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	05/25/2023

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00408505. Complaint IN00408505 - Federal/state deficiencies related to the allegations are cited at F689, F740, and F921. Survey dates: May 24 and 25, 2023 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 4 Medicaid: 55 Other: 4 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 30, 2023	F 0000	6-7-23 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis Indiana 46204 RE : Complaint University Park Rehabilitation and Healthcare 1400 Medical Park Dr Fort Wayne IN 46825 Dear Ms Buroker: On May 25, 2023 a complaint IN 00408505 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with 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. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 6-13-23. Please feel free to all me with any further questions at 1-260-486-3001	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Grabbe	RN Regional Nurse Consultant	06/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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			Respectfully submitted, Goran Prentoski Administrator	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to initiate practices to prevent avoidable accidents due to environmental issues for 2 of 3 residents reviewed for accidents (Resident J and Resident P). Findings include: 1. An Incident Audit Report, provided by the Consultant Nurse on 5/25/23 at 3:06 p.m., indicated on 5/16/23 at 2:32 p.m., Resident J was observed sitting up against the wall in her bathroom. Her sink was detached from the wall and lying on the floor. The resident indicated the sink had been loose and came off the wall "so I fell". She was assessed for injury, vitals taken, and neurological checks completed. During a confidential interview on 5/25/23, Staff 3 indicated although the room had been opened to be occupied, the sink was loose from the wall and had not been secured prior to Residnet J's fall. 2. An Incident Audit Report, provided by the	F 0689	F689 Free of Accident Hazards/Supervision/Devices **This facility request paper compliance of all citations** *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* F689 Free of Accident Hazards/Supervision/Devices 1. **What corrective actions(s) will be accomplished for those**	06/13/2023

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	Consultant Nurse on 5/25/23 at 3:06 P.M., indicated on 4/26/23 at 1:45 p.m., Resident P reported the resident next door who shared his bathroom, slammed the bathroom door shut, the closet door in his room fell and hit him behind his right ear. There was a small scabbed abrasion behind his right ear. The report indicated he was assessed for injury, vital signs taken, neurological checks done, the Nurse Practitioner and Director of Nursing notified. The report hadn't indicated what interventions were put in place to prevent the accident from occurring again. During an observation on 5/25/23 at 9:55 AM, the closet door in Resident P's room was obsereved to be leaning on the wall between the closet and the bathroom door. During a confidential interview on 5/25/23, Staff 3 indicated the Rehab hall, where Resident J and Resident P had accidents, was closed for a period of time so repairs could be made to the rooms and equipment in them. This closure had occurred prior to the 2 residents admission into rooms on the hall. They indicated, the Rehab hall had been reopened prior to all the repairs being completed. Staff 3 indicated they witnessed the closet door on top of Resident P when she entered the room, and she took the door off the resident then stood the door up against the wall between the clset and the bathroom. On 5/25/23 at 2:50 P.M., the Administrator was interviewed. He indicated the closet door, for Resident P, had been fixed previously but he had not been aware it had fallen off again nor that it had not yet been repaired. He indicated they had closed off the Rehab hall due to census and implementation of facility wide changes but had to re-open for needed space and rooms.		**residents found to have been affected by the deficient practice?** Resident J no longer resides in facility, repairs made to sink/room of prior resident. Resident P closet doors secured and functional. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** All residents that reside in the facility has the potential to be affected by deficient practice. Comprehensive review conducted on residents' rooms to ensure all closet doors and sinks are secure and functional. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Facility staff educated on reporting any loose sinks or doors or other hazards noted in facility immediately. Maintenance staff educated on ensuring that all repairs be completed in a timely fashion that could be a safety concern for residents. . **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.**	

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	Refer to F921 for findings related to failure to provide a clean and safe environment for Resident J and Resident P. This Federal tag relates to Complaint IN00408505. 3.1-45(a)		The responsible party for this plan of correction will be the Executive director/ designee. Resident rooms to be inspected for safety hazards weekly and reviewed for repairs requiring immediate repair x 6 months and then will be followed in QAPI thereafter. The results of these audits will be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance 6-13-2023	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview, and record review, the facility failed to develop and implement a comprehensive behavioral care plan for substance use disorder for 1 of 1 residents reviewed (Resident J).	F 0740	**F-740** Behavioral health services **The facility respectfully requests a desk review for this citation**	06/13/2023

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	Findings include: On 5/24/23 at 1:45 P.M., Resident J's record was reviewed. Diagnoses included diabetes, cardiomyopathy (disorders of the heart muscle), alcohol dependence, and cocaine use. An admission MDS (Minimum Data Set) assessment, dated 4/27/23, indicated she had no cognitive impairment. She was non-ambulatory and required extensive assistance with her activities of daily living. A care plan, initiated on 4/22/23, indicated the resident had the potential to be physically aggressive. The goals were the resident would demonstrate effective coping skills and would verbalize understanding of need to control physically aggressive behavior. Interventions were to analyze times of day, places, circumstances, triggers, what de-escalates behavior, document; give resident choices with care; and monitor pain and provide meds. The care plan hadn't indicated if the resident had ever been physically aggressive nor was there a care plan to address the residents substance abuse disorder. A facility form with guidelines for admissions of persons with a history of drug and/or alcohol abuse, was signed and dated by Resident J on 4/21/23. The form provided guidelines residents needed to adhere to while residing in the facility. This included random drug screening, participation in therapy, and discharge from the facility for non-compliance with the rules. An initial history and physical, completed on 4/24/23 by the NP (Nurse Practitioner), indicated		**Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** 1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident J no longer resides in facility **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** Audits conducted of residents that have diagnosis of substance abuse disorder. Care plans updated as indicated. Any other residents with substance abuse disorder have the potential to be affected. **3. What measures will be put**	

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	the resident admitted to the facility for inpatient rehabilitation. Her diagnoses included diabetes, alcohol dependence, cocaine use, cardiomyopathy, and chronic obstructive pulmonary disease. Prior to admission, she had been hospitalized for a gastrointestinal bleed, respiratory distress, and pneumonia. During the NP's exam, the resident was alert, answered questions appropriately, and had no concerns. There was no documentation regarding the resident's current substance use or recommendations made. A Social Services note, dated 4/27/23 at 2:05 p.m., indicated the Social Services Director (SSD) had met with the resident on 4/26/23 to complete an interview. The resident had no cognitive impairment. She indicated she felt depressed and had several mood indicators. She had no mental illness but had diagnoses of alcohol dependence and cocaine use. She was to be referred to psychiatric services. The resident's goal was to return home following completion of therapy. A nurse progress note, dated 4/27/23 at 4:15 p.m., indicated the resident's oxygen level was low, she was lethargic and non-responsive and sent to the hospital for evaluation and treatment. Hospital records, provided by the Administrator on 5/25/23 at 3:06 p.m., indicated the resident was hospitalized from 4/27/23 to 5/3/23. She arrived in the ER with shortness of breath, atrial fibrillation (abnormal heart beat), high blood pressure, and weakness in her left arm and face. She had a urine test positive for cocaine. An addendum, documented by the hospital physician indicated the resident's drug screen had been positive for cocaine. It indicated it would explain the residents symptoms and he was curious how the patient		**into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be identified upon admission and reviewed during clinical meeting for diagnosis substance abuse disorder . Resident with psychosocial concerns/substance abuse disorder diagnosis will be referred to and followed by appropriate psychiatric service providers as indicated. Nursing staff educated on appropriate care and of residents with substance abuse disorder diagnosis and monitoring for substance abuse. **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 party for this plan of correction will be the Director of Nursing/designee. Audits will be conducted weekly of orders/ careplans and diagnosis for new admissions/ current residents for substance abuse disorder or other psychosocial diagnosis concerns will receive appropriate referrals and services as indicated. Audits to be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive	

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	had exposure to cocaine despite being a nursing home resident. A nurse progress note, dated 5/10/23 at 2:56 p.m., the resident had been in her room shivering and saying she was cold. She had a blanket over her and the heater turned up to 88 degrees. The NP was notified. Orders were obtained for a chest x-ray and urine drug screen. The resident had a male visitor in her room. The visitor had brought her food and then took her outside to smoke. Per staff, the male visitor had an odor of marijuana. The NP and Director of Nursing (DON) was notified. On 5/11/23 at 11:33 a.m., a urine drug screen was obtained. On 5/15/23 at 11:58 a.m., the resident was visited by the psychiatric NP for an initial visit for alcohol dependence and cocaine use. The progress note hadn't indicated the resident had recently been hospitalized with symptoms of cocaine usage and positive drug screen. The note indicated, during her visit, the resident had been sitting up in a chair, engaged in conversation, and talked about having anxiety though there was no visible anxiety observed. The resident was not on any psychotropic medications. The assessment was alcohol dependence and cocaine abuse. The plan was to provide support and guidance. A nurse progress note, dated 5/16/23 at 7:42 a.m., the NP was notified of positive cocaine urine drug screen from 5/11/23. -At 2:32 p.m., an incident report indicated the resident was observed sitting up against the wall in her bathroom. Her sink was detached from the wall and lying on the floor. She was assessed for injury, vitals taken, and neurological checks		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 : 6-13-23	

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	completed. -At 4:29 p.m., the resident vomited in a cup at the bedside and appeared lethargic. She was falling asleep while trying to answer questions. She complained of a headache and nausea. The NP gave orders to send to the hospital for evaluation and treatment. -At 6:51 p.m., the hospital notified the nurse that the resident could be picked up and brought back to the facility. Her scans were negative but some of her bloodwork was abnormal. She was eating and drinking with no further vomiting or nausea. -At 8:40 p.m., Resident J returned to the facility. There were no new orders and the plan of care was to continue. On 5/25/23 at 1:56 P.M., the SSD was interviewed. She indicated there had been a care plan meeting conducted on 5/15/23 with the resident and her sister regarding the resident's positive drug screen. She indicated she had not finished the documentation in the medical record and was unable to locate her notes. There were no changes made to the care plan following Resident J's hospitalizations and positive drug screens. A current policy, titled "Castle Healthcare Drug and Alcohol Abuse" and provided by the Consultant Nurse on 5/25/23 at 4:29 P.M., indicated the following: "Guidelines for Admission with History of Drug and/or Alcohol Abuse: The resident will be asked to sign an agreement to adhere to the guidelines upon admission. This facility is not a drug or alcohol rehabilitation center. Random drug screens and/or alcohol level checks. If any positive drug screens or alcohol level checks come back as failed the resident's medications will be reviewed and any prescribed narcotics will be subject to discontinuing or lowering the dosage. Room			

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	checks if there is any suspicion of relapse. Resident may be present at time of the check. Visiting hours will be from 8 am to 5 pm for those residents identified with recent history of drug/alcohol abuse. If needing Medicaid application submitted by the facility, the resident may be asked to stay at least 60 days. Resident MAY need to attend AA meetings provided at the facility. Resident will be seen by psychiatric services and OR psychiatric NP. Residents are not permitted to keep their personal vehicles on facility property during their stay. The facility encourages no LOA's (leave of absence) from the facility during the first 14 days due to assessment period unless going out to a physician appointment. Failure to follow above guidelines may result in discharge." This Federal tag relates to Complaint IN00408505. 3.1-37			
F 0921 SS=E 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 and interview, the facility failed to maintain a clean and functional environment for 19 rooms affecting 36 residents residing in the facility. Findings include: On 5/24/23 at 9:36 A.M., during an initial tour, the following was observed: -In room 203, where 2 residents resided, the floors	F 0921	**F-921 Safe/Functional/Sanitary/ Comfortable Environment** **The facility respectfully requests a desk review for this citationPreparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is**	06/13/2023

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	were streaked with brown debris. -In room 204, where 2 residents resided, the floors were streaked with brown debris. -In room 205, where 1 resident resided, a top dresser drawer was broken and laid in the drawer. 1 of 2 closet doors was off the top track and hung by the bottom track. The floor was streaked with brown debris. In the bathroom, shared with 2 residents in room 207, the floor had brown and black streaks, smelled of ammonia, and had an orange bedpan sitting across the stool with a brown streaked plunger resting in the bedpan. -In room 217, where 2 residents resided, there was a strong odor of ammonia and body odor. The window blinds were torn in half and hadn't covered the window. The closet doors were missing and on the closet floor were several stuffed cardboard boxes. Personal items were overflowing over the bedside stand and onto the floor which had black scuff marks and brown debris. 1 of the residents present during the observation, indicated he had requested, numerous times over the past years for the blinds to be replaced but they never had been. -In room 202, where 2 residents resided, was crowded and cluttered. Both residents had many personal items including perishable and non-perishable food items that overflowed on both overbed tables and bed stands. 1 resident had a bariatric bed which took up a large amount of space in the crowded room. The resident was lying in his bed with 2 brown stained urinals which contained small amounts of yellow liquid. He had an electric scooter in the corner of his side of the room that held a mini-refrigerator still in it's cardboard box. On top of the cardboard box were		**prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Floors/ rooms were swept, cleaned and sanitized in rooms, linens changed as appropriate in 104,202 203,204,205, 207.211,212,312 214, 215,216, 217. Rooms 202,203,211, 212, 214, 313 decluttered as residents allowed. Work order put in place for repair of broken dresser drawer in 205. Work order placed for missing closet door for room 109, 205, 211. Work orders placed for broken blinds in room 217 and 312.Work order placed for missing floor tile in bathroom between rooms 215 and 217. Work order placed for repair of gap between air conditioning unit and wall in room 214. Soiled brief removed from bathroom of 307/309. Cigarette butts removed from room 312, resident education provided. Work order placed for carpet stain in room 303. Work order placed for missing threshold in room 308. **2. How the facility identified other residents:** All residents that reside in the facility have the potential to be affected by deficient practice**3. Measures put into place/ System changes:** Maintenance and other	

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	open food items and personal care items. The resident, identified as interviewable, indicated he'd had the refrigerator for several months but had no where to put it because there was no space. The floor in the room was sticky and streaked with brown debris. His roommates bed was unmade with bunched up blankets with amber-brown colored stains on them. His overbed table sagged down from all the personal items heaped upon it. On 5/24/23 at 11:06 A.M., an environmental tour was conducted with the Environmental Services Director (ESD). The ESD indicated she had been employed at the facility for only 4 days. -In room 211, where 2 residents resided, there was a missing closet door and several cardboard boxes on the floor which were streaked with brown debris. -In room 212, where 2 residents resided, both overbed tables were overflowing with old food items. The floor was very sticky with brown streaked debris. -In room 214, where 2 residents resided, there were personal items on the floor in bags and boxes. 1 resident, identified as interviewable, indicated he got flies and gnats in his room frequently due to space between the wall and air conditioner unit. He pointed out and it was observed, sunlight coming in the space between the air conditioner unit and the wall. The ESD indicated she had picked up the resident's meal tray, from his room, the day before because there had been flies around the tray. The bathroom, shared between the 2 residents of room 214 and 2 residents in room 216, had brown streaked debris on the floor and brown/black debris on the stool seat and in toilet bowl.		staff educated on components of F 921 Safe/Functional/Sanitary/Comfortable Environment, including cleanliness, proper storage of bed pans and urinals and reporting of any broken or hazardous conditions in the facility. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Administrator/designee who will audit 10 rooms in the facility for cleanliness, areas in need of repair and hazardous conditions weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 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** **6-13-23**	

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(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
	-A bathroom, shared between 3 residents from rooms 215 and 217, had missing floor tile and smelled strongly of ammonia. -In room 303, where 1 resident resided, there was a large dark colored stain in the middle of the room carpet. There were several personal items and food scattered on the floor along with bags and cardboard boxes. Briefs and pads sat on the floor next to the bed. -In room 306, where 1 resident resided, the bed was stripped of bedding and in the middle of the bare mattress was a large indent with a brown/amber/black stain which smelled strongly of ammonia. The adjoining bathroom was cluttered with several personal items on the floor and smelling strongly of ammonia. The EDS indicated the mattress would be removed and a new one placed on this day. -A bathroom, shared between 2 residents in rooms 308 and 310, had a full garbage can which smelled of ammonia. On the toilet stool were streaks of brown. -In room 308, where 1 resident resided, the threshold floor molding was missing and bare concrete was observed. -A bathroom, shared between 2 residents in rooms 307 and 309, had a soiled brief lying on the floor, beneath the sink. Next to the toilet was a large brown clump of stool. The ESD immediately summoned the nursing staff to clean up the floor. -In room 312, where 1 resident resided, the floor was streaked with brown debris. There were 2 cigarette butts on the floor and the window was			

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	155567	A. BUILDING 00 B. WING	05/25/2023

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	covered by broken blinds which were missing slates. The bathroom, shared with 2 residents in room 314, smelled strongly of ammonia. The floor had brown debris and hanging on the wall grab bar, was a orange bedpan with brown/black debris on the outside of the pan. -In room 313, where 2 residents resided, there were multiple open food items on bedside stands and overbed tables along with several pop cartons on the floor. 1 garbage can was full with soiled briefs and the other had no bag in it. -In room 203, where 2 residents resided, there were multiple personal items on the window sill, overbed table, bedside table, beneath the air conditioner unit and on the outer edges of the bed. The roommate had a milk crate filled with overflowing items at the bottom of her bed and personal items stacked up on a bedside stand. The closet floor held several cardboard boxes overflowing with personal items. The floor had black streaks and debris scattered throughout the room. -In room 104, where 1 resident resided and according to the ESD, had voiced several environmental concerns, was observed with the garbage can to be full and bed sheets with red-pink stains on them. In his bathroom was a towel on the floor in front of the stool that had red stains. There was dried red and brown debris on the toilet seat and soiled clothing on the floor in the corner of the bathroom. On 5/25/23 at 9:55 A.M., Resident P, identified as interviewable, indicated a few weeks ago, he had been sitting at the end of his bed when the door to his shared bathroom was slammed shut which caused his closet door to fall on him, striking his			

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	head behind his right ear. The closet door was observed standing upright against the wall nearest the room door and had not been replaced. He indicated when he first admitted to the facility, the closet door had come off the track but was supposedly fixed and this was the second time the door had come off. On 5/25/23 at 10:20 A.M., the Administrator was interviewed. He indicated the facility was in transition and had hired a new ESD. He acknowledged there were environmental issues and had a plan to address and fix the issues which would officially be put into place the following week. Refer to F689 for findings related to accidents secondary to a clean and safe environment for Resident J and Resident P. This Federal tag relates to Complaint IN00408505. 3.1-19(e)			