STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 20, 21, 24, 25, 2013 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Survey team: Linn Mackey, RN TC Karen Lewis, RN Toni Maley, BSW Angela Sellick, RN (6/20/13, 6/21/13) Ginger McNamee, RN (6/24/13, 6/25/13 Tina Smith-Staats, RN (6/21/13, 6/24/13, 6/25/13) Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 7 Medicaid: 38 Other: 6 Total: 51 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F000000	Dear Ms. Rhoades,Attached is University Nursing Center's Plan of Correction for annual survey conducted on June 20th through the 25th. Please accept the Plan of Correction as written. University Nursing Center is asking for paper compliance for deficiencies related to tag F 248, F309, and F 520.Thank you,Stephanie Allen, HFAExective DirectorUniversity Nursing Center	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure one to one activities were provided as care planned for 1 of 3 residents reviewed for individualized activity programs. (Resident #48) Findings include: On 6/21/13 at 10:30 a.m., Resident #48 was observed sitting in the lounge with his eyes closed. On 6/24/13 at 8:08 a.m., Resident #48 was observed sitting in the lounge. The television was on and the resident was not attuned to the television. On 6/24/13 at 1:58 p.m., Resident #48 was observed sitting in a highback wheelchair in the resident lounge while the television was on. The resident was not looking in the direction of the television, but starring at his lap. On 6/25/13 at 10:00 a.m., Resident #48 was observed in the hallway near the nurses station sitting in a highback wheelchair. No interaction	F000248	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents found to have been affected by the deficient practice will be seen per plan of care with the Activity Director or designee auditing one on one activity participation logs. Activity Director or designee will also ensure that plan of cares are updated to reflect proper activity participation needs. The resident affected has been seen per activity plan of care, which is indicated on the activity one on one participation logs (see attachment A). The resident, along with other one to one activity residents, have been placed on a calendar to communicate to activity assistants one to one needs (See attachment B). How other residents having the potential to be affected by the same deficient practive will be identified and what corrective action will be taken? All residents on one to one activities have the potential to be affected. All residents on one to one activity programs will be	07/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the staff was observed. Resident #48's record was reviewed on 6/24/13 at 1:00 p.m. Resident #48's current diagnoses included, but were not limited to, constipation, Alzheimer's type dementia with behavior disturbance and delusions, hypertension, chronic lower extremity edema, depression, benign prostate hypertrophy, and degenerative arthritis. Resident #48's activity care plan dated 5/23/12, indicated "Resident enjoys puzzles, milkshakes, donut day, movies, and books. Resident is provided 1:1 (one to one) visitation with the staff 5 times a week. Staff will provide evening activities like stimulation buckets or puzzles for resident." Resident #48's Quarterly MDS (Minimum Data Set) assessment dated 6/11/13, indicated the resident rarely or never made decisions. An Activity Quarterly Assessment dated 6/11/13, indicated the resident was passive for most facility activities. "Resident attends hymn sing, Church services, special events, newspaper/trivia readings and donut day. Staff provide resident with 1:1		audited by the Activity Director or designee to ensure residents are being seen as the program is written and care planned. Activity staff was inserviced on June 25, 2013 regarding one on one programs by the Activity Director (see attachment C). ED or designee will ensure residents who are on one on one activity programs are receiving services per plan of care. Activity Director or designee will ensure that activity programs are reviewed to ensure that one on ones are correctly reflected on the plan of care and per activity aide one on one schedule. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice doesn't occur again? All residents on one on one activity programs will be audited on the one on one participation logs daily for three months and weekly for six months by the Activity Director or designee to ensure residents are being seen per plan of care. Activity staff were inserviced on June 25, 2013 to ensure understanding and compliance of the one on one programs by the Activity Director. Activity Director will audit one on one programs weekly for six months to ensure that residents are on correct programming. Activity Director or designee will conduct daily rounds to ensure residents who receive one on one activity programming are being seen per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	visitation five times a week." Review of the One to One Participation Record for Resident #48 indicated the following visits: The week of March 3, 2013, 2 visits. The week of March 10, 2013, 2 visits. The week of March 17, 2013, 4 visits. The week of March 24, 2013, 4 visits. The week of April 1, 2013, 4 visits. The week of April 7, 2013, 4 visits. The week of April 28, 2013, 2 visits. The week of May 26, 2013, 3 visits. The week of June 9, 2013, 4 visits. The week of June 16, 2013, 3 visits. Resident #48 received 55 total 1:1 visitations out of the 75 visits care planned for the resident. During an interview on 6/24/13 at 1:00 p.m., the Activity Director indicated she was aware of the required 1:1 visitations for Resident #48. The Activity Director indicated Resident #48 was receiving 1:1 visitations from the staff. A current, 1/06, facility policy titled "Activities", was provided by the Administrator on 6/25/13 at 10:32 a.m., indicated the following: "It is the policy of this facility to provide for an ongoing program of activities designed to meet the interest and the physical, mental, and		plan of care. How the corrective actions will be monitored to ensure the deficient practice does not recur? All residents on one on one activity programs will be audited daily for three months and weekly for six months by the Activity Director or designee to ensure residents are being seen and that documentation on the participation logs correctly reflects visitation and matches the plan of care with results to CQI (see attachment D). Activity staff was inserviced on June 25, 2013 to ensure understanding and compliance of the one on one programs by the Activity Director. Activity Director or designee will audit one on one programs weekly for six months to ensure that residents are on correct programming. Executive Director or designee will monitor the Activity Director or designee's auditing weekly to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? July 25, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychological well-being of each resident in accordance with the comprehensive assessment." 3.1-33(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on record review and interview, the facility failed to administer sliding scale insulin as ordered for 2 of 5 residents reviewed for diabetic monitoring and insulin administration in a sample of 10 residents reviewed for unnecessary medications. (Resident #'s 19, and 25) Findings include: 1.) The clinical record for Resident #19 was reviewed on 6/21/13 at 2:27 p.m. Resident #19's current diagnoses included, but were not limited to, diabetes mellitus, hypertension, and Alzheimer's dementia. Resident #19 had a health care plan, dated 3/19/12, which indicated the resident had a problem listed as, "The resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia and hyperglycemia."	F000309	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents found to have been affected by the deficient practice have had MD/POA notifications completed for issues found (see attachment E). Resident 19's sliding scale order was clarified with the physician (See attachment F). The residents found to have been affected by the deficient practice will have the sliding scales audited daily by the DNS or designee to ensure the scales are being followed per physician orders. DNS or designee will clarify sliding scales as needed with the physician to ensure compliance. The affected residents' diabetic flow sheets indicate that physician orders have been followed since issue was found. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All diabetic residents with sliding scales have the potential to be affected. All diabetic	07/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interventions for this problem included "monitor blood sugars as ordered and administer medications as ordered." Resident #19 had physician's orders for the following, A.) Januvia (medication used for diabetes) 50 milligrams (mg), 1 tablet by mouth once daily. The original date of this order was 9/6/12. B.) Monitor blood sugar results 4 times daily at 6:30 a.m., 11:30 a.m., 4:00 p.m. and 9:00 p.m. The original date of this order was 9/16/12. C.) Administer Lantus insulin 16 units subcutaneously in the morning. This order originated on 4/11/13. D.) Administer Humalog sliding scale insulin according to blood sugar results as listed below, 141 - 180 = 1 unit 181 - 220 = 2 units 221 - 260 = 4 units 261 - 300 = 6 units 301 - 340 = 7 units 341 - 380 = 8 units 381 - 420 = 9 units 421 - 460 = 10 units greater than 460 = 12 units		residents on sliding scales will be audited by the DNS or designee to ensure sliding scales are being followed per physician orders. Nursing staff were all individually inserviced by the DNS on June 24/25, 2013 regarding sliding scales and medication errors (see attachment G). DNS or designee will ensure that all Diabetic residents sliding scales are followed per physician orders by conducting daily audit. DNS or designee will ensure that all Diabetic residents' sliding scales are reviewed and clarified as needed with the attending physician. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All Diabetic residents with sliding scales will be audited daily for six months by the DNS or designee to ensure sliding scales are being followed per physician orders (see attachment H). Nursing staff was inserviced on June 24/25, 2013 by the DNS to ensure understanding of medication errors and sliding scales. DNS or designee will audit sliding scales and plan of care weekly for Diabetic residents to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice does not recur? All Diabetic residents with sliding scales will be auditied daily for six months by the DNS or designee to ensure sliding scales are being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Half (1/2) coverage at bedtime The sliding scale insulin orders originated on 9/16/12. Review of the April and May 2013 "Capillary Blood Glucose Monitoring Tool" for Resident #19 indicated the incorrect dose of insulin was documented as having been given on the following dates and times: April 2, 8:00 p.m., blood sugar result was 187, 2 units of insulin were documented as having been given. The resident should have received 1 unit. April 4, 8:00 p.m., blood sugar result was 232, 4 units of insulin were documented as having been given. The resident should have received 2 units. April 5, 8:00 p.m., blood sugar result was 207, 2 units of insulin were documented as having been given. The resident should have received 1 unit. April 9, 8:00 p.m., blood sugar result was 204, 2 units of insulin were documented as having been given. The resident should have received 1 unit.		followed per physician orders with results to CQI. Nursing staff was in-serviced by the DNS on June 24/25, 2013 regarding sliding scales and medication errors. DNS or designee will audit sliding scales and plan of care weekly for Diabetic residents to ensure compliance with results to CQI (see attachment I). Executive Director or designee will monitor the DNS or designee's compliance weekly to ensure overall compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? July 25, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	April 12, 9:00 p.m., blood sugar result was 189, 2 units of insulin were documented as having been given. The resident should have received 1 unit. April 19, 8:00 p.m., blood sugar result was 226, 4 units of insulin were documented as having been given. The resident should have received 2 units. April 26, 8:00 p.m., blood sugar result was 219, 2 units of insulin were documented as having been given. The resident should have received 1 unit. May 1, 9:00 p.m., blood sugar result was 246, 4 units of insulin were documented as having been given. The resident should have received 2 units. May 2, 9:00 p.m., blood sugar result was 207, 2 units of insulin were documented as having been given. The resident should have received 1 unit. May 3, 9:00 p.m., blood sugar result was 282, 6 units of insulin were documented as having been given. The resident should have received 3 units.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	May 4, 9:00 p.m., blood sugar result was 253, 4 units of insulin were documented as having been given. The resident should have received 2 units. May 5, 9:00 p.m., blood sugar result was 234, 4 units of insulin were documented as having been given. The resident should have received 2 units. May 7, 9:00 p.m., blood sugar result was 273, 6 units of insulin were documented as having been given. The resident should have received 3 units. May 8, 9:00 p.m., blood sugar result was 223, 4 units of insulin were documented as having been given. The resident should have received 2 units. During an interview with the DoN (Director of Nursing) on 6/24/13 at 3:29 p.m., additional information was requested related to the insulin sliding scale coverage for Resident #19 in April and May 2013. During an interview with the RN Consultant on 6/25/13 at 9:45 a.m., she indicated the facility did not have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a policy related to insulin sliding scale coverage. She further indicated she would have clarified the order for half (1/2) sliding scale coverage at bedtime to avoid a medication error. During an interview with the DoN on 6/25/13 at 10:35 a.m., she indicated on 6/24/13 the facility had identified the incorrect sliding scale insulin coverage for Resident #19. 2.) The clinical record for Resident #25 was reviewed on 6/24/13 at 8:02 a.m. Resident #25's current diagnoses included, but were not limited to, diabetes mellitus, hypertension, and dementia. Resident #25 had a health care plan, dated 4/13/12, which indicated the resident had a problem listed as "The resident has a diagnosis of diabetes mellitus and is at risk for experiencing hypoglycemia and hyperglycemia." Interventions for this problem included "monitor blood sugars as ordered and administer medications as ordered." Resident #25 had physician's orders for the following,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.) Januvia (medication used for diabetes) 50 milligrams (mg), 1 tablet by mouth once daily. The original date of this order was 2/13/13. B.) Monitor blood sugar results 4 times daily at 6:30 a.m., 11:30 a.m., 4:00 p.m. and 9:00 p.m. The original date of this order was 9/16/12. C.) Administer Levemir insulin 40 units subcutaneously daily at bedtime. This order originated on 1/19/13. D.) Administer Novolog insulin 25 units subcutaneously with meals 3 times a day. This order originated on 2/15/13. E.) Administer Humalog sliding scale insulin according to blood sugar results as listed below, 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 14 units if less than 70 or greater than 400 call the physician The sliding scale insulin orders originated on 4/23/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the April, May, and June 2013 "Capillary Blood Glucose Monitoring Tool" for Resident #25 indicated the incorrect dose of insulin or no dose of insulin was documented as having been given on the following dates and times: April 11, 11:00 a.m., blood sugar result was 219, 2 units of insulin were documented as having been given. The resident should have received 4 units. May 7, 8:00 p.m., blood sugar result was 260, no insulin was documented as having been given. The resident should have received 8 units. June 2, 4:00 p.m., blood sugar result was 151, no insulin was documented as having been given. The resident should have received 2 units. June 17, 11:00 a.m., blood sugar result was 194, no insulin was documented as having been given. The resident should have received 2 units. During an interview with the DoN (Director of Nursing) on 6/25/13 at 8:50 a.m., additional information was requested related to the insulin sliding scale coverage for Resident #25 in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	April, May, and June 2013. At the time of exit on 6/25/13, the facility provided an action plan which was in process to correct the sliding scale insulin errors. 3.) The 1/06, revised "Medication Errors" policy was provided on 6/25/13 at 1:43 p.m., by the Director of Nursing and indicated it was the facility's policy to ensure residents residing in the facility were free of medication errors. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility's Quality Assessment and Assurance Committee failed to develop and implement plans of action to administer sliding scale insulin as ordered by physician, and to provide one to one activities as care planned for residents. (Resident #'s 19, 25 and 48) Findings include:	F000520	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents found to have been affected by the deficient practice have been added to the Activity and Medication CQI monthly review forms which will be reviewed at the monthly CQI meeting to ensure compliance. Activity Director or designee and DNS or designee will fill out the forms monthly to ensure residents affected remain in	07/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1.) The clinical record for Resident #19 was reviewed on 6/21/13 at 2:27 p.m. Review of the April and May 2013 "Capillary Blood Glucose Monitoring Tool" for Resident #19 indicated the incorrect dose of insulin was documented as having been given seven times in April, 2013 and seven times in May, 2013. All these times were the bedtime dose of the Insulin Coverage. 2.) The clinical record for Resident #25 was reviewed on 6/24/13 at 8:02 a.m. Review of the April, May, and June 2013 "Capillary Blood Glucose Monitoring Tool" for Resident #25 indicated the orders for insulin coverage was not followed one time in April, 2013, one time in May 2013, and two times in June, 2013. 3.) Resident #48's record was reviewed on 6/24/13 at 1:00 p.m. Review of the One to One Participation Record for Resident #48 indicated the following visits: The week of March 3, 2013, 2 visits. The week of March 10, 2013, 2 visits.		compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with one on one activity programming and Diabetic residents with sliding scales have the potential to be affected. CQI meeting will be held monthly with CQI forms reviewed each month for medication errors and one on one activities. The Activity Director or designee will fill out the activity CQI monthly. The DNS or designee will fill out the medication error form monthly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All residents on one to one activities will have the one to one activity log audited daily for three months and weekly for 6 months by the Activity Director or designee to ensure compliance. All Diabetic residents with sliding scales will be audited daily by the DNS or designee to ensure sliding scales are being followed per physician orders. Nursing staff and activities staff have been inserviced by their department heads on June 25/26 and June 26 respectively to help ensure compliance and understanding. CQI forms for activities and medication errors will be filled out monthly by the department head responsible and will be brought to the monthly CQI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The week of March 17, 2013, 4 visits. The week of March 24, 2013, 4 visits. The week of April 1, 2013, 4 visits. The week of April 7, 2013, 4 visits. The week of April 28, 2013, 2 visits. The week of May 26, 2013, 3 visits. The week of June 9, 2013, 4 visits. The week of June 16, 2013, 3 visits. Resident #48 received 55 total 1:1 visitations out of the required 75 visits during that time period per the care plan. 4.) During an interview with the Director of Nursing (DoN) on 6/25/13 at 10:35 a.m., she indicated on 6/24/13 the facility had identified issues with sliding scale insulin coverage administration. She further indicated no issue had been identified with one to one activities being provided to the residents. 5.) Review of the current policy, dated 8/1998, titled "Continuous Quality Improvement," provided by the Administrator on 6/25/13 at 10:38 a.m., included, but was not limited to, the following: "POLICY... ...The Quality Improvement Committee is responsible for identifying issues that necessitate the		meeting for discussion. How the corrective actions will be monitored to ensure the deficient practice does not recur? All residents on one on one activities will have the one to one activitiy log audited daily for three months and weekly for six months by the Activity Director or designee with results to CQI. The activity CQI form will be completed monthly by the Activity Director or designee and will be reviewed at the monthly CQI meeting to ensure compliance. All Diabetic residents with sliding scales will be audited daily for six months by the DNS or designee with results to CQI. The medication error CQI form will be completed monthly by the DNS or designee and will be reviewed at the monthly CQI meeting to ensure compliance. (see attachment J for CQI forms). Executive Director or designee will monitor the Activity Director or designee and DNS or designee's auditing weekly to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? July 25, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	action of the committee, such as issues that negatively affect quality of care and services provided to residents. Additionally, the committee develops and implements appropriate plans of action to correct identified quality deficiencies, in areas such as pharmaceutical services and infection control...." 3.1-52(b)(2)			