

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00171585.</p> <p>Complaint #IN00171585- Substantiated. Federal/state deficiencies related to the allegations are cited at F157 & F314.</p> <p>Survey dates: April 28, 29 & 30, 2015</p> <p>Facility number: 003673 Provider number: 155725 AIM number: 200450890</p> <p>Census bed type: SNF- 21 SNF/NF- 1 Residential: 43 Total- 65</p> <p>Census payor type: Medicare- 14 Other- 8 Total- 22</p> <p>Sample- 3</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>University Place (the Provider) submits this Plan of Correction(POC) in accordance with specific regulatory requirements. The POC should not be construed as an admission of any alleged deficiency cited. The Provider submits the POC with the intention that it be inadmissible by any third party in any civil or criminal claim against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and /or imposition of future remedies, whether such remedies are imposed by the centers for medicare and medicaid Services (CMS) the State of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider,. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 and the federal Rules of Evidence and should be inadmissible in any proceedings on that basis.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2015	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906			
(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			
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of the presence of a pressure area upon admission to the facility, for 1 of 3 residents reviewed for physician</p>	F 157	<p>F157</p> <p>Correction</p> <p>Resident was discharged</p>	05/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>notification in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 4/28/15 at 4:15 p.m. Diagnoses for Resident B included, but were not limited to, prostate cancer, large lymphoma- stage 3, history of clostridium difficile, pneumonia, chronic kidney disease, debility, and coronary arteriosclerosis.</p> <p>Nurses admission notes, dated 1/30/15, indicated "... Pressure area to coccyx. MD notified of arrival".</p> <p>An Evaluation for Bowel and Bladder Training, dated 1/30/15, indicated Resident B had a pressure area to the coccyx and was incontinent of bowel and bladder.</p> <p>A Braden Scale assessment (used for predicting the risk of a pressure sore), dated 1/31/15, indicated Resident B was at high risk with a score of 12/23.</p> <p>Nursing notes and assessments provided did not indicate further assessment of his identified pressure area to his coccyx and did not indicate the physician was notified of the pressure area.</p>		<p>Scope identity</p> <p>Resident skin assessments were completed on all residents identified as at risk for pressure areas. This assessment was documented by the attending nurse and reviewed by the Director of Nursing. No other residents were affected.</p> <p>Reoccurrence prevention</p> <p>Physician will be notified upon admission of any pressure areas that may need treatment. Treatment orders will be obtained as directed by physician. The Admission checklist has been amended to include a check off to notify physician and obtain orders for treatment to existing wounds. Provided nurses with information regarding admission checklist change and compliance expectation.</p> <p>Monitoring</p> <p>The Director of Nursing or designee will audit all charts within 72 hours of admission to ensure skin conditions present upon admission have appropriate notification and treatment orders in place.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>During an interview on 4/30/15 at 9:50 a.m., RN #1 indicated there was not any further documentation or assessment of Resident B's coccyx, and a wound record was not started. She indicated all of the mattresses at the facility were considered to be pressure reducing, even though the mattresses were non-specialized. Resident B was provided with one of the facility's non-specialized, pressure reducing mattress at admission.</p> <p>During an interview on 4/30/15 at 11:10 a.m., RN #1 indicated Resident B did not have treatment orders at the time of admission (January 2015) and there were not any further treatment orders until the physician prescribed calmoseptine on 3/08/15 for Resident B's coccyx. She indicated incontinent residents received a barrier cream, calmoseptine, as a skin breakdown prevention treatment after each incontinent episode.</p> <p>A Skin Integrity Policy, dated 10/1/2012, presented on 4/30/15 at 10:45 a.m., by RN #1, indicated the following: "...4. All skin injuries will be documented weekly and reported to the physician for treatment, if necessary"</p> <p>This Federal tag relates to complaint #IN00171585.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
F 314 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to provide assessments and treatment of an identified pressure area for 2 of 3 residents reviewed for pressure ulcers in a sample of 3. (Resident B & D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 4/28/15 at 4:15 p.m. Diagnoses for Resident B included, but were not limited to, prostate cancer, large</p>	F 314	<p>F314</p> <p>Correction</p> <p>Residents were discharged</p> <p>Scope identity</p> <p>Resident skin assessments were completed on all residents and skin reports were updated by the attending nurse. Any residents with identified pressure areas had treatment orders and were made a part of the resident care plan. No</p>	05/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2015	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906			
(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			
	<p>lymphoma- stage 3, history of clostridium difficile, pneumonia, chronic kidney disease, debility, and coronary arteriosclerosis.</p> <p>Nurses admission notes, dated 1/30/15, indicated "... Pressure area to coccyx. MD notified of arrival".</p> <p>An Evaluation for Bowel and Bladder Training, dated 1/30/15, indicated Resident B had a pressure area to the coccyx and was incontinent of bowel and bladder.</p> <p>A Braden Scale assessment (used for predicting the risk of a pressure sore), dated 1/31/15, indicated Resident B was at high risk with a score of 12/23.</p> <p>Nursing notes and assessments provided did not indicate further assessment of his identified pressure area to his coccyx and did not indicate the physician was notified of the pressure area.</p> <p>Care plan's for Resident B did not include skin breakdown risk, pressure ulcer risk or an identified pressure area. RN #1 indicated a care plan was not created for a known pressure area/ulcer or risk for skin breakdown, on 4/30/15 at 11:10 a.m., during an interview.</p>		<p>other residents were found to be affected.</p> <p>Reoccurrence prevention</p> <p>All pressure ulcers/wounds will be assessed and measured weekly. Documentation will be recorded in the wound/skin healing record. Requested corporate nursing instructor for inservice for nurses.</p> <p>Monitoring</p> <p>Wound/skin healing record will be audited weekly by the director of Nursing or designee to ensure F314 completion and use of the appropriate treatment to promote wound healing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>Nursing notes, dated 2/2/15, indicated Resident B had a red area to his coccyx.</p> <p>Physician orders, dated 2/05/15, indicated, Pressure reducing foam cushion on wheel chair to prevent skin breakdown. Turn and reposition every 2 hours.</p> <p>Skin status report documentation for Resident B's skin assessments, indicated the following: 2/11/15- Rash/excoriation. The location with was not indicated. 2/25/15- Rash/excoriation. The location with was not indicated. 3/04/15- Rash/excoriation. The location with was not indicated. 3/11/15- Rash/excoriation. The location with was not indicated. 3/18/15- Rash/excoriation. The location with was not indicated. 3/25/15- MASD (moisture associated skin damage) The location with was not indicated.</p> <p>Nursing notes indicated the following: 3/03/15 at 11:01 p.m., Resident continues to have loose stools with foul odor. Flagyl discontinued (Resident B was treated for clostridium difficile) one week ago and diarrhea continues. Peri area and buttocks are raw from several BM's (bowel movements) daily. MD</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>(physician) notified.</p> <p>3/04/15 at 6:29 a.m., 3 large very foul liquid mucous stools. Barrier applied as preventative. TRP q 2 hours through noc. (Turned and repositioned every 2 hours through the night.)</p> <p>3/04/15 at 3:53 p.m., Incontinent of b/b (bowel and bladder), having very loose, watery stools, awaiting MD response.</p> <p>3/04/15 at 11:15 p.m., "... Continues with loose stools. MD faxed back with orders to check for c-diff (clostridium difficile). I sent him back a fax stating he already was treated for c-diff and completed Flagyl. We need something to help with the stools and his raw broken down skin."</p> <p>3/05/15 at 11:06 a.m., Continues to have loose stools. New orders to collect stool sample for c-diff.</p> <p>3/05/15 at 3:36 p.m. Start vancomycin (antibiotic).</p> <p>3/06/15 at 5:58 a.m., continues with frequent liquid stools.</p> <p>3/06/15 at 10:37 a.m., continues with loose stools.</p> <p>3/07/15 at 6:57 p.m., Has excoriated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>buttocks from loose stools. Laid back to bed after supper.</p> <p>A wound/skin healing record, dated 3/8/15, indicated a stage 2 pressure ulcer was identified to Resident B's left buttock, 1.0 x 0.7 centimeters (cm), wound bed was described as slough. Documentation indicated the physician was notified. Nurses comments on the record indicated "calmo (calmoseptine lotion) applied and foam dressing".</p> <p>Physician orders, dated 3/08/15, indicated, Calmoseptine to buttocks TID (three times per day) and PRN (as needed), MKAB (may keep at bedside).</p> <p>Nursing notes, dated 3/09/15 to 3/13/15, indicated Resident B continued with loose stools. A nursing note, dated 3/14/15 at 4:05 p.m., indicated Resident B was incontinent of b/b and was provided routine peri care.</p> <p>Nursing notes, dated 3/22/15 at 11:48 p.m., indicated a stage 2 pressure ulcer on coccyx, BNZ (bacitracin, nystatin, zinc cream) applied. A wound record and further assessment documentation related to the stage 2 pressure ulcer to Resident B's coccyx was not provided.</p> <p>Physician orders indicated the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>3/26/15. BNZ (bacitracin/nystain/zinc) cream to stage 2 ulcer on coccyx 3 times daily until healed.</p> <p>3/31/15. Optifoam to stage 2 coccyx, daily until healed.</p> <p>On 4/29/15 at 11:50 a.m., during an interview, LPN #3 indicated all incontinent residents received a barrier cream application with every peri-care. This was an intervention to prevent skin breakdown. Nurses should notify the physician of skin breakdown because anything besides a barrier cream needed a physician's order.</p> <p>2. The clinical record for Resident D was reviewed on 4/28/15 at 2:00 p.m. Diagnoses for Resident D included, but were not limited to, altered mental status, chronic kidney disease- stage 3, peripheral vascular disease and status post cardiac pacemaker placement.</p> <p>Nurses notes, dated 3/03/15, indicated, "Red area to coccyx noted, foam dressing applied and MD notified".</p> <p>A wound/skin healing record, dated 3/03/15, indicated a 4.0 cm x 4.0 cm, stage 1 coccyx pressure wound, pink/beefy red wound bed color, was assessed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>Nursing notes indicated Resident D was transported to the emergency room secondary to critical labs on 3/13/15. Resident D was readmitted to the facility on 3/15/15.</p> <p>The wound/skin healing record, with onset date 3/03/15, indicated the stage 1 pressure wound to the coccyx was assessed on 3/18/15. The assessment indicated a 4.0 cm x 4.0 cm, stage 1 coccyx pressure wound, pink/beefy red wound bed color.</p> <p>During an interview on 4/30/15 at 2:55 p.m., RN #1 indicated Resident D was due for a skin assessment, including the coccyx, on 3/10/15. Documentation did not support that a skin assessment was completed.</p> <p>LPN #2 indicated there should have been documentation related to the coccyx assessment, weekly, and before Resident D went to the hospital on 3/13/15. If the area was healed, before leaving for the hospital, it should be documented. LPN #2 indicated there was not any such documentation.</p> <p>Minimum Data Set documentation, dated 3/17/15, indicated Resident D was readmitted to the facility with a stage 1 pressure area.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>A Pressure Ulcers/Skin Breakdown policy, dated 10/1/2012, presented on 4/30/15 at 10:45 a.m. by RN #1, indicated the following: "It is the policy of the community to develop and implement an individualized plan of care for residents with compromised skin integrity.1. Document an individual's significant risk factors for developing pressure sores.... ...the nurse shall assess and document/report... full assessment of skin condition including, but not limited to, location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue."</p> <p>A policy titled, Prevention of Pressure Ulcers, dated 10/1/2012, presented on 4/30/15 at 10:45 a.m. by RN #1, indicated the following: "General Preventative Measures...for a person in bed: b. determine if resident needs a special mattress;...10. Immediately report any signs of a developing pressure ulcer."</p> <p>A Skin Integrity Policy, dated 10/1/2012, presented on 4/30/15 at 10:45 a.m. by RN #1, indicated the following: "4. All skin injuries will be documented weekly and reported to the physician for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
--	---

(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
	<p>treatment, if necessary ...</p> <p>8. The DON (Director of Nursing) and the charge nurse will monitor all skin areas weekly for size and improvement.</p> <p>...</p> <p>10. The MDS (Minimum Data Set) Coordinator will develop an individualized care plan for residents with impaired skin integrity."</p> <p>This Federal tag relates to complaint #IN00171585.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			