

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00205617.</p> <p>Complaint IN00205617 -Substantiated. Federal/State deficiencies related to the allegations are cited at F205, F514, and F9999.</p> <p>Survey dates: July 25, and 26, 2016</p> <p>Facility number: 000459 Provider number: 155567 AIM number: 100289700</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 5 Medicaid: 48 Other: 3 Total: 56</p> <p>Sample: 6</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on July 27, 2016 by</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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F 0205 SS=D Bldg. 00	<p>17934.</p> <p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on interview and record review, the facility failed to provide written notice of the bed hold policy for 1 of 3 residents reviewed with discharge notices. (Resident #Q)</p>			F 0205	<p>F205It is the practice of the facility to ensure that the resident and a family member or legal representative is provided written information regarding notice of Bed-Hold policy before/upon transfer for hospitalization or therapeutic leave.</p>		08/31/2016

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	<p>Findings include:</p> <p>Resident #Q's record was reviewed 7-25-2016 at 11:26 AM. Resident #Q's diagnoses included, but were not limited to, high blood pressure, anxiety, and schizophrenia.</p> <p>Resident #Q's progress notes dated 7-18-2016 at 11:51 PM indicated Resident #Q was yelling and screaming that she wanted to go to the hospital, or she would kill herself. The note continued that Resident #Q then refused to go to the hospital that evening when transport was provided.</p> <p>Resident #Q's progress note dated 7-19-2016 at 11:30 AM indicated Resident #Q was insisting on going back to the hospital she had been at prior to discharge because they could look at her legs. She continued to insist on going to the hospital.</p> <p>Resident #Q's progress note dated 7-19-2016 at 10:15 AM indicated Resident #Q had been assisted to discharge to the hospital where she was prior to admission.</p> <p>In an interview on 7-25-2016 at 1:58 PM, LPN #1 indicated Resident #Q had refused to go to the hospital at first, then</p>		<p>Resident #Q no longer resides in facility. Resident was transferred to hospital setting per residents request with physician/nurse practitioner notified of request. Residents residing in the facility will have staff follow policy and procedure to provide written bed-hold policy with discharge notices.</p> <p>Licensed nurses will be re-educated on providing written information regarding notice of bed-hold policy with discharge/ transfers.</p> <p>Medical Records and/or designee will review each discharge/transfer for written information regarding notice of bed-hold policy. Medical records and/or designee will review discharge/transfer copies and audit for bed-hold policy. Audit will be completed on each discharge/transfer with weekly Director of Nursing review. Trends will be reviewed in QA monthly times 6 months and then quarterly thereafter to determine further education and/or further monitoring needs.</p> <p>Executive Director will do random checks of these reviews to ensure bed-hold policy is being provided with each discharge/transfer. Trends will be reviewed in QA monthly times 6 months and then quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one on one re-education with repeat</p>	

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	<p>the next morning decided she wanted to go. LPN #1 continued, the hospital called her before she could call report, so she talked to the nurse in ER, but could not remember her name. Further, LPN #1 indicated she had not completed a bed hold for Resident #Q because Resident #Q said she was not coming back to the facility, but was going to live in her van. LPN #1 further indicated she left management handle all further calls from the hospital.</p> <p>In an interview on 7-26-2016 at 11:09 AM, the Administrator indicated she was certain the bedhold had been completed, but it was unable to be located on the resident record.</p> <p>A current policy titled Discharge/ Transfer of the Resident dated 2006 provided by the Director of Nursing on 7-26-2016 at 11:40 AM indicated the following: "Transfer.....4. Explain and give copy of Bedhold form to the resident and/or representative."</p> <p>This Federal tag is related to Complaint IN00205617</p> <p>3.1-12(A)(25)</p>		<p>non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the executive director for review and presented to QA to determine further educational needs.</p> <p>Completed August 31, 2016</p>	

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to completely document discharge plans for 1 of 3 residents discharged to the hospital in a sample of 3. (Resident #Q)</p> <p>Findings include:</p> <p>Resident #Q's record was reviewed 7-25-2016 at 11:26 AM. Resident #Q's diagnoses included, but were not limited to, high blood pressure, anxiety, and schizophrenia.</p> <p>Resident #Q's progress notes dated 7-18-2016 at 11:51 PM indicated Resident #Q was yelling and screaming that she wanted to go to the hospital, or she would kill herself. The note</p>	F 0514	<p>F514 It is the practice of the facility to ensure the clinical records are complete by documenting discharge plans for residents discharged to the hospital.</p> <p>Resident #Q no longer resides in facility. Resident was transferred to hospital setting per residents request with physician/nurse practitioner notified of request.</p> <p>Residents residing in the facility will have staff follow policy and procedure to provide written discharge plans for residents discharging to the hospital.</p> <p>Licensed nurses will be re-educated on providing written information regarding discharge/ transfers and documenting discharge plans in residents chart.</p> <p>Medical Records and/or designee will review each discharge/transfer for written information regarding notice regarding discharge/transfer.</p>	08/31/2016

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	<p>continued that Resident #Q then refused to go to the hospital that evening when transport was provided.</p> <p>Resident #Q's progress note dated 7-19-2016 at 11:30 AM indicated Resident #Q was insisting on going back to the hospital she had been at prior to discharge because they could look at her legs. She continued to insist on going to the hospital.</p> <p>Resident #Q's progress note dated 7-19-2016 at 10:15 AM indicated Resident #Q had been assisted to discharge to the hospital where she was prior to admission.</p> <p>In an interview on 7-25-2016 at 1:58 PM, LPN #1 indicated Resident #Q had refused to go to the hospital at first, then the next morning decided she wanted to go. LPN #1 continued, the hospital called her before she could call report, so she talked to the nurse in ER, but could not remember her name. Further, LPN #1 indicated she had not completed a bed hold for Resident #Q because Resident #Q said she was not coming back to the facility, but was going to live in her van. LPN #1 further indicated she left management handle all further calls from the hospital. Additionally, LPN #1 indicated she should have documented</p>		<p>Medical records and/or designee will review discharge/transfer copies and audit for documentation of discharge/transfer. Audit will be completed on each discharge/transfer with weekly Director of Nursing review. Trends will be reviewed in QA monthly times 3 months and then quarterly thereafter to determine further education and/or further monitoring needs.</p> <p>Executive Director will do random checks of these reviews to ensure appropriate documentation is being provided with each discharge/transfer. Trends will be reviewed in QA monthly times 6 months and then quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one on one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the executive director for review and presented to QA to determine further educational needs.</p> <p>Completed August 31, 2016</p>	

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F 9999 Bldg. 00	<p>the transfer to the hospital.</p> <p>A current policy titled Discharge/ Transfer of the Resident dated 2006 provided by the Director of Nursing on 7-26-2016 at 11:44 AM indicated the following: "Documentation guidelines....whether or not the resident wishes to have a bed hold."</p> <p>This Federal tag is related to Complaint IN00205617</p> <p>3.1-50(a)(1)</p> <p>3.1-9 PERSONAL PROPERTY</p> <p>(g) The facility must inventory, upon admission and discharge the the personal effects, money, and valuables declared by the resident at the time of admission.</p> <p>This State rule is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure inventories were completed for 2 of 3 residents reviewed for personal inventory</p>	F 9999	<p>F 9999It is the practice of the facility to ensure the inventory upon admission and discharge of the personl effects, money, and valuables are reviewed and completed.</p> <p>Resident #Q no longer resides in facility. Resident was transferred to hospital setting per residents request with physician/nurse practitioner notified of request. Residents residing in the facility will have staff follow policy and procedure to provide personal inventory log of personal items inventoried on discharge. Licensed nurses will be re-educated</p>	08/31/2016

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	<p>completion in a sample of 3. (Resident #Q and Resident #R)</p> <p>Findings include:</p> <p>1. Resident #Q's record was reviewed 7-25-2016 at 11:26 AM. Resident #Q's diagnoses included, but were not limited to, high blood pressure, anxiety, and schizophrenia.</p> <p>A review of Resident #Q's personal inventory log indicated items were inventoried on admission, but there were no signatures on the log to indicate Resident #Q's personal items had been inventoried on discharge.</p> <p>A review of Resident #Q's progress notes dated 7-19-2016 at 10:45 AM indicated the facility had placed all personal items in bags as requested and verified all belongings were present and accounted for.</p> <p>2. Resident #R's record was reviewed 7-25-2016 at 2:36 PM. Resident #R's diagnoses included, but were not limited to, diabetes, lung disease, and high blood pressure.</p> <p>A review of Resident #R's personal inventory sheet indicated the inventory had been completed on a plain piece of</p>		<p>on providing personal inventory log of personal items that were inventoried on admission and through discharge. Residents are to review and sign upon discharge. If refuse to sign nurse and witness may sign.</p> <p>Medical Records and/or designee will review each discharge/transfer for personal inventory log with residents review and signature. Medical records and/or designee will review discharge/transfer copies and audit for signed copy of personal inventory log. Audit will be completed on each discharge/transfer with weekly Director of Nursing review. Trends will be reviewed in QA monthly times 6 months and then quarterly thereafter to determine further education and/or further monitoring needs.</p> <p>Executive Director will do random checks of these reviews to ensure personal inventory logs were given to residents for signature with each discharge/transfer. Trends will be reviewed in QA monthly times 6 months and then quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one on one re-education with repeat non-compliance resulting in disciplinary action per policy. Any identified trends will be forwarded to the executive director for review and presented to QA to determine</p>	

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	<p>paper dated 6-28-2016 with staff signatures, but no resident or responsible party signatures.</p> <p>In an interview on 7-26-2016 at 11:10 AM, the Director of Nursing indicated personal inventories should be completed on admission and discharge.</p> <p>A current policy titled Inventory List, Resident's Personal dated 2006 indicated "Procedure.....19. The resident or resident's representative is to verify and sign a receipt for property received."</p> <p>This State Tag is related to Complaint IN00205617.</p>		<p>further educational needs.</p> <p>Completed August 31, 2016</p>	