 and 400 ppm to be considered effective for sanitation purposes. He emptied the bucket, prepared a new supply of sanitizer water and conducted another test. He indicated the test also resulted in about 150 ppm and he intended to call a service person in to adjust the calibration of the sanitizer dispenser. 2. In an observation and interview in the Health Center kitchen on [DATE] at 9:53 AM, the Executive Chef indicated he could not locate the test strips for sanitizer solution. A current policy title Production, Purchasing, Storage, last revised ,d+[DATE] provided by the DM on [DATE] at 11:05 AM indicated all unused portions and open packages should be covered, labeled, and dated and food past the expiration date should be discarded. The policy indicated sanitizer test strips should be readily available wherever sanitizer is dispensed. 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(3)