STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00333814, IN00334323, IN00335013, IN00335399, IN00335972, IN00336421, IN00339015, IN00339469, IN00340789, IN00344892, and IN00345822. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00333814- Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00334323- Unsubstantiated due to lack of evidence. Complaint IN00335013- Substantiated. Federal/state deficiencies related to the allegations are cited at F686, F725, and F921. Complaint IN00335399- Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00335972- Substantiated. Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00336421- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00339015- Substantiated. Federal/state deficiencies related to the allegations are cited at F561, F690, and F921. Complaint IN00339469- Substantiated. Federal/state deficiencies related to the allegations are cited at F561, F684, and F686.	F 0000	2-24-2021 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey University Park Rehabilitation and Healthcare 1400 Medical Park Drive Fort Wayne IN 46825 Dear Ms. Buroker: On February 9, 2021, a complaint survey (IN00333814, IN00334323,IN00335013,IN00335399,IN00335972, IN00336421,IN0039015,IN00339469,IN00340789,IN00344892 and IN00345822) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our formal request for a desk review that the facility has achieved substantial compliance with the applicable requirements	

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

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	Complaint IN00340789- Substantiated. Federal/state deficiencies related to the allegations are cited at F561, F686, and F921 Complaint IN00344892- Substantiated. Federal/state deficiencies related to the allegations are cited at F561, F686, and F842. Complaint IN00345822- Substantiated. Federal/state deficiencies related to the allegations are cited at F921 and F9999. Survey Date: February 9, 2021 Facility number: 000459 Provider number: 155567 IM number: 100289700 Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 8 Medicaid: 68 Other: 2 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/12/21.		as of the date set forth in the Plan of Correction of March 11,2021 Please feel free to call me with any further questions at 1 (260) 484-1558. Respectfully submitted, Tamara Hunter Executive Director	
F 0561 SS=E Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident			

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	choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure residents had received a bath or shower in a timely manner and according to the resident's preference, for 4 of 4 residents reviewed for Activities of Daily Living (ADL's) . (Resident E, Resident F, Resident G and Resident H). Findings include: 1. The clinical record of Resident E was reviewed on 2/9/21 at 3:00 p.m. The record indicated diagnoses included, were not limited to, morbid obesity, lymphedema and hypertension.	F 0561	***F 561D SELF DETERMINATION*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it*	03/11/2021

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	The Quarterly Minimum Data Set (MDS) assessment, dated 11/9/20, indicated the resident was alert and oriented and required extensive assistance of 1 staff for bathing. An undated "Look Back Report" indicated the following: Resident E's baths were scheduled to be done on Tuesday and Saturday P.M. The resident's baths were documented as given on 1/23/21 and 2/6/21, which was 14 days later. On 2/9/21 at 11:45 a.m., Resident E was interviewed. Resident E indicated she had not been receiving her bed baths as scheduled, the CNA who usually gave the resident her bath had been on vacation for past 2 weeks. 2. The clinical record of Resident F was reviewed on 2/9/21 at 1:15 p.m. Diagnoses included, were not limited to, diabetes, depression and anxiety. In an interview on 2/9/21 at 1:19 p.m., Resident F indicated she had not had a bath or shower for over 2 weeks. The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/20, indicated the resident's cognition was moderately impaired and required extensive assistance of 1 staff for bathing. An undated "Look Back Report" indicated Resident F's baths were documented as given on 1/12/21, 1/15/21 and 1/19/21. There was no documentation after 1/19/21 to indicate the resident had received a bath. 3. The clinical record of Resident G was reviewed on 2/9/21 at 2:00 p.m. Diagnoses included, were		*is required by the provisions of federal and state law.* ***1) Immediate actions taken for those residents identified:*** *Resident #E, #F, #G, and #H were interviewed to determine their choice of bathing/shower times. Bath and or shower was given. Care plans were reviewed and revised.* ***2) How the facility identified other residents:*** *Facility audit was conducted by Social Services/Nursing to determine satisfaction with bathing/ shower times. Any identified concerns were addressed timely.* ***3) Measures put into place/ System changes:*** *Resident choice will be determined upon Admission. Admission audits will be completed during scheduled IDT/clinical stand-up meetings. Issues will be addressed immediately.* *Education provided to nursing staff on supporting and promoting the residents right of choice, which includes bathing/ showering and activities of daily living.* *Resident interviews will be conducted 3 times weekly to determine provision of ADL's (bathing/showering) occurred per resident choice.* *Education provided to nursing staff on accurate correct documentation of ADL'S.*	

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	not limited to, diabetes, renal failure and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/14/20, indicated the resident was alert and oriented and required extensive assistance of 1 staff for bathing. In an interview on 2/9/21 at 2:09 p.m., Resident G indicated she had not had a bath or shower in the last week. An undated "Look Back Report", dated from 1/10/21 to 2/9/21, indicated the following: Resident G's baths were documented as given on 1/15/21, 1/19/21, 1/22, 2/2 and 2/5/21 . There was no documentation from 1/10 to 1/14 and from 1/23 to 2/1/21 to indicate the resident received a bath. 4. The clinical record of Resident H was reviewed on 2/9/21 at 2:55 p.m. Diagnoses included, but were not limited to, depression, morbid obesity and chronic obstructive airway disease. An undated "Look Back Report" indicated the following: There was no documentation the resident had received a bath from 1/10/21 to 1/18/21 and from 1/22/21 to 2/8/21. In an interview on 2/9/2021 at 9:21 a.m., the resident indicated she preferred to be bathed on Monday and Thursdays. but had not been bathed consistently in recent weeks. Resident H's Activities of Daily Living care plan, dated 1/13/21, indicated an intervention initiated 1/13/21 was to provide Resident H with with a sponge bath if she could not tolerate a full bath or shower.		*Look Back reports will be reviewed by the DON/ADON/designee 3 times weekly. Issues will be reviewed during scheduled IDT meetings for correction.* ***4) How the corrective actions will be monitored:*** *The responsible party for this plan of correction is the Director of Nursing/designee with Administrative oversight.* *The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* *5) Date of compliance: 3-11-21*	

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	On 2/9/21 at 3:20 p.m., a revised policy titled "Bathing- Shower and Tub Bath", dated 1/31/18, was received from the Assistant Director Of Nursing (ADON) as current. The policy indicated the resident would be offered a shower or bath according to the resident's preference twice a week and as needed or requested. During an interview on 2/9/21 at 9:45 a.m., CNA 6 indicated frequently, first and second shift were short staffed and resident showers were not always getting done. During an interview on 2/9/21 at 2:55 p.m., the ADON indicated Resident E, Resident F, Resident G and Resident H should have received their showers. This Federal tag relates to Complaints IN00339015, IN00339469, IN00340789, and IN00344892. 3.1-3(u)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident received the necessary treatment and services related to failing to administer medications as ordered for 1 of 3 residents reviewed for quality of care. (Resident F)	F 0684	**F 684D Quality of Care** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	03/11/2021

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	Finding includes: The record for Resident F was reviewed on 2-9-2021 at 1:38 p.m. Diagnoses included, but were not limited to, diabetes and osteoarthritis. The MDS (Minimum Data Set) Quarterly assessment, dated 12-15-2020 (corrected version), indicated the resident had moderate cognitive impairment. The resident required an extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene and also required 2 staff for assistance for bathing. The resident had received insulin injections for the past 7 days. A Physician's Order dated 1-15-2021, indicated insulin Lantus solution 100 unit/ml (milliliters) inject 45 units sub q (subcutaneous) daily. The January 2021 MAR (Medication Administration Record) indicated the insulin was not documented as administered on 1-16-2021. A Physician's Order, dated 7-19-2020, indicated Tresiba Flex Touch solution Pen injection 200 unit/ml inject 45 units sub q one time a day for diabetes. This order was discontinued on 1-14-2021. The September 2020 MAR indicated the Tresiba was not documented as administered on September 7, 13, 18, 21 and 25, 2020. The October 2020 MAR indicated the Tresiba was not documented as administered on October 16, 29, and 30, 2020. Current Physician Orders indicated gabapentin		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1)What corrective action(s) will be accomplished for those residents found to have been affected:*** *Resident #F was assessed, medications reviewed per physician. Resident and family notified of assessment and medication review. Medications will be administered as ordered and accurately document administration. Nursing staff promptly educated or administration and documentation of ordered medications.* ***2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Residents residing in the facility that receive medications had the potential to be affected. No	

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	300 mg capsule to be administered 2 times per day for neuropathy. A review of the January 2021 MAR indicated gabapentin 300 mg capsule was not documented as administrated on January 19, 2021 for the bedtime dose. Resident F was listed as interviewable on a list provided by the facility on 2-9-2021 at 10:30 a.m. An interview with Resident F on 2-9-2021 at 9:55 a.m., indicated the full insulin dose was not administered consistently and sometimes the insulin was not administered at all. The resident also indicated she did not get the bedtime gabapentin medication a couple weeks ago and in the morning she was really hurting. An interview with Resident F's family member on 2-9-2021 at 10:38 a.m., indicated the biggest concern was for the resident getting the medications including the insulin as ordered. The ADON provided a current "Physician Orders--Entering and Processing" policy, revised on 1-31-2018, on 2-9-2021 at 3:23 p.m. This policy did not address the administration of medications. No further policies were presented. This Federal tag relates to Complaint IN00339469. 3.1-35(g)(1)		negative outcomes were identified. Audit was conducted of MAR and TAR to identify documentation/administration concerns. Residents interviews were conducted to determine concerns/satisfaction with medication administration. Concerns were addressed timely. ***3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** *Re-education on medication administration and documentation.* *Medication Administration Audit Report completed for missing medication documentation daily per nursing. Results reviewed daily during scheduled clinical meeting.* *Identified Licensed Nursing staff will be provided additional education and or disciplinary action.* Observation per DON/designee of Licensed Nursing staff during medication administration 3 times weekly to include all shifts. Random interviews of 3 residents weekly to determine satisfaction	

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			with medication administration. Concerns addressed immediately. ***4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place*** The responsible parties for this plan of correction is the Executive Director and Director of Nursing. Results of audits will be presented to QAPI monthly for 6 months and or until facility reaches 100% compliance for 3 months consecutively. At that time QA team can make recommendations to continue with auditing and or make changes to the plan of correction. Compliance will be determined based on results of audits. ***5) Date of Correction:*** ***3-11-21***	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure wound treatments were completed as ordered for 3 of 4 residents reviewed for pressure ulcers. (Resident F, Resident G and Resident P) Findings include: 1. The clinical record for Resident F was reviewed on 2/9/2021. Physician Orders, dated 1/21/2021, indicated to cleanse the wound to left heel with wound cleanser, pat dry, and apply Betadine every shift and PRN (as needed). The TAR (Treatment Administration Record), dated February 2021, indicated no documentation	F 0686	***F 686D Treatment/Svcs to Prevent/Heal Pressure Ulcer.*** ***The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is pre. pared and/or executed solely because it is required by the provisions***	03/11/2021

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	the facility provided the treatment on 2/3 and 2/7/2021. 2. The clinical record for Resident G was reviewed on 2/9/2021. Physician Orders, dated 1/13/2021, indicated to cleanse a sacral wound with wound cleanser, pat dry, apply hydrogel and cover with foam dressing daily on day shift. A second order, dated 12/20/2020, indicated to paint the DTI (deep tissue injury) on the right heel and left lateral ankle with Betadine daily on day shift. A third order, dated 1/25/2021, indicated to apply skin prep wipes to both heels every shift for pressure. The TAR, dated February 2021, had no documentation to indicate the facility provided the treatments to the sacral, right heel, and ankle on 2/3 and 2/7/2021, and no documentation to indicate night shift performed the skin prep treatments to both heels on 2/1 and 2/6/2021. During an interview on 2/9/2021 at 2:00 P.M., Employee 8 indicated she spoke to the nurse responsible for Resident G's treatments on 2/3. The nurse had told her she thought the wound rounding nurse was going to do the treatment; and the wound rounding nurse thought the staff nurse was going to do it. Employee 8 indicated it was a miscommunication and the treatments were not done. 3. An interview with Resident P on 2-9-2021 at 11:45 A.M., indicated he was supposed to have daily wound care on his left foot for a pressure area. Observation of Resident P's dressing on his left foot on 2-9-2021 at 11: 48 A.M. indicated the		***of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** *Residents F, G, and P were assessed, orders reviewed, treatments completed care plans updated. Family and Physician notified of treatments and wound updates. Inservice provided to all nursing staff on wound and pressure ulcer policy and guidelines for prevention and treatment of pressure ulcers.* ***2)How the facility identified other residents:*** *Any residents residing in the building had the potential to be affected. Facility Skin Sweep was completed to ensure that treatments have been provided as ordered. Weekly skin assessments will be completed as per policy. Any identified skin issues are reported to primary care physician, DON/ Administrator. Orders are received for treatments and Care plans updated. Medication/Treatment Administration Review occurs at scheduled daily clinical meetings to identify treatment documentation. Issues identified will be immediately addressed.* ***3)Measures put into place/ System changes:*** *Inservice provided to all nursing staff on wound and pressure ulcer policy and guidelines for prevention and treatment of pressure ulcers.*	

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	dressing was dated 2-6-2021. A list of interviewable residents provided by the facility at 10:30 A.M. on 2-9-2021 indicated Resident P was able to be interviewed. The facility policy, titled "Skin Condition Assessment & Monitoring-Pressure and Non-Pressure," revised 6-8-18, indicated, "Wound Assessment/Measurement: ... 7. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. ... 8. A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered ...." This Federal tag relates to Complaints IN00335013, IN00335972, IN00339469, IN00340789, and IN00344892 3.1-40		*Medication/Treatment Administration Review occurs at scheduled daily clinical meetings to identify treatment documentation. Observation per DON/designee of Licensed Nursing staff during medication/treatment administration 3 times weekly to include all shifts. Random interviews of 3 residents weekly to determine satisfaction with medication /treatment administration. Concerns addressed immediately.* ***4)How the corrective actions will be monitored:*** *The responsible party for this plan of correction is the Director of Nursing with Administrator oversight. The results of these audits/interviews will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* ***5)Date of compliance:*** *03/11/2021.*	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure incontinence care was provided promptly for 1 of 5 residents reviewed for activities of daily living (ADL's). (Resident J)	F 0690	**F 690D** **The facility requests paper compliance for this citation.**	03/11/2021

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	Findings include: On 2/9/21 at 2:23 p.m., Resident J's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and acute renal failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/2020, indicated Resident J was alert and oriented, required extensive assist with toileting and was occasionally incontinent of bladder. On 2/9/21 at 930 a.m., the following was observed during continence care: Resident J was in his room sitting up in his bed. The Resident's bed was located against the wall. Under the resident's bed on the linoleum floor, where the resident's hips and buttocks were located on the mattress, was a light yellow colored stain round in shape. The stain continued out from under Resident J's bed all the way out to the middle of the floor. Staff did not notice the yellow substance on the floor. CNA 6 explained the procedure to the resident then washed hands, donned gloves, ran water over both of the washcloths and applied peri-wash to 1 washcloth. CNA 6 removed the resident's incontinent brief. On the inside of the brief by the resident's left thigh was a dark brown stain in the elastic part of the brief. CNA 6 provided incontinence care then assisted the resident on his right side. CNA 6 removed a folded up cream colored blanket from under the res buttocks. The blanket smelled of a strong odor of urine. CNA 6 placed a towel under the resident's buttocks, finished incontinence care then applied an incontinent brief. CNA 6 then stepped in the dried yellow substance and her shoe briefly stuck to the floor. In an interview on 2/9/21 at 9:45 a.m., CNA 6		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J was assessed, incontinent care was provided, linens changed, and yellow stain cleansed from the floor. Orders reviewed, and care plan updated to reflect ADL status. **2) How the facility identified other residents:** Audit was conducted to identify those residents that were assessed to be incontinent and required assistance with ADL's. Any resident had the potential to be affected, however no negative outcomes were identified. **3) Measures put into place/ System changes:** Nursing staff which includes licensed nurses, QMA's and	

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	indicated her shift had started 7:00 a.m. There were no CNAs from third shift to do bed check with, so CNA 6 and the first shift nurse had gone from room to room, but did not check any of the residents for incontinence like the CNAs are suppose do at shift change. The yellow substance on the floor was not there when CNA 6 had delivered the resident's breakfast tray. CNA 6 indicated frequently there were no thrid shift CNAs still on the unit to do bed check when day shift started. She indicated the residents should be checked every 2 hours and provided with incontinence care as needed. On 2/9/21 at 2:55 p.m., an interview with the Assistant Director Of Nursing (ADON) indicated Resident J was alert and oriented. There was a language barrier which made it difficult at times to ensure the resident comprehended what was being said. This Federal tag relates to Complaint IN00339015. 3.1-41(a)(2)		C.N.A's were educated on the provision of incontinent care. IDT team will observe for the provision of incontinent care during daily Angel Rounds. Identified areas will be corrected immediately. **4) How the corrective actions will be monitored:** The Director of Nursing / designee will be the responsible party for this plan of correction. Audits will be conducted 3 times weekly to include all shifts for the provision of incontinent care and timely assistance with ADL care. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **3-11-21**	
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical,			

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UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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	mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure enough direct care nursing staff was available to meet the needs of the residents, related to toileting, call light response, dressing changes, care rounds, bathing and other activities of daily living (ADL's), which had the potential to affect the 78 residents who resided in the facility. Findings include: 1. On 2-9-2021 at 10:57 a.m., the following was observed: a. West Hall, one nurse was observed passing medications. 2 CNAs (Certified Nurse Aide) were observed on the hall. An interview at 10:58 a.m. with Nurse 4 indicated there were 34 residents on	F 0725	***F 725 Sufficient Nursing Staff*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	03/11/2021

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	West hall. Nurse 4 indicated she was the only nurse working the hall and there was not a QMA (Qualified Medication Aide) assigned to assist her. Nurse 4 indicated there were 2 CNAs working with her. At 10:59 a.m., the Unit Manager was observed sitting at the West hall desk. She indicated she was the Unit Manager for the whole building and was waiting on a fax. The Unit Manager's name was not on the schedule as providing direct care to residents. b. On the East Hall at 11:00 a.m., one nurse was observed leaving a resident room, one QMA was passing medications, and 2 CNAs were observed on the hall. An interview with Nurse 1 indicated there were 44 residents on the East Hall. In an interview at 11:02 a.m., CNA 10 indicated a third CNA was assigned, but the CNA had to go out with a resident for an appointment. c. Confidential Resident interviews were conducted with interviewable residents identified on a list provided by the facility on 2-9-2021 at 10:30 a.m. A confidential interview with a resident indicated the facility had agency staff that would constantly say they could not provide the care needed. A confidential interview with a resident indicated there were too many agency staff at the facility. The resident indicated they have had to wait 1-2 hours with their call light on for staff to answer the light to be changed and upper management staff had to be contacted in order to get the assistance needed to be changed. The resident also indicated the wound treatments on her heel and bed baths were not being completed as		*required by the provisions of federal and state law.* ***1) Immediate actions taken for those residents identified:*** *Facility resident interviews were conducted by DON/Designee/Social Services to identify concerns regarding provision of toileting, call light response times, dressing changes, care rounds, bathing and activities of daily living.* *Staffing patterns were reviewed/revised to ensure appropriate staffing levels were met.* ***2) How the facility identified other residents:*** *Any resident that resides in the facility had the potential to be affected.* *Resident interviews conducted regarding toileting, call light response times, dressing changes, care rounds, bathing and activities of daily living. Audit was conducted of the TAR to identify those residents that receive treatments. Any areas of concern were addressed timely.* ***3) Measures put into place/ System changes:*** *Staffing will be reviewed daily by the Administrator/Director of Nursing and to determine appropriate staffing available to*	

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	scheduled. A confidential interview with a resident indicated there was supposed to be daily wound care for a pressure area. An observation of the dressing indicated the date on the dressing was 2-6-2021. The resident indicated the nurse had been in to administer medications but did not change the dressing at that time. The nurse did not have time as the nurse had to finish the medication pass to the other residents. The resident indicated the facility just did not have enough nurses to ensure the dressing was changed daily. A confidential interview with a resident who was recently admitted, indicated their arrival time was 12:30 p.m. and nobody came to help her get cleaned up until 7:00 p.m. The entire night went by without anyone checking in until 2:00 p.m. the next day. The resident indicated no one came and changed the wet bed pads and the wait time for the call light to be answered was sometimes an hour while sitting in wet pads. The resident indicated they didn't have enough staff as "1 person couldn't get 25 people up" and 2 staff were needed to assist with changing pads. The resident also indicated water was just brought to the room near lunchtime, when the shift began at 7:00 a.m. A confidential interview with a resident indicated there was not enough staff and waiting for call lights to be answered took forever. The resident indicated the facility did not have a reliable staff and did not know what staff was going to show up to work or who was going to call off. The resident also indicated bed baths were not being done as scheduled. A confidential interview with a resident indicated		*meet the needs of the residents.* *Emergency staffing agenda reviewed which includes Agency usage.* *Facility Managers that provide direct resident care will be placed on the daily schedule.* *Provision of On-Call rotation to support staffing needs.* *Manager on duty for weekend rotation will review and ensure staffing is appropriate. If problems noted the Administrator/On Call staff are contacted.* *Education provided on the provision of toileting assistance, call light response time, ADL's, Medication Administration Audit Report completed for missing treatments documentation daily per nursing. Results reviewed daily during scheduled clinical meeting.* *Education provided on call light response time.* *Facility rounding will be completed daily during Angel rounds for identification of* *Areas identified will be brought to the attention of the Administrator.* *for delegation of correction* ***4) How the corrective actions will be monitored:*** *Daily review during morning meeting, of staffing patterns to determine enough staff is scheduled to meet resident needs per Administrator and Director of*	

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	there was not enough staff and the staff did not pass ice water. The resident indicated the water in the pitcher on the overbed table was from the prior evening. No ice was available as the ice machine was broken. If assistance was needed to get to the bathroom, it took a while for staff to get there. Then, when getting to the bathroom, there was frequently either a bowel movement mess on the toilet or a bedpan that needed to be emptied on the toilet, which needed to be taken care of prior to transferring to the toilet. d. Confidential staff interviews were conducted on 2-9-2021 and indicated the following: A confidential interview with nursing staff indicated shift change was at 7:00 am. There were no CNAs from third shift to complete the resident bed check with, so the nursing staff and the first shift nurse had gone from room to room, but did not check any of the residents for incontinence like the CNAs are supposed to do at shift change. The nursing staff indicated there were a lot of times when the first shift starts, there was not third shift CNA to provide a report. Residents should be checked every 2 hours and provided with incontinence care as needed. Frequently first and second shift were short staffed and resident showers were not always getting done. A confidential interview with nursing staff indicated there was not enough staff for the number of residents to meet their needs on the shift. Confidential interviews with 2 nursing staff indicated there were a lot of residents which required 2 staff assist for care. Confidential interviews with 2 additional nursing		*Nursing* *Director of Nursing/designee will randomly audit weekly to include all shifts concern related to Activities of Daily Living which includes the provision of care, toileting/bathing and call light response times.* *Observation of treatments/dressing changes and documentation 3 times weekly (to include all shifts) per Director of Nursing/designee.* *The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* ***5) Date of compliance: 3-11-21***	

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	staff indicated there were a lot of 2 staff assist residents and there was not enough staff to take care of the needs of the residents. e. A review of the nurse staff schedule for a census of 78 residents on 2-9-2021 was provided by the facility at 10:40 a.m., and indicated the following: On West Hall for 1st shift, 2 nurses and 4 CNAs were listed. On East Hall, a nurse, a QMA, and 4 CNAs were listed on the schedule. Next to the name of one CNA, it was marked "to West Hall." The actual staff assigned to resident care on 2-9-2021 were 2 LPNs, 1 QMA, and 4 CNAs for the entire facility. 3 nursing staff were scheduled to pass medications. The West hall nurse had 34 residents, the East hall nurse and QMA would have had 22 residents each. For assessment and treatments, the West hall nurse was responsible for 34 residents and the East Hall nurse was responsible for 44 residents. The CNAs on West hall would have been responsible for 17 residents each for toileting/incontinence care, bathing, passing ice water and meals and on East hall each CNA would have been responsible for 16 residents each for the same tasks. The CNAs would have had to work together to provide 28 of the 78 residents who required 2 staff assist for care. A list of residents who required 2 staff assist for care was provided by the facility on 2-9-2021 at 1:03 p.m. The were 15 of 34 residents on West hall who required 2 assists for care and 13 of 44 residents on East hall who required 2 assists for care. In an interview with the Administrator on 2-9-2021 at 12:15 p.m., she indicated on the nursing schedule for West hall, one nurse was not there			

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	and 2 CNAs were no shows. For one of the CNAs scheduled, this date would have been her first day. The other 2 CNAs on the West Hall were agency staff. For East Hall, the Administrator indicated the nurse and the QMA were agency staff and there were 3 CNAs on the hall, but one CNA was out with a resident for an appointment. One CNA assigned to East hall was re-assigned to West hall. An interview with the ADON (Assistant Director of Nursing) on 2-9-2021 at 2:50 p.m., indicated the Administrator did the scheduling. The ADON indicated the facility was short staffed and the facility was using 2 agencies for staffing. The managers who were CNA/QMA/nurse certified were on an on-call rotation to assist with staffing. None of those managers were listed on the schedule for 2-9-2021 for first shift. A current copy of the Facility Assessment, last updated on 2-2-2021, was provided by the facility on 2-9-2021 at 10:30 a.m. The Facility Assessment indicated "...The purpose of the assessment is to determine what resources are necessary to care for residents competently...Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well being...Facility resources needed to provide competent care for residents, including staff, staffing plan...Licensed Nurses: RN, LPN, providing direct care...Total # of Licensed Nurses staffed per shift on average Day shift: 3...." 2. On 2/9/21 from 11:55 a.m. to 12:03 p.m., a continuous observation was conducted in the hallway just outside Resident F's room indicated the following: Resident F's call light was on and visible from the hallway. 4 staff members walked			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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	past Resident F's room., and returned, walking past the room again, without answering Resident F's light. On 2/9/21 at 3:20 p.m., the Call light policy, revised on 2/2/18, was received from the Assistant Director Of Nursing (ADON). The policy indicated "All staff should assist in answering call lights. Nursing staff members shall go to resident room to respond to call system and promptly cancel the call light when the room is entered." In an interview on 2/9/21 at 2:55 p.m., the ADON indicated someone should have answered Resident F's call light as they passed the room. This Federal tag relates to Complaint IN00335013. 3.1-17(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			

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	(iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;			

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UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview, and record review, the facility failed to ensure a resident's fall was accurately documented for 1 of 3 residents reviewed for accidents. (Resident H) Findings include: On 2/9/2021 at 11:45 a.m., Resident H was observed in her room, lying in her bed, she grabbed the side rails of the bed to adjust herself in bed. During an interview on 2/9/2021 at 11:40 a.m., Resident H indicated she had a fall in January 2021, and had severe back pain since then. She indicated the fall happened in her bathroom. The toilet was low and it was hard for her to get up from the sitting position. A female CNA (Certified Nurse Aide) was with her and had suggested she scoot forward on the seat. When she did, she went down on the floor. 4 staff and 2 lifts were used to assist her off the floor. She indicated the NP (Nurse Practitioner) had known about the fall and prescribed her prednisone for the pain in her back. She indicated she had come to the facility for rehab and was doing well until the fall occurred. Resident H's record was reviewed on 2/9/2021 at 2:35 p.m. Diagnoses included, but were not	F 0842	***F 842D Medical records*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1)Immediate actions taken for those residents identified:*** *Resident H was assessed. No further falls have occurred since reported fall in January. Care Plan was reviewed and updated as needed. Nursing was educated on Fall Prevention Program with a focus on documentation*	03/11/2021

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	155567	A. BUILDING 00 B. WING	02/09/2021

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	limited to: heart disease, depression, and weakness. The MDS (Minimum Data Set) Quarterly Assessment, dated 1/20/2021, indicated the resident was cognitively intact. A Post Fall Evaluation, dated 1/21/2021 at 5:42 p.m., indicated that a fall had occurred on 1/20/2021 at 4:45 p.m., but was not witnessed. The fall had occurred in the bathroom of the resident's room. The resident had been trying to move forward on the toilet seat. An IDT (Interdisciplinary Team) note, dated 1/25/2021, included a summary of the fall. The report indicated the resident and her sister stated two different times that the resident fell. The staff on shift during the fall were interviewed and staff stated that they did not have to get the resident off the floor and that no fall had occurred. The note indicated the root cause of the fall was weakness, and indicated the Care Plan was updated. A Risk Management note, dated 1/25/2021, indicated a fall that had occurred on 1/21/2021. The resident and her sister had different times as far as when the fall happened. The writer of the note had indicated they interviewed multiple staff members who worked the night of 1/21/2021, during the time of said fall, and per staff, no fall occurred. There was no documented interviews of who or when staff was interviewed. A Risk Management note, dated 1/25/2021 at 10:05 a.m., by the ED (Executive Director), indicated the resident had reported she fell off the toilet on 1/20/2021 at 4:45 p.m. The sister of the resident, had called to inform the facility of the fall and		*requirements.* ***2)How the facility identified other residents:*** *Any resident that resides within the facility had the potential to be affected however none were identified.* *Audit was conducted for the last 30 days (of falls) to identify accurate documentation is present.* ***3)Measures put into place/ System changes:*** *Education provided to Nursing staff on completing Risk Management documentation.* *Director of Nursing/designee will review within 24 hours of event for accuracy.* *Fall Follow up Log (Audit Log) utilized to ensure required documentation is completed.* *Falls/Events reviewed during scheduled stand-up meetings to review documentation is complete and accurate.* ***4)How the corrective actions will be monitored:*** *The responsible party for this plan of correction is the Director of Nursing with Administrator oversight. Falls will be reviewed during daily scheduled stand-up meeting to ensure documentation is reflective of event and accurately documented.* *No issues revolve around those*	

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	indicated the resident fell out of bed at 7 p.m., while using the bedpan. The resident and sister stated it took 4 staff members and 2 pieces of equipment to get the resident off the floor. The resident description indicated the resident was sitting on the toilet when she scooted forward and fell off the toilet. The description of action taken was they encouraged the resident to use call light for assistance. The document also indicated the resident was confused. The resident had no diagnoses of dementia, or cognitive impairment, and had a BIMS score of 15 (cognitively intact). During an interview on 2/9/2021 at 3:44 p.m., the ADON (Assistant Director Of Nursing) indicated there was no Progress Note documented of the fall by staff on duty. A current facility policy, Fall Prevention Program, dated 11/21/2017, provided by the ADON on 2/9/2021 at 3:32 p.m., indicated the following: "...Immediate change in interventions that were successful. Documentation requirements. Care Plan incorporates: Addresses each fall. Interventions are changed with each fall, as appropriate..." This Federal tag relates to Complaint IN00344892. 3.1-50 (a)		*residents that currently reside in the facility. Electronic record maintenance will be reviewed monthly during Quality Assurance Meetings until 100% compliance has been achieved for 3 months. QA committee will make recommendations to revise the plan of correction as indicated.* . ***5)Date of compliance:** 3-11-21*	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain the	F 0921	***F 921 F Environment*** ***The facility requests paper***	03/11/2021

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	environment in clean and good repair on three of three hallways throughout the facility. (100, 200 and 300 Halls) Findings include: 1. 100 Hall a. In an observation on 2-9-2021 at 9:42 A.M. there were dust bunnies by the baseboard at the 100 hall Nurses station. b. In an observation on 2-9-2021 at 9:43 A.M. in room 107, there was a large spot of yellow dried substance on the floor about 6 inches in diameter, connected to another area of dried yellow substance about 12 inches long by about 3 inches wide connected to a pooled yellow substance about 4 inches in diameter under bed B. c. In an observation on 2-9-2021 at 9:45 A.M. by room 117, 3 spherical brown pellets about 1/4 inch in diameter were observed in the hall by the isolation cart. The housekeeper was observed at the other end of the hall with the housekeeping cart. d. In an interview on 2-9-2021 at 10:06 A.M., Housekeeper 5 indicated there was a floor tech to take care of the floors. He indicated the facility had a check sheet that the housekeepers were to follow to clean rooms. Housekeeper 5 indicated CNAs were to clean bed frames and wheelchairs. There was no mop water observed in the mop bucket and the bucket was observed to be dry. e. In an observation on 2-9-2021 at 1:22 P.M., by room 117, spherical brown pellets about 1/4 inch in diameter were observed in the hall by the isolation cart. Dust bunnies were observed by the baseboard at the nurse's station. The		***compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1)Immediate actions taken for those residents identified:*** *No resident was identified to have been affected.* *1.100 Hall* *A) Dust Bunnies on the baseboard at Nurses station were cleaned.* *B) Room 107 was deep cleaned.* *C) 3 Brown pellets by rm 117 were removed.* *D) Housekeeper #5 was re-educated on room cleaning procedures.* *2.200 Hall* *A) Transition strip replaced, and area cleansed* *B) Maintenance Director will review daily work orders with Administrator for scheduled repair.* *C) Room 206 floor was mopped.* *D) Housekeeping Duties Checklist*	

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	Housekeeping cart was observed to be at the end of the hall, past room 117. The housekeeper was overheard to tell a resident they were done for the day. 2. 200 Hall a. During an observation on 2-9-2021 at 10:10 A.M., the transition strip in the hall floor by room 206 was damaged/ missing with black residue on the floor at the transition about 1 inch wide where the transition stir would have been located. Housekeeper 5 indicated the strip had been damaged since he began work several months ago. b. During an observation on 2-9-2021 at 10:12 A.M., the threshold to room 206 was observed to be damaged/missing with black residue about 1 inch wide between the hall and room floors. In an interview on 2-9-2021 at 10:22 A.M., the Maintenance Director indicated the facility had asked for monies and were working on getting funding for paint and new flooring, but the capitol expense had not been approved yet. He did fix a window recently that had been broken. The staff were to make out a work order when they observed something needing repair, and he was to fix the request the day he got the work order or as soon as he could get parts thereafter. c. In an observation on 2-9-2021 at 2:42 P.M., the floor in room 206 was noted to be sticky. In an interview on 2-9-2021 at 2:42 P.M., Resident H indicated the housekeeper had not mopped that day. A review of the interviewable list provided by the facility on 2-9-2021 at 11:45 A.M. indicated		*will be reviewed/initialed by Administrator 2times weekly to determine completion.* *3.300 Hall* *A) Plastic cup and lid were disposed of and baseboard was dusted by rm 307.* *B) Room 210 and 309 screens were replaced* *C) Wall was cleaned behind the sink* ***2)How the facility identified other resident:*** *No resident was identified to have been affected related to identification of needed facility repairs.* *Facility wide walk through was completed by Administrator, Maintenance Director and Housekeeping Supervisor to identify facility needed cleaning and repairs.* ***3)Measures put into place/ System changes:*** *Maintenance added identified needed facility repairs to Preventative Maintenance. Log and with Administrator assistance prioritized needed repairs.* *Housekeeping Supervisor and Administrator reviewed/revised cleaning checklist.* *Identified area of needed repairs were placed on a repair schedule.* *Educated staff to notify their supervisor should any resident*	

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	Resident H was alert and able to be interviewed. A review of the room pull out schedule, provided by the facility on 2-9-2021 at 10:30 A.M., indicated room 206 had a deep cleaning, including the floor mopped on January 9th, 2021. A review of the Daily Housekeeping Duties checksheet indicated the rooms on the East hall (200 hall) had been swept and mopped on 2-8-2021. The checksheet indicated to dust in the halls weekly. The checksheet for the South hall (300 hall) was last completed on 2-6-2021, with no documentation the housekeeping tasks were completed on 2-2 or 2-3 2021. There was no check sheet provided to address the West hall (100 hall). 3. 300 Hall a. In an observation on 2-9-2021 at 11:16 A.M., a plastic lid cover and plastic cap were observed on the floor in the hallway by room 307. Dust bunnies were observed by the baseboard. The housekeeping cart was in the middle of the 300 hall. b. In an observation on 2-9-2021 at 1:38 P.M., a review of facility windows and screens was conducted. The screen in the window of room 210 was torn screen about 12 inches, held onto the screen frame with duct tape. Room 309 had a torn screen about 18 inches held onto the screen frame by strips of duct tape. In an interview on 2-9-2021 at 1:46 P.M., Resident L indicated the screen had been torn a long time, and although he had told the staff about it, the screen had not been fixed. A review of the interviewable list provided by the facility on 2-9-2021 at 11:45 A.M. indicated		*voice concerns regarding. Maintenance (repairs) or Housekeeping (cleanliness). Angel Rounds will be completed 5 times weekly to identify any areas of needed repair or cleaning and reviewed in scheduled stand-up meeting.* ***4)How the corrective actions will be monitored:*** *Responsible party for this plan of correction is the joint effort of the Administrator/Maintenance Director/and Housekeeping Supervisor who will round 2 times weekly. Identified areas are placed on a PM log for follow up. Cleaning issues identified will be immediately addressed.* *The results of these audits will be reviewed in QAPI monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* ***5)Date of compliance: 3-11-21***	

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	Resident L was able to be interviewed. c. In an observation on 2-9-2021 at 2:17 P.M., a plastic lid cover and plastic cap were observed on the floor in the hallway. Dust bunnies were observed in the hall by the baseboard by room 307. The housekeeping cart was not visible in the hall. This Federal tag relates to Complaints IN00333814, IN00335013, IN00335399, IN00339015, IN00340789, and IN00345822. 3.1-19(e)			
F 9999 Bldg. 00	3.1-13(g)(1) Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This State rule was not met as evidenced by:	F 9999	***F 9999 FINAL OBSERVATIONS*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1)Immediate actions taken for those residents identified:*** *Resident #I no longer resides within the facility. Reportable was completed and submitted to Indiana State Department of*	03/11/2021

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	Based on record review and interview, the facility failed to inform the Indiana State Department of Health (ISDH) of an unusual occurrence related to an overdose for 1 of 3 residents reviewed for reportable incidents. (Resident I) Finding includes: Resident I's record was reviewed on 2/9/2021 at 12:11 p.m. Diagnoses included, but were not limited to: substance abuse, hepatitis C, and heart disease. A Progress Note, dated 1/18/2021 at 12:44 p.m., indicated Resident I had been nodding off during his Care Plan meeting. A Progress note, dated 1/18/2021 at 12:54 p.m., indicated the NP (Nurse Practitioner) was there to make a visit related to a Blood Drug screen and an earlier administration of Narcan (a medication to counter the effects of an overdose). Physician Order's indicated give Narcan liquid 4 mg (milligrams)/0.1 ml (milliliters), 1 spray in the right nostril one time only, dated 1/18/2021. A Progress Note, dated 1/18/2021 at 10:14 p.m., indicated Resident I had been found in his room impaired, and hard to arouse. Vital signs were as follows: BP (blood pressure) 136/76, pulse 136, and an oxygen saturation level of 82%. A Nurse Practitioner ordered the resident be sent to the hospital. A review of the Care Plans indicated there was no Care Plan implemented for Substance Abuse. During an interview on 2/9/2021 at 11:11 a.m., the ED (Executive Director) indicated there was no		*Health. Nursing staff and management were educated on timely reporting requirements to Indiana State Department of Health per facility policy.* ***2) How the facility identified other residents:*** *Any resident had the potential to be affected, however none were identified. Interviews were conducted with facility staff and residents to determine/ensure no other events/allegations required reporting.* ***3) Measures put into place/ System changes:*** *Education provided to facility staff on reporting allegation/events and requirement of timely reporting per facility policy. Weekly interviews with 3 residents per social services to determine no unreported events or allegations exist. Should any be identified reporting will occur immediately, re-education will be provided, and disciplinary actions taken as appropriate. Abuse/reporting audit completed 2x weekly per Director of Nursing/designee. Corporate Director of Clinical Services will review all reportable events with Administrator. Reportables will be reviewed daily during scheduled departmental meetings to ensure timely reporting and follow up. All staff will be educated on Abuse Prevention and reporting requirements upon hire, Annually and as needed.*	

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	documented unusual occurrence report to ISDH completed for Resident I's overdose. A current facility policy, "Abuse Prevention and Reporting-Indiana", dated 1/22/2019, was provided by the facility as current on 2/9/2021. The policy indicated the following: "...Timing of reporting...not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. If reasonable suspicion exists that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report shall be made to local law enforcement and ISDH within 24 hours of when the suspicion was formed..." This state finding relates to Complaint IN00345822.		***4) How the corrective actions will be monitored:*** *The responsible party for this plan of correction is the Administrator/ Director of Nursing.* *The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* *5) Date of compliance: 3-11-21*	