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	06/06/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00435281, Complaint IN00434632, Complaint IN00434654, and Complaint IN00434516. Complaint IN00435281 - No deficiency related to the allegation is cited. Complaint IN00434632 - No deficiency related to the allegation is cited. Complaint IN00434654 - No deficiency related to the allegation is cited. Complaint IN00434516 - No deficiency related to the allegation is cited. Survey dates: June 2, 3, 4, 5 and 6, 2024 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: NF: 56 SNF/NF: 3 Total: 59 Census Payor Type: Medicaid: 56 Other: 3 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The facility respectfully requests a desk review for the citations listed within this survey.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.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brent Swan	HFA	06/27/2024

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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	Quality review completed June 11, 2024			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure services and assistance was provided to maintain correct posture for 1 of 1 resident reviewed (Resident 4). Findings include: On 6/2/24 at 12:08 PM, Resident 4 was observed sitting in their wheelchair in the hallway. Resident 4 was leaning to the far right bent over at the waist. On 6/2/24 at 12:10 PM a staff member was observed assisting Resident 4 into an upright position.	F 0688	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #4: Resident was evaluated and treated by Occupation Therapy for posture support and wheelchair positioning. The care plan was updated with resident specific interventions. Physician contacted for any needed order changes/updates. Staff will follow the plan of care to ensure that	07/05/2024

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	On 6/2/24 at 1:38 PM, Resident 4 was observed sitting in their wheelchair in the hallway. Resident 4 was bent over at the waist leaning to the far right. Resident 4's lower body was nearly off the chair. A staff member instructed Resident 4 to straighten up. Resident 4 attempted to raise their torso and was not successful. Resident 4 did not assume an upright position in the wheelchair. On 6/2/24 at 1:40 PM, a staff member was observed assisting Resident 4 to an upright sitting position in the wheelchair. The staff member placed Resident 4's right foot into the right wheelchair footrest. On 6/2/24 at 3:10 PM, Resident 4 was observed sitting in their wheelchair in the smoking section. Resident 4 was leaning to their far-right side bent over at the waist. Resident 4 was smoking a cigarette while their lower body was hanging off the edge of their wheelchair. A staff member was present. Resident 4's record was reviewed on 6/3/24 at 10:25 AM. Diagnoses included generalized muscle weakness, wheelchair dependence, polyneuropathy, (malfunction of numerous nerves) cognitive communication deficit, peripheral vascular disease, (poor blood circulation of arms and legs) and chronic pain syndrome. Resident 4's Annual MDS dated 4/13/24 indicated the resident's BIMS score was 10 (moderate cognitive impairment). The MDS indicated Resident 4 was impaired on 1 side of their upper and lower body. Resident 4's Care Plan dated 3/25/24 indicated the resident had a risk for falls as evidenced by		services and assistance is provided to maintain proper posture/positioning support. **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?** All residents are at risk to be affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit will be completed by the nurse management team on all residents to review current mobility status and review of the latest comprehensive assessment. Any resident identified with limitations in function and/or mobility will be reviewed. The team will make necessary observations of any residents identified. The IDT will review the plan of care and update as needed to reflect interventions to promote proper positioning and posture support by 7/5/24. An all-nursing staff in-service will be completed by 7/5/24 to review the importance of resident positioning and posture and maintaining resident's functional mobility status. The policy for "Resident Mobility and Range of Motion' will	

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	agitation, fall risk assessment, impaired mobility, impaired cognition, weakness, traumatic brain injury, pseudobulbar affect, (inappropriate and/or uncontrollable laughing or crying) neuropathy, cardiomyopathy, (heart disorder) and dementia. The target goal was for Resident 4 to have minimal falls and minimal injuries by the next review. Interventions included medications as ordered, therapy evaluations as indicated, psychiatry services as needed, new shoes for transfers, non-skid footwear, and non-skid strips on the floor. Resident 4's care plan dated 6/2/24 indicated the resident was at risk for functional decline due to depression, falls, impaired mobility, pain, poor balance, neuropathy, impaired vision, poor balance, past myocardial infarction, (heart attack) anxiety, behaviors, generalized weakness, dementia, peripheral vascular disease, cardiomyopathy, bipolar disorder, coronary artery disease, post-traumatic stress disorder and high blood pressure. The Care Plan focus indicated Resident 4 was able to sit up with proper posture in their wheelchair but chose to lean to the sides. The care plan indicated Resident 4 had been resistant to wheelchair positioning support efforts from therapy. The target goal was for Resident 4 to maintain their current level of functioning through 6/26/23. Interventions included Resident 4 occasionally likes to sit on the floor, encourage to request staff assistance for transfers, keep urinal within reach, wheelchair for mobility, the resident does not walk, brace to right foot and call light in reach. Resident 4's Care Plan did not indicate the resident was at risk of leaning to the right while in their wheelchair. Resident 4's Care Plan did not indicate the		be reviewed. Staff will be educated on importance of ensuring any needed positioning equipment is utilized per plan of care. Staff will also be encouraged to make frequent visual observations of residents during tour of duty. Upon discovery of a resident with altered posture or positioning the staff will be instructed to provide resident with needed assistance to change position and restore proper positioning/posture. Nurse managers will participate in routine walking rounds and observational audits on various shifts/times to monitor that staff are providing the necessary supervision and assistance to maintain/attain residents highest level of functional mobility while ensuring posture support as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The DON or other designee will be responsible to complete the "Mobility/Assistive Device/Posture Review Tool" on 10 residents bi-weekly for 6 weeks, then weekly x6weeks, then monthly thereafter to monitor for ongoing compliance. Any issues noted will be corrected upon discovery and logged on facility QA tracking log	

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	resident was at risk for falls due to leaning to the right side while in their wheelchair. Resident 4's Care Plan did not indicate they required an assistive device to avoid leaning to the right while in their wheelchair. A progress note dated 9/27/23 at 2:21 PM indicated Resident 4 had been evaluated after having a fall. Resident 4 had displayed right sided weakness. A progress note dated 12/1/23 at 10:49 AM indicated Resident 4 had right sided weakness. A progress note dated 12/27/23 at 2:44 PM indicated Resident 4 had been evaluated after having a fall. Resident 4 was noted as having weakness on their right side. A progress note dated 1/24/24 at 9:34 PM indicated Resident 4 had been evaluated after multiple falls. Resident 4 displayed weakness to their right side. A progress note dated 1/26/24 at 12:35 PM indicated Resident 4 had weakness to their right side. A progress note dated 1/31/24 at 1:03 PM indicated Resident 4 had weakness to their right side. A progress noted dated 5/20/24 at 6:19 PM indicated Resident 4 had continued to get their right hand stuck in their wheelchair. The note indicated Resident 4 chronically leaned to the right while in their wheelchair. The note indicated Resident 4 had a strap-like device to help keep the resident upright. The note indicated Resident 4		reviewed at the monthly facility QAPI meeting. Audit results will be reported, reviewed, and trended for compliance at the monthly facility QAPI meeting for a minimum of 6 months and/or until compliance is met at 90% for three consecutive months.	

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	was noncompliant with the strap-like device. An Initial Occurrence Note dated 5/20/24 at 1:43 PM indicated Resident 4 had injured their right 5th finger in the wheel of their wheelchair. Resident 4's right 5th fingernail was missing. Resident 4's 4th fingernail bed was noted to be discolored. An Initial Occurrence Note dated 5/27/24 at 6:13 AM indicated Resident 4 had gotten their right hand caught in the wheel of their wheelchair while outside. A progress note dated 5/27/24 at 9:22 PM indicated Resident 4 had caught their right hand in the wheel of their wheelchair causing a skin tear to their right middle finger. An Occupational Therapy Evaluation and Plan of Treatment dated 1/10/24 at 2:58 PM indicated Resident 4's diagnoses included an encounter for orthopedic aftercare following surgical amputation and muscle wasting. Resident 4's goal was to increase participation during care. Resident 4's prior equipment was a manual wheelchair and a shower chair. An Occupational Therapy Discharge Summary dated 5/24/24 at 6:54 PM indicated Resident 4 had been discharged due to refusal of treatment. The goal of increasing Resident 4's strength in both arms had been met on 5/8/24 (page 2). Resident 4's prior equipment was a manual wheelchair and a shower chair (page 3). Resident 4 had reached their maximum potential with skilled services (page 4). Resident 4's strength in their arms was not tested due to the resident's request to be discharged (page 4). An Occupational Therapy Evaluation and Plan of			

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	Treatment dated 6/3/24 at 4:03 PM indicated resident 4's diagnoses were diffuse traumatic brain injury, abnormal posture and muscle wasting. Resident 4's goal was to decrease right sided leaning while in their wheelchair. Resident 4's current posture score was 40 out of 100. Resident 4 was expected to increase their posture score to 75 out of 100. The current reason for referral was Resident 4 had gotten their right hand caught in the wheel of their wheelchair resulting in a skin tear. Resident 4's prior treatment outcome was maximum rehab potential had been met. Resident 4's prior equipment was a manual wheelchair and a shower chair. Resident 4's current equipment included a reclining wheelchair, lateral supports on the right and left sides and a right arm bolster. In an interview on 6/5/24 at 11:19 AM, Resident 4 indicated the left side of their brain was injured in a motorcycle crash when they were 21 years old (Resident 4 was currently 53 years old). Resident 4 indicated they were weak on their right side due to the left side of the brain controlling the right side of the brain. Resident 4 indicated they had been weak on the right side since the motorcycle crash. Resident 4 indicated they had experienced a problem with involuntarily leaning to the right side since the motorcycle crash. Resident 4 indicated they used to be able to realize they were leaning and return to an upright position. Resident 4 indicated it was getting harder to adjust themselves into an upright position after their body decided to lean to the right. Resident 4 indicated the staff did not like to assist the resident with returning to a sitting position and they were often instructed to do it themselves. Resident 4 indicated they were also unable to sit upright on the edge of the bed. Resident 4 indicated they had received therapy services. Resident 4 indicated they did not recall being			

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	educated about upright posture in therapy. Resident 4 indicated they did not recall the use of positional assistive device. In an interview on 6/5/24 at 2:50 PM, the Chief Nursing Officer indicated Resident 4 had received therapy services after the resident had a series of falls. The Chief Nursing Officer indicated Resident 4 had a behavior of leaning to the right and placing themselves on the floor when they were upset. The Chief Nursing Officer indicated they did not believe Resident 4's falls were related to the resident leaning to the right. The Chief Nursing Officer indicated Resident 4 had refused therapy's recommendations for assistive devices to maintain upright posture in the past. The Chief Nursing Officer indicated they were not aware postural assistive devices were not included in Resident 4's Care Plan. The Chief Nursing Officer indicated they were not aware of upright posture not being a focus of therapy. The Chief Nursing Officer indicated they had observed Resident 4 leaning to the far right bent over at their waist and believed the resident could sit up straight if they chose to. The Chief Nursing Officer indicated reducing Resident 4's leaning to the right was a therapy goal as of yesterday (6/4/24). In an interview on 6/5/24 at 3:01 PM, Physical Therapy Assistant (PTA) 6 indicated they did not believe Resident 4's falls were due to their right leaning posture. PTA 6 indicated Resident 4 had expressed to the therapy staff leaning to the right was the most comfortable position for them. PTA 6 indicated therapy services had provided Resident 4 with a new wheelchair on 6/4/24. PTA 6 indicated Resident 4 had been using a high back wheelchair since the resident had been admitted to the facility. PTA 6 indicated the new wheelchair would be better for upright posture. PTA 6			

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	indicated Resident 4 had always leaned to the right. PTA 6 indicated Resident 4's leaning to the right had gotten more severe the last month or two. PTA 6 indicated they had observed Resident 4 leaning to the far right bent over at their waist. PTA 6 indicated Resident 4 had refused several different postural assistive devices. PTA 6 indicated they were not aware postural assistive devices were not included in Resident 4's Care Plan. PTA 6 indicated they were aware posture had not been a focus of therapy in the past. PTA 6 indicated upright posture was a therapy goal for Resident 4 starting on 6/3/24. PTA 6 indicated Resident 4 had refused further therapy services in the past. PTA 6 indicated therapy had offered a variety of postural assistance devices. PTA 6 indicated posture training had not been a therapy goal, but therapy had encouraged Resident 4 to sit upright in their chair. On 6/5/24 at 3:33 PM, PTA 6 provided Occupational Therapy Treatment Encounter Notes. A therapy note dated 5/14/24 at 8:32 PM indicated Resident 4 had self-propelled in the hallway with a new support in place without issues. Resident 4 had been educated on the importance of not leaning to the right while in their wheelchair. Resident 4 actively participated during the session. A therapy note dated 5/16/24 at 6:59 PM indicated upon the therapist's arrival, Resident 4 was leaning over the right armrest of their wheelchair. Resident 4 allowed the application of lateral support during the treatment session. Resident 4 indicated the support was easy to remove and they could remove the support after the therapy session was completed if they desired to do so. Resident 4 required encouragement for			

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	active participation due to decreased motivation. In an interview on 6/6/24 at 12:40 PM the Chief Nursing Officer indicated the facility had missed some things related to Resident 4's decline. The Chief Nursing Officer indicated the issue had already been corrected as therapy's new goal was for posture training. A current facility policy dated 9/11/23 provided by the Chief Nursing Officer on 6/4/24 at 1:24 PM indicated residents would be provided with care, treatment and services to prevent or minimize functional decline unless their decline is declared unavoidable. 3.1-42(a)(1) 3.1-42(a)(2)			
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 ensure adequate supervision for prevention of falls for 1 of 1 resident reviewed (Resident 4). Findings include: On 6/2/24 at 12:08 PM, Resident 4 was observed sitting in their wheelchair in the hallway. Resident	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #4: The IDT reviewed the fall history for the last 90 days and fall risk assessment by 7/5/24. Room has been relocated closer	07/05/2024

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	4 was leaning to the far right bent over at the waist. On 6/2/24 at 12:10 PM a staff member was observed assisting Resident 4 into an upright position. On 6/2/24 at 1:38 PM, Resident 4 was observed sitting in their wheelchair in the hallway. Resident 4 was bent over at the waist leaning to the far right. Resident 4's lower body was slightly off the chair. A staff member instructed Resident 4 to straighten up. Resident 4 attempted to raise their torso and was not successful. Resident 4 did not assume and was not assisted to an upright position in the wheelchair. On 6/2/24 at 1:45 PM, a staff member was observed assisting Resident 4 to an upright sitting position in the wheelchair. The staff member placed Resident 4's right foot into the right wheelchair footrest. On 6/2/24 at 3:10 PM, Resident 4 was observed sitting in their wheelchair in the smoking section. Resident 4 was leaning to their far-right side bent over at the waist. Resident 4 was smoking a cigarette while their lower body was hanging off the edge of their wheelchair. The staff member present did not assist Resident 4 to an upright position. Resident 4's record was reviewed on 6/3/24 at 10:25 AM. Diagnoses included traumatic brain injury, generalized muscle weakness, wheelchair dependence, polyneuropathy, (malfunction of numerous nerves) cognitive communication deficit, chronic pain syndrome and vascular dementia.		to the nurse's station for increased supervision, referral to therapy with interventions for positioning and posture support implemented. HCP has been updated and reviewed to reflect current plan of care and resident specific interventions to ensure proper supervision and use of assistive devices in an ongoing effort to reduce falls and prevent significant injury. **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?** All residents are at risk to be affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All resident care plans will be reviewed by the nurse management team by 7/5/24 to ensure fall risk factors are identified and interventions are appropriate to ensure adequate supervision. Additionally, any resident with a fall in the last 90days will be reviewed by the IDT to review that resident specific interventions are followed and effective in the reduction of resident falls. Updates will be made as indicated to plan of care.	

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	Resident 4's Annual MDS dated 4/13/24 indicated the resident's BIMS score was 10 (moderate cognitive impairment). The MDS indicated Resident 4 was impaired on 1 side of their upper and lower body. Resident 4's Care Plan dated 3/25/24 indicated the resident had a risk for falls as evidenced by agitation, fall risk assessment, impaired mobility, impaired cognition, weakness, traumatic brain injury, pseudobulbar affect, (inappropriate and/or uncontrollable laughing or crying) neuropathy, cardiomyopathy, (heart disorder) and dementia. The target goal was for Resident 4 to have minimal falls and minimal injuries by the next review. Interventions included medications as ordered, therapy evaluations as indicated, psychiatry services as needed, new shoes for transfers, non-skid footwear, and non-skid strips on the floor. The care pplan did not address leaning in the wheelchair. Resident 4's care plan dated 6/2/24 indicated the resident was at risk for functional decline due to depression, falls, impaired mobility, pain, poor balance, neuropathy, impaired vision, poor balance, past myocardial infarction, (heart attack) anxiety, behaviors, generalized weakness, dementia, peripheral vascular disease, cardiomyopathy, bipolar disorder, coronary artery disease, post traumatic stress disorder and high blood pressure. The Care Plan focus indicated Resident 4 was able to sit up with proper posture in their wheelchair but chose to lean to the sides. The care plan indicated Resident 4 had been resistant to wheelchair positioning support efforts from therapy. The target goal was for Resident 4 to maintain their current level of functioning through 6/26/23. Interventions included Resident 4 occasionally liked to sit on the floor, encourage		All staff educated by 7/5/24 on facility “Fall Management Policy”. Staff educated on components of F689 and the prevention of accidents/hazards/supervision, to include intervention implementation and prompt communication to staff. Nursing participates in change of shift huddles and will be instructed to discuss resident accidents/falls during this time to ensure new interventions are followed and implemented promptly. An investigation will be completed at the time of fall/accident and nursing staff will be instructed to put an immediate intervention into place to prevent reoccurrence and document these actions in the EMR. The IDT routinely meets to review the 24-hour report and any documented occurrences. The team will use this information to complete root cause analysis and to determine that intervention is appropriate to prevent/reduce occurrences while ensuring proper supervision. Nurse managers will participate in routine walking rounds to monitor that fall interventions are in place as indicated in plan of care and staff providing necessary supervision to reduce prevent accidents. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance**	

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	155567	A. BUILDING 00 B. WING	06/06/2024

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	to request staff assistance for transfers, keep urinal within reach, wheelchair for mobility, the resident does not walk, brace to right foot, call light in reach and evaluations by physical therapy, occupational therapy or speech language therapy as needed. Resident 4's Care Plan did not indicate the resident had a tendency to lean to their right side while in their wheelchair. Resident 4's Care Plan did not indicate the resident was at risk for falls due to leaning to the right side while in their wheelchair. Resident 4's Care Plan did not indicate they required an assistive device to avoid leaning to the right while in their wheelchair. Resident 4's falls and Fall Risk Assessments for the past year included the following: - A progress note dated 6/22/23 at 1:00 PM indicated Resident 4 had been found sitting on the floor next to their wheelchair. Resident 4 indicated they wanted to sit on the floor. Resident 4 was noted to have right sided weakness. A Fall Risk Assessment dated 6/26/23 at 1:21 PM indicated Resident 4's fall risk score was 16. The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 9/26/23 at 2:53 PM indicated Resident 4 had an unwitnessed fall. A progress note recorded as a late entry dated 9/27/23 at 2:21 PM indicated Resident 4 had been evaluated for a ground level fall. A Fall Risk Assessment dated 9/26/23 at 2:52 PM indicated Resident 4's fall risk score was 9.The note did not indicate any actions or interventions were added to prevent falls.		**program will be put into place?** The DON or other designee will be responsible to complete the “Fall Review Tool” on 5 residents weekly to determine compliance with fall intervention, prevention, and supervision. The results of these audits will be reviewed in the monthly QAPI meeting for a minimum of 6 months and until an average of 90% or greater 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.	

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- An Initial Occurrence Note dated 10/30/23 at 1:08 AM indicated Resident 4 had an unwitnessed fall. A progress note dated 10/30/23 at 10:36 AM indicated Resident 4's wheelchair would be removed while the resident was in bed. A Fall Risk Assessment dated 10/30/23 at 1:19 PM indicated Resident 4's fall risk score was 14.The note did not indicate any actions or interventions were added to prevent falls.

- An Initial Occurrence Note dated 11/14/23 at 12:00 AM indicated Resident 4 had an unwitnessed fall. The note did not indicate an assessment was completed or any actions or interventions added to prevent falls.

- An Initial Occurrence Note dated 11/14/23 at 12:15 AM indicated Resident 4 had an unwitnessed fall. A Fall Risk Assessment dated 11/14/23 at 12:44 PM indicated Resident 4's fall risk score was 9.The note did not indicate any actions or interventions were added to prevent falls.

- A progress note dated 12/9/23 at 11:36 PM indicated Resident 4 had been found lying on the floor on their right side. A Fall Risk Assessment dated 12/10/23 at 6:37 AM indicated Resident 4's fall risk score was 14.The note did not indicate any actions or interventions were added to prevent falls.

- A progress note dated 12/10/23 at 11:05 PM indicated Resident 4 had slid from their chair while attempting to turn off the light.The note did not indicate an assessment was completed or any actions or interventions added to prevent falls.

- An Initial Occurrence Note dated 12/24/23 at

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	12:55 AM indicated Resident 4 had an unwitnessed fall. A progress note dated 12/24/23 at 12:42 AM indicated Resident 4 had been found lying face down in their room. A Fall Risk Assessment dated 12/24/23 at 3:57 AM indicated Resident 4's fall risk score was 11.The note did not indicate any actions or interventions were added to prevent falls. - A progress note dated 12/27/23 at 2:44 PM indicated Resident 4 had been evaluated after having a fall. Resident 4 was noted as having weakness on their right side. The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 1/23/24 at 5:18 PM indicated Resident 4 had an unwitnessed fall. A progress note dated 1/24/24 at 9:39 PM indicated Resident 4 had fallen multiple times over the last couple of days. A Fall Risk Assessment dated 1/23/24 at 5:17 PM indicated Resident 4's fall risk score was 9.The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 1/24/24 at 3:55 PM indicated Resident 4 had an unwitnessed fall. The note did not indicate any actions or interventions were added to prevent falls. - A Fall Risk Assessment dated 2/9/24 at 12:07 PM indicated Resident 4's fall risk score was 11.The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 3/22/24 at 5:45 PM indicated Resident 4 had an unwitnessed fall. A Fall Risk Assessment dated 3/22/24 at 5:37 PM indicated Resident 4's fall risk score was 9.The			

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	note did not indicate any actions or interventions were added to prevent falls. - A progress note dated 3/26/24 at 10:14 AM indicated Resident 4 had been found in their room on their knees on 3/22/24. The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 3/28/24 at 1:07 AM indicated Resident 4 had a witnessed fall. A progress note dated 3/28/24 at 12:56 AM indicated Resident 4 had been angry and had a witnessed fall in the hallway. A Fall Risk Assessment dated 3/28/24 at 1:03 AM indicated Resident 4's fall risk score was 7.The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 4/17/24 at 11:35 PM indicated Resident 4 had an unwitnessed fall. A progress note dated 4/18/24 at 10:29 AM indicated Resident 4 had fallen on 4/17/24. Resident 4 had fallen while transferring themselves from the wheelchair to the bed. A Fall Risk Assessment dated 4/17/24 at 11:34 PM indicated Resident 4's fall risk score was 8.The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 5/13/24 at 3:26 PM indicated Resident 4 had an unwitnessed fall. A progress note dated 5/14/24 at 9:56 AM indicated Resident 4 had been bleeding from their right knee. The note indicated Resident 4 had fallen from their bed. A Fall Risk Assessment dated 5/13/24 at 3:24 PM indicated Resident 4's fall risk score was 7. Resident 4 was alert, oriented, ambulatory and continent. Resident 4 had fallen 1			

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	to 2 times in the past 3 months. Resident 4 was prescribed 1 to 2 high fall risk medications (anesthetics, antihistamines, antihypertensives, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, anticonvulsants, sedatives or hypnotics) and had no medication changes.The note did not indicate any actions or interventions were added to prevent falls. - An Initial Occurrence Note dated 5/29/24 at 1:00 Pm indicated Resident 4 had an unwitnessed fall. A Fall Risk Assessment dated 5/29/24 at 1:00 PM indicated Resident 4's fall risk score was 17. Resident 4 had intermittent confusion and was chairbound. Resident 4 had fallen 3 or more times in the past 3 months. Resident 4 had been prescribed 3 to 4 high fall risk medications and had no medication changes. The note did not indicate any actions or interventions were added to prevent falls. In an interview on 6/5/24 at 11:19 AM, Resident 4 indicated the left side of their brain was injured in a motorcycle crash when they were 21 years old. Resident 4 indicated they were weak on their right side due to the left side of the brain controlling the right side of the brain. Resident 4 indicated they had been weak on the right side since the motorcycle crash. Resident 4 indicated they had had a problem with involuntarily leaning to the right side since the motorcycle crash. Resident 4 indicated they used to be able to realize they were leaning and return to an upright position. Resident 4 indicated it was getting harder to adjust themselves into an upright position after their body decided to lean to the right. Resident 4 indicated the staff did not like to assist the resident with returning to a sitting position and was often instructed to do it themselves. Resident			

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	4 indicated they were unable to sit upright on the edge of the bed. Resident 4 indicated they had received therapy services. Resident 4 indicated they did not recall being educated about upright posture in therapy. Resident 4 indicated they did not recall having a positional assistive device. In an interview on 6/5/24 at 2:50 PM, the Chief Nursing Officer indicated Resident 4 had received therapy services after the resident had a series of falls. The Chief Nursing Officer indicated Resident 4 had a behavior of leaning to the right and placing themselves on the floor when they were upset. The Chief Nursing Officer indicated they did not believe Resident 4's falls were related to the resident leaning to the right. The Chief Nursing Officer indicated Resident 4 had refused therapy's recommendations for assistive devices to maintain upright posture. The Chief Nursing Officer indicated they were not aware of positional assistive devices not being included on Resident 4's Care Plan. The Chief Nursing Officer indicated they were not aware of upright posture not being a focus of therapy until the most recent therapy evaluation dated 6/2/24. The Chief Nursing Officer indicated they were not aware of Resident 4's fall risk score of 7 on 5/13/24 and their fall risk score had raised to 17 on 5/29/24. The Chief Nursing Officer indicated the facility's Fall Risk Scale was low to high with the higher number corresponding with a higher fall risk. In an interview on 6/5/24 at 3:01 PM, Physical Therapy Assistant (PTA) 6 indicated they did not believe Resident 4's falls were due to their right leaning posture. PTA 6 indicated Resident 4 had explained to the therapy staff they leaned to the right due to comfort. PTA 6 indicated therapy services had provided Resident 4 with a new wheelchair on 6/4/24. PTA 6 indicated Resident 4			

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	had been using a high back wheelchair since the resident had been admitted to the facility. PTA 6 indicated the new wheelchair would be better for upright posture. PTA 6 indicated Resident 4 had always leaned to the right. PTA 6 indicated Resident 4's leaning to the right had gotten more severe the last month or two. PTA 6 indicated Resident 4 had refused postural assistive devices. PTA 6 indicated they were aware posture had not been a focus of therapy in the past. PTA 6 indicated upright posture was a therapy goal for Resident 4 with a start of care date of 6/3/24. PTA 6 indicated Resident 4 had refused further therapy services in the past. PTA 6 indicated they would provide documentation of posture assistance. Occupational Therapy Treatment Encounter Notes included: A therapy note dated 5/14/24 at 8:32 PM indicated Resident 4 had self-propelled in the hallway with a new support in place without issues. Resident 4 had been educated on the importance of not leaning to the right while in their wheelchair. Resident 4 actively participated during the session. A therapy note dated 5/16/24 at 6:59 PM indicated upon the therapist's arrival, Resident 4 was leaning over the right armrest of their wheelchair. Resident 4 allowed the application of lateral support during the treatment session. Resident 4 indicated the support was easy to remove and they could remove the support after the therapy session was completed if they desired to do so. Resident 4 required encouragement for active participation due to decreased motivation. In an interview on 6/6/24 at 12:40 PM the Chief Nursing Officer indicated the facility had missed			

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	some things related to Resident 4's decline. The Chief Nursing Officer indicated the issue had already been corrected as therapy's new goal for Resident 4 was for posture training. A current facility policy dated 2/22/22 provided by the Chief Nursing Officer on 6/4/24 at 1:24 PM indicated all residents would be assessed for a fall risk upon admission, with a significant change, annually and as needed post fall. Each resident would have a resident centered plan of care for a risk for falls with relevant interventions. If falls continued, staff would try different interventions until falling is reduced or stopped or until the reason for continued falls is identified as unavoidable. 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents respiratory equipment was maintained to prevent contamination for 1 of 2 residents reviewed respiratory care (Resident 38). Findings include: During an observation on 6/2/24 at 11:28 AM, on	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #38: A new respiratory mask and the suction canister	07/05/2024

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	the bedside stand next to Resident 38's bed, a respiratory face mask was observed lying on top of a nebulizer machine, undated, unbagged, with cloudiness observed on edges of clear plastic mask. A suction machine with an attached suction container full of cloudy light tan liquid was observed next to the nebulizer machine on the bedside stand. The suction container had a clear, plastic tube extending from it open to air. No dates were found on the suction container or tubing. Resident 38's record was reviewed on 6/2/24 at 1:05 PM. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, type 2 diabetes mellitus with hyperglycemia, acute respiratory failure with hypoxia. Resident 38's current quarterly Minimum Data Set (MDS) dated 4/7/24 indicated her Basic Interview for Mental Status (BIMS) score was 9 (moderately cognitively impaired). The MDS indicated Resident 38 received tracheostomy care and suctioning. Resident 38's current care plan titled ... altered respiratory status ...indicated the resident had a problem of difficulty breathing, with a goal date of 8/31/24. Interventions included administering nebulizer treatments as ordered. Resident 38's current care plan titled ...tracheostomy ...indicated the resident had a problem with respiratory failure, with a goal date of 8/31/24. Interventions included suctioning as necessary. Physician orders dated 12/22/22 indicated suction tubing and canisters should be changed every		were replaced and dated. Unused respiratory mask/tubing/nebulizer will be stored in a bag when not in use. Resident experienced no negative outcomes related to the deficient practice. **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?** All residents using respiratory equipment have the potential to be affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The nurse managers completed an audit of all residents in the facility utilizing any type of respiratory equipment. Respiratory tubing/masks, nebulizer sets, and suction canisters were all replaced and dated accordingly. Respiratory masks, nebulizers, tubing, etc. will be placed in a bag when not in use. An all-nursing in-service will be completed by 7/5/24 to include education regarding the frequency for changing and dating respiratory equipment every 7 days and prn visibly soiled. Suction canisters will be monitored/emptied on each	

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	Sunday night and as needed. Physician orders dated 3/20/24 indicated nebulizer tubing should be changed every Sunday night. In an interview on 06/02/24 at 10:39 AM, the Corporate Nursing Officer (CNO) indicated the resident 52's NC oxygen tubing was not labeled and should have been. In an interview on 6/4/24 at 9:38 AM, the CNO indicated nebulizers masks and tubing should be replaced weekly, labeled and dated. She indicated the full suction canister and its tubing should have been discarded. She indicated respiratory equipment should be bagged and dated at bedside. She indicated the suction equipment should have been covered. A current policy titled Respiratory, Oxygen Therapy, General Standard, last revised 11/23 provided by the Administrator on 6/3/24 at 8:56 AM indicated tubing should be changed and dated weekly. A current policy titled Tracheostomy Care, dated 8/1/23, provided by the CNO on 6/5/24 at 1:50 PM did not address storage guidelines for respiratory equipment not in use. In an interview on 6/4/24 at 10:08 AM the CNO indicated there were no further policies pertaining to respiratory care were available for review. 3.1-47(a)(6)		shift and changed no less than every 7 days. All nursing staff were instructed on the importance of placing unused oxygen tubing, masks, nebulizers etc. in a bag while not in use. Charge nurses will participate in routine walking rounds. Nurse managers will participate in routine walking rounds of units to make observations of respiratory equipment to ensure dated, changed out as needed, and placed in bag when not in use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The DON or other designee will be responsible to complete bi-weekly x 6weeks, then weekly x 6 weeks, then monthly thereafter on 10 residents identified to utilize respiratory equipment by completing the “Respiratory Equipment Review Tool” (Attachment A). Any issues noted will be corrected upon discovery and logged on facility QA tracking log reviewed at the monthly facility QAPI meeting. Audit results will be reported, reviewed, and trended for compliance at the monthly facility QAPI meeting for a minimum of 6 months and/or until compliance is met at 90% for three consecutive	

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			months.	
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview and record review, the facility failed to ensure triggers were identified, communicated, and interventions in place to avoid or alleviate re-traumatization for 2 of 2 residents reviewed (Resident 2 and Resident 22). Findings include: 1) On 6/2/24 at 11:22 AM, Resident 2 was observed to have a flat facial expression. In an interview on 6/2/24 at 11:23 AM, Resident 2 avoided eye contact. Resident 2 answered 2 survey questions and abruptly ended the interview. Resident 2's record was reviewed on 6/5/24 at 1:28 PM. Diagnoses included anxiety, major depressive disorder, current nicotine use and post-traumatic stress disorder (PTSD). Resident 2's Quarterly Minimum Data Set (MDS) dated 2/3/24 indicated the resident's Brief Interview for Mental Status (BIMS) was 15 (no cognitive impairment). The MDS indicated	F 0699	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 2 and 22 were assessed for psychosocial behavior, treatments, orders, interventions, triggers, and care plan reviewed and updated for all with physician notified of any findings. No adverse effects noted. **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?** All residents with services for mental and/or psychosocial concerns were assessed by the DON and Social Services director. Education was immediately provided to staff for monitoring of	07/05/2024

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

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	Resident 2 sometimes displayed social isolation. The MDS indicated Resident 2 had not displayed behaviors of verbal aggression, physical aggression, wandering or resistance of care. The MDS indicated Resident 2 had diagnoses of anxiety, depression and PTSD. A Social Service Abuse and Neglect Screening dated 4/12/24 at 10:36 AM indicated Resident 2 had a moderate problem with severe mental health diagnoses and possible misinterpretation of events and the intentions of others. Resident 2 had a moderate problem with recent aggressive or agitated behavior and/or resistance to care. Resident 2 had a moderate problem of a history or recent relapse of substance abuse or compulsive behaviors. Resident 2 had a moderate problem with a history of abuse or neglect either as a recipient or a perpetrator. Resident 2 had a moderate problem with a history of criminal behavior. Resident 2 had a moderate problem with factors that increase vulnerability such as severe mental illness, poor insight, poor judgement, dementia, confusion or poor ambulation abilities. Resident 2 had a moderate problem with depressive symptoms such as distressed mood, low self-esteem, isolation, withdrawn behavior, illness, chronic pain or self-destructive behavior. Resident 2 had no problem or minimal problem with denial of mental illness or minimizing the significance of psychosocial issues or mental health. A Social Service Psychosocial Assessment dated 6/12/23 at 4:20 PM indicated Resident 2 had a diagnosis of PTSD. Resident 2 had full recollection and awareness of the event. Resident 2 did not display any changes in mood or behavior. Resident 2's relevant psychosocial history was physical and emotional trauma.		emotional triggers and additional monitoring. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** New admissions and residents with behaviors will be reviewed daily during clinical meeting. Clinical record reviews and audits will be completed for 3 residents weekly to determine accurate documentation and care plans for those residents identified with behaviors and/or triggers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Results of psychosocial audits will be reviewed in QAPI committee meeting for six months or until 100% compliance is achieved for three consecutive months. QAPI committee will work to identify trends and patterns to make recommendations on revising the Plan of Correction as needed.	

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	Resident 2's triggers that caused them alarm or distress were loud noises, touch or affection and certain environmental odors. A physician order dated 1/17/24 indicated Resident 2 was to be administered paliperidone palmitate once every 28 days for delusions. A physician order dated 3/9/24 indicated Resident 2 was to be administered divalproex sodium once daily for major depressive disorder. A progress note dated 1/2/24 at 3:33 PM indicated Resident 2's delusions were intermittent. A progress note dated 1/8/24 at 12:58 PM indicated Resident 2 had intermittent delusions, paranoia and PTSD from burns. A progress note dated 4/15/24 at 7:25 AM Resident 2 had intermittent confusion. The note indicated Resident 2 had some paranoia and delusions but less than before. Resident 2's Care Plan focus dated 6/26/23 indicated the resident was at risk for psychosocial impairment related to anxiety, depression, insomnia/sleep disorder, domestic violence, and PTSD. The target goal was for Resident 22 to be free of psychosocial complications through the next review date. Interventions included medications as ordered, do not overwhelm with too many choices, familiar items for a homelike environment, encourage to socialize with others, approach in a calm manner, reapproach later if the resident is agitated, attempt to redirect when the resident is displaying behaviors, psychiatric services as needed, monitor sleep patterns, promote quiet sleeping environment, trauma triggers to avoid and coping strategies.			

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Resident 2's Care Plan focus dated 12/23/23 indicated the resident was at risk for altered activity patterns as evidenced by the need for reminders and encouragement to attend activities and the resident likes to spend a lot of time in their bed. The target goal was for the resident to express satisfaction with activities by 8/27/24. Interventions included getting consent for facility outings, informing the resident of outings, and praising the resident for increased attendance in group activities.

Resident 2's Care Plan did not include a focus for anxiety, depression, delusions, paranoia or PTSD. Resident 2's Care Plan did not include resident specific behaviors. Resident 2's Care Plan did not include the resident's signs and symptoms of distress or behaviors such as self-isolation and insomnia. Resident 2's Care Plan did not include resident specific stressors such as loud noises, touch, affection or certain smells. Resident 22's Care Plan did not include interventions to reduce their stressors.

2) On 6/2/24 at 10:50 AM, Resident 22 was observed sitting in a wheelchair in their room. Resident 22 made eye contact and smiled.

In an interview on 6/2/24 at 10:51 AM, Resident 22 indicated they sometimes experienced bad feelings related to being a trauma survivor. Resident 22 indicated they managed their feelings by keeping to themselves and getting along with everybody. Resident 22 indicated they did not like to ask for much. Resident 22 indicated they occasionally had bad dreams and had to remind themselves the trauma was a long time ago. Resident 22 indicated they put the traumatic memories in the back of their mind. Resident 22

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	indicated they had been shot in their head, had been in a coma for 1 year, had been wrongfully convicted for selling drugs and had been in prison for 5 years. Resident 22's record was reviewed on 6/5/24 at 12:26 PM. Diagnoses included generalized anxiety disorder, major depressive disorder, traumatic brain injury (TBI), impulsiveness, current daily nicotine use and PTSD. Resident 22's Annual MDS dated 4/20/24 indicated the resident's BIMS score was 12 (mild to no cognitive impairment). The MDS indicated Resident 22 sometimes displayed social isolation. The MDS indicated Resident 22 had not displayed behaviors of verbal aggression, physical aggression, wandering or resistance of care. The MDS indicated Resident 22 had diagnoses of TBI, anxiety, depression and PTSD. A Social Service Psychosocial Assessment dated 9/19/23 at 7:14 PM indicated Resident 22 had been involved in a verbal and physical alteration with another resident. Resident 22 had full recollection and awareness of the event. Resident 22 did not display any observable changes in mood or emotion. Resident 22's relevant psychosocial history was alcohol use, illicit or prescription drug use and traumatic injury. Resident 22's triggers that alarmed or distressed them were a change in routine or a change in living arrangement. The assessment indicated no follow-up was needed. A Social Service Abuse and Neglect Screening dated 1/20/24 at 12:30 AM indicated Resident 22 had a moderate problem with severe mental health diagnoses and possible misinterpretation of events and the intentions of others. Resident 22 had a moderate problem with recent aggressive or			

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	agitated behavior and/or resistance to care. Resident 22 had a moderate problem of a history or recent relapse of substance abuse or compulsive behaviors. Resident 22 had a moderate problem with a history of abuse or neglect either as a recipient or a perpetrator. Resident 22 had a moderate problem with a history of criminal behavior. Resident 22 had a moderate problem with factors that increase vulnerability such as severe mental illness, poor insight, poor judgement, dementia, confusion or poor ambulation abilities. Resident 22 had no problem or minimal problem with depressive symptoms such as distressed mood, low self-esteem, isolation, withdrawn behavior, illness, chronic pain or self-destructive behavior. Resident 22 had no problem or minimal problem with denial of mental illness or minimizing the significance of psychosocial issues or mental health. A progress note dated 1/18/24 at 2:40 PM indicated Resident 22 had behaviors of physical aggression and refusing care. Resident 22 had been hard to redirect when the behaviors occurred. The note did not indicate any trigger had been identified related to her behavior, A progress note dated 1/19/24 indicated Resident 22 had felt depressed for the last 7 to 11 days. Resident 22 was unable to state the reason they felt depressed. A progress note dated 3/11/24 at 5:02 PM indicated Resident 22 and their sister had attended a Care Plan Meeting. Resident 22's sister indicated they had plans to move the resident out of state to be closer to their family. Resident 22's sister indicated although they wanted Resident 22 closer to their family, they did not want relocating the resident from the facility to cause the resident			

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	any stress. A progress note dated 3/18/24 at 7:04 AM indicated Resident 22 had an acute (serious or severe) psychiatric evaluation for increased insomnia. Resident 22 had denied insomnia at the time of the evaluation. Resident 22 had denied feeling depressed, anxious or worried. Resident 22 had a short attention span. Resident 22 had maintained fair eye contact. Resident 22 had poor insight and poor judgement. Resident 22's visit diagnoses were anxiety and insomnia. Resident 22's treatment plan was for the staff to provide support for the resident's anxiety and insomnia. Resident 22's lack of hygiene was noted. Resident 22's Care Plan focus dated 1/7/24 indicated the resident was at risk for altered activity patterns as evidenced by minimal involvement in scheduled group programs. The target goal was for the resident to express satisfaction in self-directed activities through the next review date. Interventions included encouragement to attend group activities, respect choices and allowance of choices, there was no indication of triggers for the altered pattern. Resident 22's Care Plan focus dated 6/3/24 indicated the resident had a risk of impaired safety or injury as evidenced by chronic obstructive pulmonary disease, psychosis, PTSD and unsteadiness on their feet. The target goal was for the resident to have a minimized risk for falls and injuries through the next review date. Interventions included medications as ordered, call light within reach, items within reach, adequate lighting, safe footwear, psychiatry services as needed, and therapy evaluations as needed. The plan did not indicate triggers related to PTSD.			

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Resident 22's Care Plan did not include a focus for depression, anxiety or PTSD. Resident 22's Care Plan did not include resident specific behaviors. Resident 22's Care Plan did not include the resident's signs and symptoms of distress or behaviors such as poor hygiene, self-isolation, denial of feelings and insomnia. Resident 22's Care Plan did not include resident specific stressors such as a change in routine or a change in living arrangement. Resident 22's Care Plan did not include interventions to reduce their stressors.

In an interview on 6/4/24 at 8:20 AM, Qualified Medication Aide (QMA) 8 indicated they were not aware of Resident 22's triggers of change in routine or living arrangement. QMA indicated they were not aware of Resident 22's sister plan to relocate the resident. QMA 8 indicated they were not aware of Resident 22's anxiety and insomnia after the resident spoke with their sister about moving from the facility.

In an interview on 6/5/24 at 4:10 PM, the Chief Nursing Officer indicated they were unaware of the facility's process of monitoring behaviors. The Chief Nursing Officer indicated they were not aware of the lack of a Care Plan for the residents' mental health diagnoses. The Chief Nursing Officer indicated they were not aware of the lack of resident specific triggers on resident Care Plans. The Chief Nursing Officer indicated the Social Service department was responsible for mental health diagnoses. The Chief Nursing Officer indicated the Social Service Director was not available.

A current facility policy dated 1/26/23 provided by the Administrator on 6/6/24 at 12:33 PM indicated the facility would identify residents who

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	were trauma survivors by interview, observation and screening assessment tools. The policy indicated the facility must identify triggers that may re-traumatize residents who are trauma survivors. The policy indicated the facility would ensure each resident's Care Plan would describe resident specific interventions to eliminate or mitigate triggers that may cause traumatization and/or psychosocial harm. Symptoms of depression can include insomnia, feeling anxious, feeling sad, restlessness, difficulty with concentration, self-isolation and poor hygiene (CDC, 2024). Factors that may increase the risk of depression include a life changing event even if the event was planned, experiencing a traumatic event, alcohol use, nicotine use and experiencing chronic medical problems. Symptoms of PTSD can include insomnia, difficulty with concentration, self-isolation, memories or dreams of the event, and avoidance of thoughts or feelings associated with the event (NIMH, 2024). Risk factors for PTSD include exposure to traumatic events, history of mental illness, history of substance abuse, added stress after the event such as loss of home, loss of income, loss of support system, and engagement in high risk or destructive behaviors. References Center for Disease Control and Prevention, (cdc.gov, 2024) https://www.cdc.gov/tobacco/campaign/tips/diseases/depression-anxiety.html# National Institute of Mental Health, (nimh.nih.gov, 2024). https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd			

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure medications were secured for 2 of 19 residents reviewed (Resident 21, and Resident 35). Findings include: 1) During an observation and interview on 6/2/24 at 11:42 AM, a cup containing two round white pills were observed on Resident 21's bedside table. Resident 21 indicated the pills were Tylenol	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents #21 and #25 were not negatively impacted by the deficient practice. Upon discovery of the alleged concern the facility nursing managers immediately	07/05/2024

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	and the nurse had left them for him to take when he was ready. He indicated he had never been told that medication needed to be secured if he was not ready to take it at the time it was offered. At the end of the interview, Resident 21 left the room with the pills remaining in the cup at his bedside. Residnet 21 had a roommate in the room. Resident 21's record was reviewed on 6/5/24 at 9:24 AM. Diagnoses included old myocardial infarction, lumbago with sciatica, and low back pain. Resident 21's current quarterly Minimum Data Set (MDS) dated 3/22/24 indicated his Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident 21's current care plan titled resident has chronic conditions with risk for discomfort ... indicated the resident had a problem of pain, with a goal date of 10/11/23. Interventions included provide medications as ordered. Physician orders dated 5/29/24 indicated 2 Tylenol extra strength oral tablets, 500 milligrams, were to be given 3 times daily for pain. No physician's orders for self-administration of medications for Resident 21 were available for review. No medication self-administration assessments for Resident 21 were available for review. In an interview on 6/4/24 at 10:10 AM, the Chief Nursing Officer (CNO) indicated Resident 21 did not have an assessment to self-administer his medications. She indicated the medications should not have been left at bedside. She		conducted a facility wide audit to ensure medications and treatment supplies were stored properly, in a locked storage area with limited access to authorized personnel only. Nurse managers began immediate re-education on 6/4/24 during shift change huddles to promptly address proper storage of medications and treatments. **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?** All residents are at risk to be affected by the deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Routine walking rounds continue by the nurse managers to monitor that medications and treatments are properly stored and are that nurses remain with residents during the administration. An all-staff in-service was completed by 7/5/24 to advise staff report any observations of medications or treatments not properly stored. Staff will be advised to report to the charge nurse upon discovery. All licensed nurses and QMA's received education by 7/5/24 on	

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	indicated the staff member providing the medication should have watched him swallow the pills before leaving the room. A current policy titled Medication Administration General Guidelines, dated 5/20/22, provided by the CNO on 6/5/24 at 3:50 PM indicated the licensed nurse or authorized personnel administering medication must stay with the resident to ensure medications were completely ingested. 2) During an observation and interview on 6/2/24 at 12:07 PM a bottle of povidone iodine was observed on Resident 35's dresser in plain sight of the doorway. Several residents were walking through the hallway. Resident 35 indicated the staff left the dressing supplies in the room so they would not have to go down the hall to get it from the treatment cart each time they changed the dressing on her leg. Resident 35's record was reviewed on 6/5/24 at 09:40 AM. Diagnoses included type 2 diabetes mellitus without complications, pressure ulcer of the right heel stage 3, and peripheral vascular disease. Resident 35's current quarterly MDS dated 4/12/24 indicated her BIMS score was 13 (mild cognitive impairment). The MDS indicated Resident 35 had a stage 3 pressure ulcer. Physician orders dated 6/2/24 indicated Resident 35's right food should be cleansed with wound cleanser, povidone-iodine solution 10 % should be applied and then covered with an abdominal pad (large, padded gauze bandage) and wrapped with kerlex (rolled gauze). Resident 35's current care plan titled ...at risk for		the facility policy for medication administration and labeling/storage of medications and treatments. Nurses and QMA's were advised that observation of the resident swallowing medications is expected and that no medications/treatments are to be left at residents bedside. In the event a resident indicates the desire not to accept medication/treatment when offered then the nurse/QMA must return the medication/treatment to a secured area of storage until the resident is ready to receive or accept. The facility leadership team participates in random observations and rounds of the facility on various shifts and will monitor that medications/treatments are not left at bedside and that medication carts/med rooms/ and treatment carts are kept locked when not in direct site of authorized staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Medication administration and proper storage of medications and treatment supplies will be audited utilizing the audit tool titled " Medication Administration Storage Review" tool. The DON or other	

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	impaired skin integrity ... indicated Resident 35 had a problem of peripheral vascular disease and non-compliance with wound care and treatment, with a goal date of 5/31/24. Interventions included providing treatment as ordered. No physician's orders for self-administration of medications for Resident 35 were available for review. No medication self-administration assessments for Resident 35 were available for review. A current policy titled Medication and Biological Storage Requirements, dated 5/20/22, provided by the CNO on 6/5/24 at 3:50 PM indicated the facility should secure all medication in a locked storage area with access limited to authorized personnel. 3.1-25 (m)		designee will be responsible to complete the audit 3x per week for 12 weeks to include both shifts, then weekly on an ongoing basis. Any identified issues will be corrected upon discovery and logged on facility QA tracking log. The tracking logs will be reviewed by the QAPI team during the monthly meeting. Ongoing audits will be conducted for a minimum of 6 months and 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	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained in a sanitary manner to promote food safety. 59 of 59 residents residing in the facility ate food prepared in the facility kitchen. Findings include: During an observation and interview on 6/2/24 at 9:41 AM red spots of dried liquid in a splattered pattern were observed on the wall containing the kitchen entry door. In the meal service area where bowls of cereal and condiments were stored, a partial piece of toast with jelly with missing portions in a bite pattern on a napkin. A Styrofoam cup filled with oatmeal and a spoon sat next to the toast. Dietary aide (DA) 2 indicated both items belonged to DA 3. The back door leading to the outside of the building was open, leading to a receiving area including the dumpsters. The closest dumpster had open lids and was located about 34 feet from the kitchen door. Cook 4 indicated the staff would leave the back door open to help keep the kitchen cool. She indicated she was not aware the door should be shut when not directly attended to. In the dry storage area, a box containing thickener contained an open plastic bag with the product open to air. Cook 4 indicated the bag should have been secured shut and dated. In the walk-in cooler and walk-in freezer, no	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. Kitchen was deep cleaned by IDT immediately. Placement of thermometers was verified. Floor tiles were cleaned and replaced. Resident food committee meetings have been started on a weekly basis to update residents of kitchen changes and updates. **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?** No other residents are at risk due to the alleged deficient practice as all residents were potentially affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	07/05/2024

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	interior thermometer was found. Cook 4 indicated she did not know what device was used to record temperatures on the temperature log. In the walk-in cooler, a large cart containing trays of individual servings of mixed fruit and individual servings of chocolate pudding was uncovered and undated, with each individual serving open to air. Cook 4 indicated the servings were in the cooler when she arrived for work that morning and she did not know when they were prepared. On a shelf in the walk-in cooler, a bag of parmesan cheese was observed open with the product open to air. A tray containing bags of shredded cheese, chopped lettuce, shredded carrots, and hot dogs. None of the bags were labeled and dated. A container of sliced black olives was covered with plastic wrap with no label or date. Cook 4 indicated each item should be covered, labeled, and dated. The floor throughout the kitchen and service area had gray dime to quarter sized spots, too many to count and scattered multicolored crumbs and particles, speck to dime sized, too many to count. In an interview, Cook 4 indicated there were not any housekeeping or maintenance staff available to clean the kitchen floors when they get ready to leave for the day, so the floor does not get cleaned. During an observation in the kitchen on 6/2/24 at 1:10 PM, the Dietary Manager (DM) washed her hands for 11 seconds between washing dishes and moving to another kitchen area. Cook 4 dropped a serving spoon on the floor, rinsed her hands under water for 5 seconds, dried them with a paper towel and returned to her workstation. A current policy titled Employee Hygiene and		On 6/2/24, staff was immediately in-serviced on proper hygiene and sanitation in the kitchen areas, including staff consuming food within work areas. Staff was also immediately in-serviced regarding cross contamination of the kitchen area as evidenced by the door to the dry storage area being left open. Signage has been placed to remind staff not to prop exit doors and to use designated exit doors for entering and exiting the facility. The door to the storage area has been labeled as a shipment receiving door only. All food storage areas were audited for open containers and immediately discarded if opened, uncovered, and/or without appropriate opened on and use by dates. On 6/3/24, both the walk in cooler and freezer were checked for interior thermometers. Thermometers were located in both areas. Dietary staff was immediately in-serviced as to the location of the thermometers and the policies and procedures for checking fridge and freezer temps daily via the indoor thermometers only. On 6/2/24, dietary staff and the	

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	Handwashing, undated, provided by the Administrator on 6/3/24 at 8:56 AM, indicated hands should be washed using posted handwashing procedures and work areas should be cleaned after each use. A current policy titled Food Safety and Sanitation, undated, provided by the Administrator on 6/3/24 at 8:56 AM, indicated all foods requiring temperature control for safety should be labeled, covered, and dated. The policy indicated when a food package is opened, the food item should be marked to indicate the open date, and the open date should be used to determine when to discard the food. A current policy titled Food Storage, undated, provided by the Administrator on 6/3/24 at 8:56 AM, indicated plastic containers with tight fitting covers or sealable bags must be used for dry stored products. All containers or storage bags must be legible and accurately labeled and dated. The policy indicated refrigerators should be equipped with an internal thermometer. A current policy titled Handwashing/Hand Hygiene/Gloving, provided on 6/5/24 at 1:01 PM by the Regional Director of Operations indicated hands should be washed with soap and water rubbing vigorously for at least 20 seconds. 3.1-21(i)(2) 3.1-21(i)(3)		Executive Director inspected the walk-in freezer and cooler. All undated foods were discarded immediately. Both areas were immediately cleaned as well. On 6/3/24, the Maintenance director replaced any broken and discolored floor tiles. Dietary staff was re-educated about proper cleaning and sanitation of all kitchen surfaces, including floor. Director of Dietary Services was in-serviced as to Dietary department's cleaning schedule. Appropriate cleaning schedules were then delegated to each shift and explained dietary staff's responsibility of cleaning their workspace. Additionally, quotes were obtained to epoxy finish all floor and wall tiles with an expected completion date of no later than 10/15/24. Handwashing audits were completed on 6/3/24, including return demonstrations of all dietary staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** All dietary staff were re-educated on the location of interior thermometers of the cooler and	

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			freezer. Temperature logs were verified to be complete and full. Daily temperature logs will continue of both storage spaces. Temp logs will be reviewed at QAPI meetings until two consecutive quarters of compliance are noted. Weekly Executive Director or designee sanitation audit walkthroughs of the kitchen and food storage spaces will occur starting the week of 6/3/24 indefinitely. Results of walkthroughs will be immediately distributed to the Director of Dietary Services to provide feedback to dietary staff. Dietary staff was in-serviced by the Corporate Director of Dining Services for proper cleaning procedures. Temperature log record reviews are part of sanitation audit form. Daily audits were started 6/3/24 for Dietary staff to check all food storage areas, including the freezer and cooler to ensure proper labeling and dating of all food items. The Dietary Manager will continue audits will until two consecutive weeks of full compliance daily are observed. At that point, audits will continue on a weekly basis indefinitely. Handwashing audits for all scheduled dietary staff with return	

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			demonstration will continue weekly x 4 weeks until two weeks of full compliance with staff is observed. Upon obtaining that level of compliance, monthly audits with a minimum of 25 observations will continue until 2 consecutive months with full compliance of proper handwashing technique are demonstrated. Handwashing compliance will be reviewed through the QAPI committee. Return demonstrations will also be a part of the Kitchen Audit Walkthrough sheet.	
F 0814 SS=D Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, record review and interview the facility failed to ensure garbage and refuse were contained inside the dumpster for 1 of 2 observations. Findings include: During an observation and interview on 6/2/24 at 9:59 AM, the kitchen door leading to the outside loading dock was propped open. All kitchen staff had been at the opposite end of the kitchen performing meal service. The dumpster was located about 34 feet from the kitchen door. The dumpsters' lids were open with bags of trash inside. A bag of trash was observed on the ground in front of the dumpster torn open. Piles of food debris including partial pieces of pizza, open Chinese food containers with bits of food, fast food cups, straws, and bags, soda bottles and	F 0814	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified as being affected by the alleged deficient practice. Dumpster doors are to be closed when not in use. **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?** All staff will be in-serviced by the Executive Director or designee on	07/05/2024

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	cans, used gloves, lip balm, plastic bags and other debris were lying on the ground around the dumpster, in the grassy area near the dumpster and scattered throughout the parking lot. Cigarette butts, too many to count, were observed on the pavement of the loading area in front of the dumpster area. Cook 4 indicated all departments should make sure the lids were closed on the dumpster. Cook 4 also indicated there should not be trash lying on the ground around the dumpster. During an interview on 6/2/24 at 2:16 PM. The Regional Director of Operations indicated the dumpster lids should be closed and there should not have been anything on the ground around the dumpster. He indicated the kitchen door should be closed and not propped open when not directly attended to. A current policy titled Store, Distribute, and Serve Food Safely and Disposal of Garbage and Refuse, dated 11/22, titled was provided by the Administrator on 6/3/24 at 1:34 PM. The policy indicated facility dumpsters should always remain covered, with no garbage on the ground and waste properly contained. The policy indicated loading docks used for transport of garbage and clean food transport should be kept clean and free of debris. The policy indicated the garbage storage area should be maintained in a sanitary condition to prevent the harborage and feeding of pests. 3.1-21(i)(5)		ensuring the dumpster doors remain closed when not in use by 6/25/24. Signage has been placed on each individual dumpster to inform staff that lids are to be shut immediately after use. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Location of the dumpster left open was relocated beside the second dumpster. To help aid staff in closing the dumpster lids, both dumpsters were replaced with side and/or back load dumpsters with accessible doors. Management inter-disciplinary team and its designee(s) will also check for proper lid closure on a daily basis. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** The Director of Food Services or their designee will be responsible for monitoring and auditing dumpster closure logs weekly for four weeks, then monthly for six months, and then quarterly until compliance is assured for two consecutive e quarters. All audit results will be reviewed by the	

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			QAPI committee and Executive Director.	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.			

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	§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those			

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	areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality			

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	deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on observation, record review, and interview, the facility failed to ensure a process was in place to identify and correct deficiencies from re-occurring. 59 residents resided in the facility Findings include: The facility annual survey completed on 6/16/23 identified noncompliance regarding labeling and dating of food products. The facility indicated the noncompliance would be corrected by 7/5/23. See F812 for additional information about current kitchen sanitation findings. A QAPI (Quality Assurance Performance Improvement) committee list was provided by the Executive Director (ED) on 6/3/24 at 11:41 AM. The member list included Executive Director, DON, ADON, Admissions director, MDS coordinator, Medical Records in central supply, Therapy Director, Business Office manager, HR director, Director of Food services, Maintenance Director, Medical Director, Nurse practitioner. The 2nd quarter QAPI Plan, dated 5/24/24, was reviewed. The QAPI Plan indicated segments of care including Performance Improvement Plan (PIP) for environment, human resources, social services, operations, dietary, staff development, environmental services, and maintenance were reviewed in each monthly QAPI meeting. The dietary discussion included: 1) development of	F 0867	**F687 QAPI/QAA** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No Residents were affected. **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** All Residents in the facility have the potential to be affected. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The facility Administrator or designee will ensure QAPI meetings and necessary audits related to this citation are reviewed in QAPI/QAA on a monthly basis. A deep clean of the	07/05/2024

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	the ballpark style menu that catered to the request of residents, 2) development of an alternative menu option that catered to the request of residents, 3) hiring and development of dining and food service staff, 4) staff development, and 5) deep clean of kitchen with staff assistance. Completion timeline goal 6/21. In an interview on 06/06/24 at 11:36 PM, the Executive Director (ED) indicated dietary was an ongoing topic in QAPI meetings. He indicated there was a current PIP pertaining to dietary but the PIP was not located in the 5/24/24 QAPI Plan. A current policy titled Food Safety and Sanitation, undated, provided by the Administrator on 6/3/24 at 8:56 AM, indicated all foods requiring temperature control for safety should be labeled, covered, and dated. The policy indicated when a food package is opened, the food item should be marked to indicate the open date, and the open date should be used to determine when to discard the food. A current policy titled Food Storage, undated, provided by the Administrator on 6/3/24 at 8:56 AM, indicated plastic containers with tight fitting covers or sealable bags must be used for dry stored products. All containers or storage bags must be legible and accurately labeled and dated. 3.1-52		kitchen area was completed along with re-initiation of a kitchen sanitation schedule. All present food related items were appropriately dated and labeled as necessary. All kitchen staff were re-educated on these expectations along with proper infection control related to hand washing. A weekly audit which will be conducted three times per week was implemented to monitor sanitation, dating & labeling of food along with proper handwashing. Any noted deficiencies will be corrected in a timely manner. Monthly QA meetings will be further reviewed, monitored and discussed on a monthly basis by the RDO or Designee to ensure proper completion and follow through of the plan of correction. These audits will continue x6 months or until 100% compliance is achieved for x3 consecutive months. **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 results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until 100% compliance is achieved x3 consecutive months.	

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			The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance:** 7/5/2024	
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, interview and record review, the facility failed to ensure a clean environment was maintained in 4 of 5 rooms reviewed. 4 residents resided in the 4 rooms affected (Resident 35, Resident 14, Resident 21, Resident 5, and Resident 32). Findings include: During an observation on 6/2/24 at 10:49 AM, Resident 35's floor (Room 303) had multiple dime to quarter sized yellow/orange spots on the right side of the bed. The resident had a foley catheter hanging in this location. The catheter was emptied by staff. On the left side of Resident 35's bed, near the top, 5 disposable chucks/chux pads (incontinence pad used under resident to protect mattresses by containing urine or feces) were observed wadded up and piled on the floor in the corner of the room by the left side near the head of the bed. A strong urine odor was in the room and radiated to the hall. A Mountain Dew and empty pop bottles were on the floor. During an observation on 6/2/24 at 10:32 AM,	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Room 303 – Room was cleaned out of all trash and associated items. Floor was mopped and disinfected per protocol. Room 310 – All flooring in room was cleaned, stripped and waxed. Room 311 – Housekeeping assisted resident in sorting laundry and re-washed clothing items in room. Room 302 – Mattress was discarded. New mattress was provided with mattress protector. **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?**	07/05/2024

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	06/06/2024

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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	Resident 14's floor (Room 310) had multiple gray spots and marks consistent with wheelchair wheels. The floor in the area of the marks was sticky. During an observation on 6/2/24 at 1:52 PM, Resident 5's (Room 311) dirty clothes were observed on the floor behind her bed. During an observation on 6/3/24 at 9:31 AM, Resident 32's (Room 302) room had a pervasive urine odor eminating into the hall. The Assistant Director of Nursing (ADON) indicated the urine odor was coming frim the matterss. Daily Housekeeping Schedules indicated housekeeping should wipe furniture (tables, dressers, etc..), toilet bowl and seat (spot clean walls, etc..), restock paper supplies, empty waste basket, sweep, and mop. The Daily Housekeeping Schedule dated from 5/20/24 to 6/4/24 indicated 300 Hall rooms were cleaned 5/27/24, 5/31/24, 6/4/24. The Floor Tech Cleaning Schedule indicated on 5/24/24 Room 313 no mention what was done, and 6/4/24 Room 316's floor was waxed. In an interview on 06/04/24 at 10:23 AM, the Chief Nursing Officer (CNO) indicated the hall was hard to keep clean and smelling good because so many residents refuse to bathe, ad/or leave the room. The CNO indicated the facility had thrown away 2 mattresses. In an interview on 06/06/24 11:36 PM with the Executive Director (ED) and Regional Director of Operations (RDO) they indicated the environment of the facility was part of their Performance		No other resident was identified to have been affected related to identification of needed housekeeping and/or sanitation. Facility wide walk through was completed by Executive Director and RDO, Maintenance Director, and Housekeeping designee to identify facility needed cleaning. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility wide walkthrough was conducted by corporate support team and Executive Director. As part of QAPI plan, 300 hallway will be renovated throughout the year, with work scheduled to be completed by end of year. Work is to include new flooring and new painting throughout identified hallway. Housekeeping staff has been in-serviced on daily schedule and tasks to be completed. Employees have been designated hallways by assignment with detailed instructions on cleaning processes. Schedule for deep cleaning of rooms has been adjusted to focus on daily room assignments. Preventative maintenance log will be reviewed weekly for completed repairs. Housekeeping supervisor	

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	Improvement Plan (PIP). The facility Quality Assurance and Performance Improvement (QAPI) indicated the facility had been focusing on the East and South halls (100 and 200 units) deep cleaning one to two resident rooms daily and developed a cleaning guide for housekeeping with a completion timeline of 7/5/24. There was no indication the 300 hall had been included in the plan. A current policy titled, "Daily Cleaning in Residents Rooms", provided by the ED on 6/4/24 at 11:30 AM, indicated the floor should be swept and mopped thoroughly; mattresses should be washed if bed is stripped and needed cleaned. 3.1-19(4)(f)		or designee will review cleaning checklist weekly. Educated staff will notify their supervisor should any resident voice concerns regarding Maintenance or Housekeeping. Rounds will be completed 3x weekly to identify any areas of needed repair or cleaning and reviewed in stand-up meeting daily. Specific attention will be paid to painting, drywall, trash removal and resident floors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Executive Director, Maintenance Director, and Housekeeping designee will round together 2x weekly. Areas of focus will be placed on a preventative maintenance log sheet for follow up. Cleaning issues identified will be immediately address and placed on deep cleaning schedule for housekeeping staff. ED or designee will review schedules for completion. Results will be reviewed in QAPI meetings for 6 months or until 90% compliance is achieved in two quarters.	