

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 01/06/2016
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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 a Recertification and State Licensure Survey.</p> <p>Survey dates: December 28, 29, 30 & 31, 2015 and January 4, 5, & 6, 2016.</p> <p>Facility number: 000459 Provider number: 155567 AIM number: 100289700</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 3 Medicaid: 48 Other: 8 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3-1.</p>	F 0000	<p>This Plan of Correction is for the Annual Recertification and State Licensure Survey of University Park Health and Rehabilitation Center by the Division of Long Term Care, Indiana State Department of Health beginning on January 6, 2016</p> <p>This Plan of Correction is not an admission of guilt to any findings cited during the above mentioned survey, but is to serve as compliance with the regulations as required</p> <p>With the submission of this Plan of Correction, we respectfully request desk compliance</p> <p>Thank you</p>	
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered</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.

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	<p>into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report 2 allegations of resident to resident altercations in a timely manner for 1 of 1 residents reviewed for abuse (Resident #78).</p>	F 0225	The facility strives to have all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property, immediately reported to the facility Executive Director/designee and to other	02/05/2016

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	<p>Findings include:</p> <p>An interview with Resident #78 on 12/28/15, at 2:45 P.M., indicated three allegations of resident to resident abuse occurred in the past year. Resident #78 indicated on all three occasions she reported the incidents to staff members. Resident #78 reported: Resident #48 hit her in the back; Resident #19 hit her on the wrist; Resident #7 ran into her with his wheelchair.</p> <p>An interview with the Administrator on 1/4/16 at 11:19 A.M. indicated, one of the three allegations of resident to resident abuse (Resident #19) had been investigated and reported in a timely manner. The Administrator provided a copy of the reported incident on 1/6/16 at 10:00 A.M. which indicated on 10/26/15 at 2:30 P.M., at a social event at the facility, Resident #78 had asked Resident #19 to move aside so others could get through the food line, and Resident #19 had made contact with Resident #78's left arm. Both residents were assessed for injury and none were noted and neither resident indicated pain or discomfort. Notifications were made to ISDH, both resident's families and physician at 2:55 P.M. The administrator indicated a report of an incident between Resident #78 and Resident #48 had not been reported to</p>		<p>officials in accordance with State law including the State survey and certification agency. Resident # 78 is not a current Resident. Resident #19 has not been listed in the State Survey sample. Resident #s 48 and # 7 were re-assessed by the Social Service Director for any behavior that may affect others and plan of care have been reviewed and revised as necessary. Interviews were conducted by the Social Service Director with other residents having the potential to be affected by the deficient practice to ensure alleged violations involving mistreatment, neglect or abuse have been reported to the ISDH and resolutions obtained. Negative findings were corrected by the facility Executive Director. Upon identification, the Executive Director/designee will be immediately notified and investigations/reporting will be initiated and completed in accordance with facility policy and state reporting guidelines. Facility staff including management staff have been re-educated by Executive Director/designee on the facility's abuse and reporting guidelines. To determine adherence with Abuse Reporting timely, by state guide lines and facility policy, the ADON/designee will conduct audits to include: charting review, Resident Council Review, Angel Rounds, Resident 1:1 and staff interviews utilizing</p>		

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	<p>ISDH in a timely manner. The administrator indicated a document was located in Resident #78's chart dated 12/24/15 at 8:20 A.M. in which it was reported Resident #48 had hit Resident #78 in the back. The document indicated the residents were separated and Resident #78 complained of pain to the upper back and Tylenol was given. The document indicated Resident #78's family and physician were notified on 12/24/15 at 10:00 A.M. The incident reported by Resident #78 to the ISDH surveyor on 12/28/15 at 2:45 P.M. regarding Resident #7 having run into her with his wheelchair was not located on Resident #78's chart. The administrator did locate a document from 2/28/15 at 2:15 P.M. of an unspecified resident hitting Resident #78 on the right knee during a card game. No injuries were noted and the incident was reported to Resident #78's family and physician on 2/28/15 at 2:20 P.M. The incident had not been reported to ISDH in a timely manner.</p> <p>The policy titled Abuse Prevention, Intervention, Investigation and Crime Reporting Policy was provide by the RN Consultant on 1/4/16 at 4:00 P.M. The policy indicated under #6, Reporting: "Regulations require employees that provide services to elderly persons or dependent adults (mandated reporters) to</p>		<p>the Abaqis format for a minimum of 3 staff and 3 Residents at varying shifts at least 5x/week for a month, weekly for 2 months and monthly for 3 months Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6months. Date of Completion: February 5, 2016</p>	

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F 0226 SS=D Bldg. 00	<p>report instances of suspected or allegations of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection."</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure for Abuse Prevention and reporting for 2 allegations of resident to resident altercations in a timely manner for 1 of 1 residents reviewed for abuse (Resident #78).</p> <p>Findings include:</p> <p>An interview with Resident #78 on 12/28/15, at 2:45 P.M., indicated three allegations of resident to resident abuse</p>	F 0226	The facility strives to have all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property, immediately reported to the Executive Director and to other officials in accordance with State law including the State survey and certification agency. Resident # 78 is not a current resident. Resident #19 has not been listed in the State Survey sample. Resident #s 48 and # 7 were re-assessed by the Social Service Director for any behavior that may	02/05/2016

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	<p>occurred in the past year. Resident #78 indicated on all three occasions she reported the incidents to staff members. Resident #78 reported: Resident #48 hit her in the back; Resident #19 hit her on the wrist; Resident #7 ran into her with his wheelchair.</p> <p>An interview with the Administrator on 1/4/16 at 11:19 A.M. indicated, one of the three allegations of resident to resident abuse (Resident #19) had been investigated and reported in a timely manner. The Administrator provided a copy of the reported incident on 1/6/16 at 10:00 A.M. which indicated on 10/26/15 at 2:30 P.M., at a social event at the facility, Resident #78 had asked Resident #19 to move aside so others could get through the food line, and Resident #19 had made contact with Resident #78's left arm. Both residents were assessed for injury and none were noted and neither resident indicated pain or discomfort. Notifications were made to ISDH, both resident's families and physician at 2:55 P.M. The administrator indicated a report of an incident between Resident #78 and Resident #48 had not been reported to ISDH in a timely manner. The administrator indicated a document was located in Resident #78's chart dated 12/24/15 at 8:20 A.M. in which it was reported Resident #48 had hit Resident</p>		<p>affect others and plan of care have been reviewed and revised as necessary. Interviews were conducted by the Social Service Director with other residents having the potential to be affected by the deficient practice to ensure alleged violations involving mistreatment, neglect or abuse have been reported to the ISDH and resolutions obtained. Negative findings were corrected by the facility Executive Director. Upon identification, the Executive Director/designee will be immediately notified and investigations/reporting will be initiated and completed in accordance with facility policy and state reporting guidelines. Facility staff including management staff have been re-educated by Executive Director/designee on the facility's abuse and reporting guidelines To determine adherence with Abuse Reporting timely, by state guide lines and facility policy, the ADON/designee will conduct audits to include: charting review, Resident Council Review, Angel Rounds, Resident 1:1 and staff interviews for a minimum of 3 staff and 3 Residents, utilizing the Abaqis format at varying shifts at least 5x/weekfor a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported</p>				

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	<p>#78 in the back. The document indicated the residents were separated and Resident #78 complained of pain to the upper back and Tylenol was given. The document indicated Resident #78's family and physician were notified on 12/24/15 at 10:00 A.M. The incident reported by Resident #78 to the ISDH surveyor on 12/28/15 at 2:45 P.M. regarding Resident #7 having run into her with his wheelchair was not located on Resident #78's chart. The administrator did locate a document from 2/28/15 at 2:15 P.M. of an unspecified resident hitting Resident #78 on the right knee during a card game. No injuries were noted and the incident was reported to Resident #78's family and physician on 2/28/15 at 2:20 P.M. The incident had not been reported to ISDH in a timely manner.</p> <p>The policy titled Abuse Prevention, Intervention, Investigation and Crime Reporting Policy was provide by the RN Consultant on 1/4/16 at 4:00 P.M. The policy indicated under #6, Reporting: "Regulations require employees that provide services to elderly persons or dependent adults (mandated reporters) to report instances of suspected or allegations of abuse, neglect, or misappropriation of resident property to the local ombudsman or local law enforcement agency and to State</p>		<p>immediately if needed, and submitted to the QualityAssurance Committee for further review and/or recommendations monthly x 6months. Date of Completion: February 5, 2016 Date of Completion: February 5, 2016</p>		

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F 0242 SS=D Bldg. 00	<p>Licensing and Certification immediately or as soon as practically possible within 24 hours of detection."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents received showers according to personal preferences for 3 of 3 residents reviewed for choices (Resident #7, #49, and #21)</p> <p>Findings include:</p> <p>1. On 12/29/15 at 1:57 P.M., an interview with Resident #7 indicated he had not been given a choice on how many times a week he received a shower and he indicated his last shower had been one and a half months ago.</p> <p>The Activity Daily Living (ADL) flow</p>	F 0242	The facility strives to provide resident showers as scheduled and according to residents' preferences. Resident #7, #49 and #21 have been interviewed and shower preferences have been obtained by the ADON/designee. The Residents' Care Plans and Point of Care were updated with preferences. Refusals will be documented in the clinical records accordingly. Interviews were conducted by members of the IDT, utilizing the Abaqis format, for other Residents having the potential to be affected by the alleged deficient practice to ensure shower preferences are honored. Current Residents'	02/05/2016

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	<p>sheet provided by RN #3 for November and December 2015, indicated between 11/1-11/5, 11/24-11/29, 12/12 -12/20, and 12/22- 12/31/15 there was no documentation the resident had received his showers timely.</p> <p>Interview on 01/05/2016 at 1:00:07 P.M. indicated RN Nurse Consultant #1 was unable to find any documentation the resident had declined any showers on the above dates.</p> <p>A care plan for bathing and showering, initially dated 11/25/14, indicated the resident required extensive assistance by 1 staff with showering twice weekly as scheduled and as necessary.</p> <p>#2. On 12/29/15 at 9:34 P.M. Resident #49 indicated she had only had one shower since she was admitted to the facility on 11/11/15.</p> <p>The Activity Daily Living form for showers indicated there was no documentation from 11/11- 11/25/15 indicating the resident had received a shower.</p> <p>The shower form for December 2015 indicated there was no documentation between 12/3-12/8, 12/10-12/18/15, and,</p>		<p>shower schedules and preferences have been reviewed and resident's Plan of Care and Point of Care have been revised as needed by the ADON/designee. Nursing staff have been re-educated on documentation of Residents' shower acceptance or refusals by the DON/Designee.</p> <p>To determine adherence with scheduled showers and appropriate clinical documentation the ADON/designee will conduct shower audits at varying shifts at least 5x/week for a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH.</p> <p>Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee monthly for review and recommendations. Compliance will be determined by review of these audits by the Quality Assurance Committee monthly. This practice will continue until maintenance of compliance has been achieved. Date of Completion: Feb. 5, 2016</p>	

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	<p>12/20-12/31/15 to indicate the resident had received a shower.</p> <p>3. During an interview with Resident #21 on 12/28/2015 at 2:15 P.M., the resident indicated she was scheduled to receive two showers each week, but she would like to have showers more often at times, but she had never been asked. Resident #21 further indicated she frequently only received one shower each week</p> <p>The record for Resident #21 was reviewed on 1/4/2016 at 1:00 P.M.</p> <p>A BIMS (Brief Interview for Mental Status) assessment, included in the Minimum Data Set (MDS) assessment, dated 12/3/2015, indicated Resident #21's memory was not impaired. The MDS further indicated Resident #21 required the physical assistance of one person for bathing.</p> <p>A care plan for ADLs (Activities of Daily Living) for Resident #21, with a revision date of 4/27/2015, indicated the resident required extensive assistance by one staff with bathing/showering and showering was to be done twice weekly and as necessary.</p>			

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F 0280 SS=D Bldg. 00	<p>A flow sheet for documenting ADLs for Resident #21 for December 2015 indicated the resident had only received showers on 12/7/2015, 12/14/2015, 12/28/2015, and 12/31/2015.</p> <p>RN #3 was interviewed on 1/5/2016 at 9:00 A.M. During the interview, RN #3 indicated staff were to document all showers actually provided to residents on the ADL flow sheet.</p> <p>CNA #4 was interviewed on 1/5/2016 at 10:55 A.M. During the interview, CNA #4 indicated showers were to be provided to residents according to their schedules and documented on the ADL flow sheet.</p> <p>3.1-3(u)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged</p>			

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	<p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to invite a resident's representative to quarterly care plan meetings for 1 of 3 residents reviewed for participation in care planning (Resident #17). The facility also failed to initiate a care plan for use of an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #10).</p> <p>Findings include:</p> <p>1. An interview with Resident #17's family member/Power of Attorney (POA), on 12/30/2015, at 10:00 A.M., indicated she had not been invited to care plan meetings in a long time. The Resident's POA indicated the resident</p>	F 0280	<p>The facility will invite resident/resident's representative to participate in care plan meetings; and will include the use of antipsychotic drug in the resident's plan of care as applicable. Resident #17's POA has been contacted and will be sent invitation for quarterly meetings by the Social Services Director and/or designee. Resident #10's plan of care has been reviewed and revised to include the current use of antipsychotic medication by the Social Service Director. Residents' families/POA's of other residents having potential to be affected by the alleged deficient practice were contacted about care plan meetings by the Social Service Director. A review of residents currently prescribed anantipsychotic medication was</p>	02/05/2016

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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		
(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>had been in the facility for 3 years and she used to be invited to care plan meetings but had not been invited in a long time.</p> <p>Review of Resident #17's clinical record on 1/4/16, at 1:00 P.M. indicated the most recent care plan meeting was held on 10/1/15 and the POA was not noted to have attended the meeting.</p> <p>An interview with the MDS nurse on 1/4/16, at 1:32 P.M., indicated no invitations to quarterly care plan meetings in the past year for Resident #17's POA could be located.</p> <p>An interview with the Medical Records Manager on 1/4/16 at 2:15 P.M. indicated the only other quarterly care plan meeting in the past year for Resident #17, of which documentation was located, was on 2/9/15. Review of the Interdisciplinary Progress Notes/Care Conference Notes for 2/9/15, provided by the Medical Records Manager on 1/4/16 at 3:30 P.M., did not indicate Resident #17's POA had been in attendance at the meeting.</p> <p>A policy, Care Conference, Resident and Family Participation, dated December 2011, was provided by RN Consultant #1 on 1/5/16.</p>		<p>conducted by the Social Services Director to ensure plans of care were updated accordingly. The Social Service Director has been re-educated by the RDCO/designee to provide invitation to each resident and/or resident's known representative to participate in careplanning meetings in accordance with the facility's Care conference, Resident and Family Participation policy. Licensed nurses have been re-educated by the DON/designee on the inclusion of antipsychotic medication in resident's plan of care as applicable. To determine adherence with Resident right to participate in care planning and Resident's Representative notification of same, by state guide lines and facility policy, the Executive Director/designee will conduct audits to include: scheduled care plan meetings, and Resident clinical records for a minimum of 3 Residents at least 5x/week for a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6months. Date of Completion:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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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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	<p>The policy indicated: "Objective: Each resident and his/her responsible party shall be permitted to participate in the development of the resident's comprehensive careplan. Process: 1. Resident and his/her responsible party are invited to attend the resident's careplan conference. 2. Advance notice is provided to the resident and responsible party by mail and/or telephone at least seven days prior the scheduled care conference meeting. 3. The notice will include: a. Date of conference b. Time c. Location d. Name of responsible party e. Date and signature of the staff member. 4. A copy of the notice is placed in the medical record. 5. Every effort will be made, including the option of telephone conference call, to schedule meeting to accommodate the requests of the responsible party."</p> <p>2. Resident #10's clinical record was reviewed on 12/28/15 at 2:39 P.M. and indicated current medications included, but were not limited to, Risperidone (an antipsychotic medication) 0.75 milligrams for unspecified psychosis.</p> <p>Review of Resident #10's documented care plans did not indicate a care plan was in place for use of an antipsychotic medication.</p>		February 5, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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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 0282 SS=E Bldg. 00	<p>An interview with RN Consultant #1, on 12/31/15, at 11:20 A.M., indicated no care plan for use of an antipsychotic medication could be located.</p> <p>A policy titled Psychopharmacological Agents, Clinical Use of, dated December 2015, was provided by RN Consultant #1 on 1/5/16 at 10:15 A.M. The policy indicated, under care plan documentation guidelines: "Problem: include functional impairment prompting the need for psychopharmacological agent. Goal: Maintain highest practicable mental, physical, and psychological well-being (define). Approaches: Include)primary) non=pharmacological and (secondary) pharmacological interventions to alleviate behavior and limit identified trigger (antecedents) as practical."</p> <p>3.1-3(o) 3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</p>			

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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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	<p>written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an antibiotic medication and insulin were administered as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #102). The facility also failed to ensure interventions for falls were implemented as care planned for 2 of 3 residents reviewed for accidents (Resident #72 and Resident #21). The facility further failed to obtain a laboratory test as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #64).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #102 was reviewed on 12/31/2015 at 8:40:33 A.M. and indicated Resident #102's diagnosis indicated, but were not limited to, diabetes and a urinary tract infection.</p> <p>The hospital discharge Physician's Orders dated 12/22/15 for the resident indicated to start Invanz (antibiotic) Intravenously (IV) 1 gram daily to start start on 12/23/15.</p> <p>The December 2015 Medication Administration Record (MAR) for Resident #102 indicated the Invanz IV was not documented as given on</p>	F 0282	<p>The facility will provide insulin and IV antibiotic administration according to physician's orders; will implement fall interventions according to plan of care; will obtain laboratory tests as ordered. Resident #102's intravenous IV medication has been completed. Current insulin order is being monitored for consistent administration. Resident #s 72 and 21's has been re-assessed by the Interdisciplinary Team for fall risks; fall care plan has been reviewed and implemented. Resident #64's clinical records have been reviewed for ordered laboratory testing. Laboratory orders will be completed as ordered. Resident #64 available pain medication will be reviewed by the DON and physician assigned for adequate pain control Resident #64 will be re-assured pain medication is available for pain control and Social Services will follow Residents with orders for insulin, IV medications, laboratory orders, and those with falls/risks are residents who have the potential to be affected by the deficient practice. These residents will be identified through review of clinical records during the daily clinical meetings. Follow up care will be provided accordingly. Licensed Nurses have been re-educated by the DON/designee on new/admission</p>	02/05/2016

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 01/06/2016
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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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	<p>12/23/15.</p> <p>A document provided by the RN Nurse Consultant #2 on 1/5/16 at 9:00 A.M. from the Pharmacy dated 12/23/15 indicated the medication Invanz IV 1 gram was delivered to the facility on 12/23/15.</p> <p>On 1/5/16 at 9:15 A.M. interview with RN Nurse Consultant #2 indicated Resident #102's medication Invanz IV was available in the facility on 12/23/15 and the Nurse who transcribed the hospital discharge Physician's Orders dated 12/22/15 thought the order for the medication Invanz IV was completed on 12/23/15.</p> <p>The hospital discharge Physician's Orders dated 12/22/15 for Resident #102 indicated administer Novolog (insulin) 20 units 3 times a day with meals.</p> <p>The December 2015 MAR for Resident #102 indicated between the dates of 12/23 through 12/30/15 the medication Novolog was not administered a total of 9 times.</p> <p>On 1/5/16 at 9:15 A.M. an interview with RN Nurse Consultant #2 indicated the routine medication Novolog insulin 20 units was held 9 times without a</p>		<p>orders, falls/care plans updates and Pharmacy recommendation implementation. To determine adherence with services by qualified persons per Resident Care Plan, state guide lines and facility policy, the DON/ADON/Designee will conduct audits to include: weekly audits of clinical records to identify new physician orders, fall care plan update/need and any pharmacy recommendations including laboratory tests to determine compliance. These audits will be completed for a minimum of 5 Residents at least 5x/weekfor a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the QualityAssurance Committee for further review and/or recommendations monthly x 6months. Date of Completion: February 5, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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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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(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's order.</p> <p>2. The clinical record of Resident #72 was reviewed on 12/31/2015 at 10:41:03 A.M. and indicated Resident #72's diagnosis included, but were not limited to, chronic kidney disease stage 4, urinary tract infection, and orthostatic hypotension.</p> <p>The Care Plan for falls dated 9/11/15 for Resident #72 indicated the resident was at high risk for falls "... (related to) unaware of safety needs...." On 10/14/15 the resident had a fall and the falls care plan was updated on 10/14/15 with a new intervention to add non-skid strips to the bedside.</p> <p>On 01/06/2016 9:29:36 A.M. Resident #72 was observed laying in bed and there were no non-skid strips noted on the residents floor at his bedside.</p> <p>An observation with RN Nurse Consultant #2 and RN #3 on 01/06/2016 at 11:34:38 A.M. indicated Resident #72's floor in his current room did not have the non- skid strips on the floor. An interview with RN #3 indicated the resident had been moved from room 309 on 12/15/15.</p> <p>An observation on 1/6/16 at 11:34 A.M.</p>			

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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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	<p>with RN Nurse Consultant #2 and RN #3 indicated non- skid strips were on the floor of Resident #72's last room #309. An interview with RN #3 indicated the maintenance man is responsible for the placement of non-skid strips.</p> <p>3. LPN #5 was interviewed on 12/28/2015 at 1:50 P.M. During the interview, LPN #5 indicated Resident #21 had fallen on 12/6/2015 and had received a laceration to her scalp.</p> <p>The record for Resident #21 was reviewed on 1/4/2016 at 1:00 P.M.</p> <p>A "Report of Incident SBAR (Situation, Background, Assessment, Recommendation) for Actual or Suspected Falls", dated 12/6/2015 at 10:50 P.M., indicated the resident had an unwitnessed fall from a chair in her room while leaning forward to pick something up. The SBAR indicated the resident had hit her head on a bedside table during the fall and had received a laceration to the top of her head. The resident was transferred to a local hospital emergency room for evaluation and treatment and was returned to the facility.</p>			

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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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	<p>A care plan for Resident #21, with a revision date of 6/18/2015, indicated the resident was a high risk for falls. Interventions on the care plan, included, but were not limited to, an alarm to the residents bed and chair. The initiation date of the intervention was 12/8/2015.</p> <p>On 1/5/2016 at 9:00 A.M., Resident #21 was observed in her room sitting in a wheelchair. No alarm was observed in her chair. An alarm was observed laying on top of a small bookcase in the room.</p> <p>On 1/5/2016 at 9:45 A.M., Resident #21 was observed in the West Hall sitting in a wheelchair. No alarm was observed in her chair.</p> <p>On 1/5/2016 at 10:30 A.M., Resident #21 was observed in her room lying in bed. No alarm was observed in her bed. An alarm was observed laying on top of a small bookcase in the room.</p> <p>During an observation with the facility DON (Director of Nursing) of Resident #21 in her room on 1/5/2016 at 10:45 A.M., the resident was observed in her room lying in bed. No alarm was observed in her bed. An alarm was observed laying on top of a small bookcase in the room. During an</p>			

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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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	<p>interview with the DON, the DON indicated the resident should have the alarm in place as indicated on the care plan.</p> <p>4. The record for Resident #64 was reviewed on 12/29/2015 at 11:15 A.M. A current Physician Order's sheet, with a renewal date of 11/30/2015, indicated the Resident was prescribed pravastatin 40 mg (milligrams) daily for disorder of lipid metabolism.</p> <p>A Consultation Report by the facility's consultant pharmacist, dated 9/29/2015, indicated "(Resident's name) receives lipid-lowering therapy with Pravastatin 40 mg, and does not have a fasting lipid profile (a laboratory test to check lipid levels) documented in the resident record." The report further indicated "Please consider monitoring a fasting lipid panel on the next convenient lab day and annually thereafter." The physician signed the report on 10/27/2015 and indicated he accepted the recommendation and wanted it implemented as written.</p> <p>Review of Resident #64's record did not indicate the fasting lipid panel had been obtained as recommended by the pharmacist consultant and as ordered by the physician.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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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 0309 SS=D Bldg. 00	<p>The facility DON (Director of Nursing) was interviewed on 1/4/2016 at 1:05 P.M. During the interview, the DON indicated the fasting lipid panel had not been obtained as ordered.</p> <p>3.1-35(g)(2)</p> <p>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.</p> <p>Based on interview and record review, the facility failed to initiate pain medication as recommended by the physician for 1 of 1 resident reviewed for pain management. (Resident #64)</p> <p>Findings include:</p>	F 0309	The facility strives to provide the necessary care and services according to physician recommendation and orders. Resident # 64 had been re-assessed and clinical records reviewed by the DON on 1/12/2016. Resident is currently receiving physician recommended and ordered laboratory tests.	02/05/2016

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 01/06/2016
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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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	<p>The record for Resident #64 was reviewed on 12/29/2015 at 11:15 A.M. Diagnoses included, but were not limited to, diabetes mellitus and lumbar radiculitis (nerve pain that radiates from the lower back to the legs).</p> <p>A "Doctor's Progress Note", dated 12/1/2015, indicated Resident #64 had been seen by the physician for complaints of "neuropathic pain" (pain caused by nerve damage or injury) of the legs. The progress note indicated the physician's assessment was diabetic neuropathy (pain caused by nerve damage related to diabetes mellitus). The progress note further indicated the plan was to start Neurontin (a non-narcotic medication used to treat neuropathy).</p> <p>A "Doctor's Progress Note", dated 12/10/2015, indicated Resident #64 was seen for continued complaints of pain in her legs and also in her back. The note indicated the assessment was diabetes mellitus and possible radiculopathy (pain caused by compressed nerves in the spine). The note indicated the plan was to increase Neurontin.</p> <p>Resident #64's clinical record did not indicate the Neurontin had ever been started as indicated in the "Doctor's Progress Notes.</p>		<p>Resident #64 available pain medication will be reviewed by the DON and physician assigned for adequate pain control Resident #64 will be re-assured pain medication is available for pain control and Social Services will follow Audit of physician progress notes was conducted by theADON/designee of those residents that had the potential to be affected by thealleged deficient practice to ensure that no other physician orders have beenmissed. Licensed Nurses have been re-educated by the DON/designee on managing physician visit andreviewing progress notes to ensure that new recommendations are addressed andcorresponding physician orders are obtained. To determine pain medication is initiated as ordered by the physician and adequate for pain control of each resident per Resident Care Plan, state guide lines and facility policy, the DON/ADON/Designee will conduct audits to include: weekly audits of clinical records to identify new physician orders, pain assessments, and PRN medication follow through. These audits will be completed for a minimum of 5 Residents at least 5x/weekfor a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2016
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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	<p>Nurse Consultant #1 was interviewed on 1/5/2016 at 2:30 P.M. During the interview, Nurse Consultant #1 indicated physicians did not enter their medication orders into the facility electronic medical record system themselves. Nurse Consultant #1 indicated the physicians would either give the orders verbally to the nurse or would write them down in the progress notes and the nurse would later enter the orders into the system. Nurse Consultant #1 reviewed Resident #64's record and indicated the order for the Neurontin had not been started as indicated in the "Doctor's Progress Notes".</p> <p>Nurse Consultant #1 was interviewed on 1/5/2016 at 2:50 P.M. During the interview, Nurse Consultant #1 indicated she had just called the physician's office and the physician had indicated he had written the order to start the Neurontin "on a piece of paper for the nurse" on 12/1/2015. The Nurse Consultant indicated the physician wanted the Neurontin started for Resident #64.</p> <p>3.1-37(a)</p>		<p>Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6months. Date of Completion: February 5, 2016</p>		

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 01/06/2016
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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 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to ensure residents received showers as scheduled and according to personal preferences for 3 of 3 residents reviewed for choices (Resident #7, #49, and #21)</p> <p>Findings include:</p> <p>1. On 12/29/15 at 1:57 P.M. an interview with Resident #7 indicated he was not given a choice on how many times a week he received a shower and his last shower was 1 and 1/2 months ago.</p> <p>The Activity Daily Living (ADL) flow sheet provided by RN #3 for November and December 2015 indicated between 11/1-11/5, 11/24-11/29, 12/12 -12/20, and 12/22- 12/31/15 there was not documentation the resident had received his showers timely.</p>	F 0312	<p>The facility will ensure that resident showers are provided as scheduled and according to residents' preferences. Resident #7 and #49 have been interviewed, utilizing the Abaqis format, and shower preferences have been obtained by the ADON/designee. These preferences will be reflected in the clinical records. Refusals will be documented in the clinical records accordingly. Current resident's shower schedules have been reviewed by the ADON/designee to reflect patient expressed preferences. Each resident's plan of care have been reviewed and revised as needed. Nursing staff have been re-educated by DON/designee on the documentation of resident's shower acceptance or refusals. To determine Resident's receive showers according to personal preference and as scheduled per state guide lines and facility policy, the DON/ADON/Designee will</p>	02/05/2016

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 01/06/2016	
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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	<p>Interview on 01/05/2016 at 1:00:07 P.M. indicated RN Nurse Consultant #1 was unable to find any documentation the resident had declined a shower on the above shower dates.</p> <p>The care plan for BATHING/SHOWERING date 11/25/14 indicated the resident requires extensive assistance by 1 staff with showering twice weekly as scheduled and as necessary and can be non-compliance with showering.</p> <p>#2. On 12/29/15 at 9:34 P.M. Resident #49 indicated she had only had one shower since she was admitted on 11/11/15.</p> <p>The Activity Daily Living form for showers indicated there was no documentation until 11/25/15 the resident had received a shower which is 14 days delay.</p> <p>The shower form for Dec 2015 indicated there was no documentation between 12/3-12/8, 12/10-12/18/15, and, 12/20-12/31/15 the resident had received a shower.</p> <p>3. During an interview with Resident #21 on 12/28/2015 at 2:15 P.M., the resident indicated she was scheduled to receive</p>		<p>conduct shower audits to include: Care Plans, Resident Personal preference, and charting documentation to reflect same. These audits will be completed for a minimum of 5 Residents at least 5x/week for a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6 months. Date of Completion: February 5, 2016 Date of Completion: Feb. 5, 2016</p>				

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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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	<p>two showers each week, but she would like to have showers more frequently at times. Resident #21 further indicated she frequently only received one shower each week.</p> <p>The record for Resident #21 was reviewed on 1/4/2016 at 1:00 P.M.</p> <p>A BIMS (Brief Interview for Mental Status) assessment, included in the Minimum Data Set (MDS) assessment, dated 12/3/2015, indicated Resident #21's memory was not impaired. The MDS further indicated Resident #21 required the physical assistance of one person for bathing.</p> <p>A care plan for ADLs (Activities for Daily Living) for Resident #21, with a revision date of 4/27/2015, indicated the resident required extensive assistance by one staff with bathing/showering twice weekly and as necessary.</p> <p>A flow sheet for documenting ADLs for Resident #21 for December 2015 indicated the resident received showers on 12/7/2015, 12/14/2015, 12/28/2015, and 12/31/2015.</p> <p>RN #3 was interviewed on 1/5/2016 at 9:00 A.M. During the interview, RN #3 indicated staff were to document all</p>			

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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 0329 SS=D Bldg. 00	<p>showers provided on the ADL flow sheet.</p> <p>CNA #4 was interviewed on 1/5/2016 at 10:55 A.M. During the interview, CNA #4 indicated showers were to be provided to residents according to their schedules.</p> <p>3.1-38(3)(b)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>			

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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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	<p>these drugs.</p> <p>Based on record review and interview, the facility failed to identify individualized target behaviors to be monitored for residents on antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications (Resident #64 and Resident #10).</p> <p>Findings include:</p> <p>The record for Resident #64 was reviewed on 12/29/2015 at 11:15 A.M. Diagnoses included, but were not limited to, schizophrenia. Medications ordered by the physician for Resident #64 included, but were not limited to, Invega (antipsychotic medication) 3 mg (milligrams) by mouth once daily and Invega Sustenna (extended release form of Invega) 234 mg by injection monthly.</p> <p>A Physician's Order sheet for Resident #64, with a renewal date of 11/30/2015, indicated "For those residents on anti-psychotic psychoactive medications, please identify targeted behaviors to be monitored." The behaviors listed included, but were not limited to, delusions, sensory hallucinations with the type of hallucination to be specified, fear or paranoia, substantial difficulty with ADL's (activities of daily living), danger symptoms such as hitting, kicking, or</p>	F 0329	<p>The facility strives to identify individual target behaviors to be monitored for residents on antipsychotic medications. Residents #64's and #10's were re-assessed and clinical records were updated by the Social Worker to reflect individual target behaviors to be monitored and documented by the licensed nurses in the Medication Administration Records. Residents on antipsychotic medications who have the potential to be affected by the alleged deficient practice are identified through current physician orders and Medication Administration Records. These resident's clinical records were reviewed and updated by the Social Service Director to reflect targeted behaviors to be monitored and documented in the Medication Administration Records. Nursing and Social Service Director have been re-educated by the Regional Nurse Consultant/designee on Behavior Management Program that include use of antipsychotic drugs and appropriate clinical documentation of individual target behaviors. To determine that Resident individualized target behaviors are monitored for Residents with antipsychotic medications, and per state guide lines and facility policy, the DON/ADON/Designee will conduct audits to include: weekly</p>	02/05/2016

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	<p>slapping, verbally aggressive toward others, continuous yelling or screaming, functional impairment, spitting, resisting medications or treatment, resisting care or therapy, distress with end of life, crying, and "other". Each listed behavior had a box next to it to be checked if it was identified as a specific target behavior for the resident. None of the listed behaviors were checked as being identified as a target behavior to be monitored for Resident #64.</p> <p>The Medication Administration Record (MAR) for Resident #64 for December 2015 had a section for recording targeted behaviors for residents on anti-psychotic medications. The section listed the same behaviors as listed on the Physician Order sheet with instructions to identify target behaviors to be monitored and to document behaviors in the "Comments field" using a numeric scale and if no behaviors occurred, a "0" was to be placed in the comments section. None of the behaviors listed were identified as target behaviors to be monitored for Resident #64 and there was no documentation in the "Comments" section.</p> <p>Nurse Consultant #2 was interviewed on 1/6/2016 at 11:00 A.M. During the interview, Nurse Consultant #2 indicated</p>		<p>audits of Medication Administration Record, Behavior charting, and care plan. These audits will be completed for a minimum of 5 Residents at least 5x/week for a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6 months. Date of Completion: February 5, 2016 Completion Date: February 5, 2016</p>	

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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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	<p>the behaviors listed on Resident #64's Physician Order sheet were not specific for that resident based upon assessment, but were generic behaviors listed for any resident on an anti-psychotic medication. Nurse Consultant #2 further indicated none of the behaviors listed on the Physician Order sheet or on the MAR had been identified as target behaviors to be monitored and there was no documentation in the "Comments" section indicating the resident was either having any behaviors or was not having any behaviors. Nurse Consultant #2 indicated target behaviors based upon assessment of Resident #64 should have been identified.</p> <p>2. Resident #10's clinical record was reviewed on 12/28/15 at 2:39 P.M. The record indicated the resident had physician's orders for Risperidone (medication used to treat psychosis) 0.75 mg daily for unspecified psychosis.</p> <p>Review of Resident #10's Physician's orders, most recently renewed 12/1/2015 and Medication Administration Record (MAR) for December 2015, provided by RN Consultant #1, indicated "For those residents on anti-psychotic psychoactive medications, please identify targeted behaviors to be monitored." The behaviors listed included, but were not</p>			

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	<p>limited to, delusions, sensory hallucinations with the type of hallucination to be specified, fear or paranoia, substantial difficulty with ADL's (activities of daily living), danger symptoms such as hitting, kicking, or slapping, verbally aggressive toward others, continuous yelling or screaming, functional impairment, spitting, resisting medications or treatment, resisting care or therapy, distress with end of life, crying, and "other". Each listed behavior had a box next to it to be checked if it was identified as a specific target behavior for the resident. None of the listed behaviors were checked as being identified as a target behavior to be monitored for Resident #10.</p> <p>The Medication Administration Record (MAR) for Resident #10 for December 2015 had a section for recording targeted behaviors for residents on anti-psychotic medications. The section listed the same behaviors as listed on the Physician Order sheet with instructions to identify target behaviors to be monitored and to document behaviors in the "Comments field" using a numeric scale and if no behaviors occurred, a "0" was to be placed in the comments section. None of the behaviors listed were identified as target behaviors to be monitored for Resident #10 and there was no</p>			

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F 0412 SS=D Bldg. 00	<p>documentation in the "Comments" section.</p> <p>An interview with RN Consultant #1 on 12/31/15 at 11:20 A.M. indicated Resident #10 did not have individualized specific target behaviors identified to be monitored on physician's orders and the MAR.</p> <p>3.1-48(a)(3)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review, and</p>	F 0412	The facility strives to meet residents' dental service needs	02/05/2016	

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	<p>interview, the facility failed to ensure dental services were provided as recommended for 1 of 3 residents reviewed for dental status and services (Resident #7).</p> <p>Findings include:</p> <p>On 12/29/15 at 2:28 P.M. Resident #7 was observed to have some missing teeth.</p> <p>The Dental Exam form dated 9/16/14 indicated the resident was not seen by the dentist and there was no explanation documented. The Dental Exam form further indicated the resident was last seen on 7/30/14 and the next Dental exam was due in January 2015.</p> <p>RN Nurse Consultant #1 was interviewed on 01/06/2016 10:08:58 A.M. indicated she was unable to find any documentation the resident had been seen by the dentist in 2015, or that the res refused to see the dentist in 2015. RN Nurse Consultant #1 indicated she had called the dentist's office and they had no documentation that resident had been seen or refused to be seen by the dentist in 2015.</p> <p>3.1-24(a)(1)</p>		<p>and follow up on recommendations. Resident #7 has been scheduled dental appointment by the Social Service Director but has refused on 1-18-2016. Corresponding documentation is available in the clinical records. Residents in need of dental care and have the potential to be affected by the alleged deficient practice will be identified through IDT and physician recommendations. Patients in need of dental care will be scheduled by the Social Service Director on the next routine dental visit in the facility, or community based dental services as needed. Licensed Nurses and Social Service staff have been re-educated on dental service scheduling and documentation, by the DON/designee. To determine that Resident Dental Services are provided as recommended, requested by the Resident, and per state guide lines and facility policy, the Health Information Manager/Designee will conduct audits to include: dental service notes, physician orders, and care plan. These audits will be completed for a minimum of 5 Residents at least 5x/week for a month, weekly for 2 months and monthly for 3 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported</p>	

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F 0428 SS=D Bldg. 00	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure a Pharmacy Consultation Report was reviewed and acted upon in a timely manner for 1 of 5 residents reviewed for unnecessary medication (Resident #11).</p> <p>Findings include:</p> <p>The record for Resident #11 was reviewed on 12/30/2015 at 2:09:40 P.M. and indicated Resident #11's diagnoses included, but were not limited to, major depressive disorder and psychosis.</p> <p>The Pharmacy Consultation Report dated 7/30/15 indicated Resident #11 was receiving "...Seroquel for depression</p>	F 0428	<p>immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6 months. Date of Completion: February 5, 2016 Completion Date: Feb. 5, 2016</p> <p>The facility strives to review Pharmacy Consultation Report and act upon recommendations in a timely manner. Resident #11's medication list have been reviewed by the Pharmacy Consultant and is deemed current and based on resident's needs and pharmacy recommendations. Current residents receiving medications have the potential to be affected by the deficient practice. These residents' most recent month's Medication Regimen Reviews have been audited and needed follow-up was completed by the DON/designee. The policy of MRR (Medication Regimen Review) has been reviewed by the DON/designee with the Assist Director of Nursing and nursing</p>	02/05/2016

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 01/06/2016
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	<p>without a recommendation to add a concomitant antidepressant." The Nurse Practitioner (NP) signed the Pharmacy Consultation Report on 10/19/15 and accepted the recommendation to add an antidepressant to Resident #11's medication regimen.</p> <p>There was no Physician's Order written for the medication Lexapro (an antidepressant) until 11/2/15.</p> <p>The November 2015 Medication Administration Record for Resident #11 indicated the medication Lexapro was not started until 11/2/15.</p> <p>On 01/04/2016 at 1:28:50 P.M. an interview with Director Of Nursing (DON) indicated she was unsure why the pharmacy recommendation for Resident #11 had not been reviewed timely or implemented timely after N.P. signed the Pharmacy Consultation Report. The DON indicated she was not working at the facility at that time.</p> <p>The Medication Regimen Review (MRR) Policy dated 12/1/07, received from RN Nurse Consultant #1 on 1/4/16 at 4:00 P.M., indicated "7. Facility should encourage Physician/Prescriber ...receiving the MRR and the Director of Nursing to act upon the recommendations</p>		<p>staff to ensure that recommendations are acted upon in a timely manner. To determine that the facility Pharmacy Consultation Report is reviewed and acted upon in a timely manner, the DON/Designee will conduct audits at least monthly for 6 months or until substantial compliance is determined by the ISDH. Results of these audits will be reviewed by the Executive Director/designee, reported immediately if needed, and submitted to the Quality Assurance Committee for further review and/or recommendations monthly x 6months. Date of Completion: February 5, 2016</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	contained in MRR..." 3.1-25(i)				