STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00418458. Complaint IN00418458 - Federal/state deficiencies related to the allegations are cited at F622. Survey date: September 28, 2023 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 2 Medicaid: 52 Other: 13 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 4, 2023.	F 0000		
F 0622 SS=G Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's			

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

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	needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that			

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	the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on interview and record review, the facility failed to ensure a resident was free from	F 0622	University Nursing Center submits this response and Plan of	10/20/2023

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	involuntary transfers without identified necessity for 1 of 1 resident reviewed for involuntary transfers (Resident C). This deficient practice resulted in emotional distress to the resident requiring an extra dose of psychoactive medication, the resident experiencing a stressful life change, the resident being moved to a facility not of the family's choosing, and the resident now residing in a facility a greater distance for the family to drive to for visit. Findings include: The current "CMS 672 Census and Condition Detail" report, provided by the RN Consultant on 9/28/23 at 2:00 p.m., indicated the following regarding "mental status" for the current resident population: 34 of the current 67 residents had depression, 25 of the current 67 residents had a psychiatric diagnoses, 42 of the current 67 residents had a diagnoses of dementia or a related disorder. During an interview on 9/28/23 at 12:27 p.m., Resident C's family indicated the following: The facility discharged the resident and it was not the family's request. The facility did not provide the paper work or opportunity for a 30-day notice of involuntary transfer. They were not told they could appeal or object to the transfer. On or around 9/22/23, the facility called and said they were going to have to transfer their loved one, as they could not met his needs. The family and facility had 30 days to work all this out. On 9/25/23, the facility called and said they were transferring Resident C tomorrow. The family was not given a choice, it felt like it was a done deal.		Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. **F 622** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C has been discharged from the facility. Receiving facility identifies	

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	The family member told the facility she wanted to inform the resident about the transfer. The Administrator told the resident before the family arrived at the facility and led the resident to believe the move was the family's idea, which upset him even more. After the facility informed the resident , he was very upset and couldn't be calmed. The resident indicated he couldn't calm down and needed medication. An "as needed" psychoactive medication had to be ordered and given to try to calm him down. He did not deal well with change, and it could make his condition worse. The family had chosen University Nursing Center because it had a good reputation, good star scores, the family had a history with the facility, it was close enough for regular visits. The family did not choose the facility Resident C was transferred to, it was only a three (3) star facility. The new facility was in a different town and further away, making it difficult to visit. Since the transfer, the resident was doing okay and was in the process of adjusting. He was not a danger to himself or others at the new facility. Review of a map search, retrieved from www.maps.google.com, indicated the new facility was 22 miles and approximately 34 minutes' drive from University Nursing Center. During an interview on 9/28/23 at 2:21 p.m., the psychiatric Nurse Practitioner (NP), who offered in house counseling and psychiatric services to Resident C, indicated the following: She believed the regional or corporate office of the nursing home had been concerned about the resident's mental health needs and had requested more frequent rounding visits. The NP and psychiatric Doctor had both visited regularly. The resident had not been deemed a danger to himself or others at any time following his 9/8/23 discharge		Resident C is doing well and participating in activities. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents receiving a facility initiated discharge have the potential to be affected. Audit completed by Social Services identifying no other facility initiated discharges to review. IDT and Medical Director educated per Regional Director of Nursing Services on Facility Initiated Discharge policy by 10/19/23. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; IDT and Medical Director educated per Regional Director of Nursing Services on Facility Initiated Discharge policy by 10/19/23. IDT will review all facility initiated discharges to ensure notice of transfer or discharge form is used, 30 day notice is offered, appeal process reviewed with family/resident and receiving facility receives the appropriate paper work. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	

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	from a mental health facility. He had been doing well during her last visit, and was out of his room and playing Yahtzee with two ladies. He indicated he knew he needed to get out of his room and socialize more for his mental health and well-being and had a positive outlook. According to the doctor's notes, the resident was calm and in a good disposition. She had been told the family was requesting the transfer. The resident had experienced atrial fibrillation (A-Fib) recently and was showing manic symptoms during the event. Research has shown A-Fib can impact bipolar and manic episodes, and she was concerned if that could be the case and sent the resident to the emergency room (ER). As often happened, the resident was out of A-Fib when he arrived to the ER. She would have liked to explore that issue further. The transfer out had been very quick, and she had not been aware it was happening. The resident was regimented and negatively impacted by change, which could potentially cause an increase in manic episodes. Resident C's clinical record was reviewed on 9/28/23 at 11:10 a.m. The resident was admitted to the facility on 11/28/22 and discharged from the facility on 9/26/23. The resident's admission and discharge diagnoses included dementia, paranoid schizophrenia, major depressive disorder, bipolar disorder, and anxiety disorder. No additional mental health-related diagnoses were received or added during the residents stay in the facility. An 11/29/23, "Preadmission Screening and Resident Review-Level 1" form, completed as part of the admission process, indicated he had a history of suicide attempts or gestures greater than five years prior to the assessment and a history of hallucinations or delusions currently or within the past 30 days. Diagnoses included		place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. CQI Tool facility initiated discharge will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: October 20, 2023. IDR being requested due to not receiving fair survey and disagreement with scope and severity of citation.	

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	dementia, schizophrenia, depression, anxiety, and diabetes. He was no longer appropriate to stay in a group home setting and was admitted to the skilled nursing facility for long term placement. The resident's admission orders, dated 11/28/22, indicated diagnoses of paranoid schizophrenia, bipolar disorder, dementia, and anxiety. The resident received six (6) psychoactive medications for the treatment of "paranoid schizophrenia" as follows: benztropine(improve the movement side effects caused by antipsychotic drugs), buspirone (an anti-anxiety medication), clonazepam (medication used for panic disorders and anxiety), Risperdal Consta (an injected antipsychotic medication), risperidone (an antipsychotic medication), and sertraline (an antidepressant medication). A 7/19/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident understood others and was understood by others, was cognitively intact, and displayed no hallucination, delusions or maladaptive behaviors during the assessment period. An 8/28/23, discharge with return anticipated, MDS assessment did not contain a cognitive assessment and indicated the resident was delusional. He was not rejecting care nor displaying maladaptive behaviors towards himself or others. The resident had the following current care plan problems/needs at the time of his discharge: Mood State: Risk for alteration in mood status: depression/depressive symptoms due to placement in nursing facility, loss of independence. This problem originated at the			

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	time of his admission on 11/28/22, and continued throughout the resident's stay at the facility. Mood State: Resident at risk for signs and symptoms of anxiety as evidenced by worried facial expression, repetitive movements, SOB (shortness of breath), nausea, sweating, tremors, irritability, insomnia, reports of anxiety, etc. Resident had a diagnosis of anxiety. This problem originated at the time of his admission on 11/28/22 and continued throughout the resident's stay at the facility. Mood State: Resident at risk for signs and symptoms of depression as evidenced by sad facial expression, withdrawal, decreased appetite, tearfulness, insomnia, verbalization of depression, etc. Resident had a diagnosis of major depressive disorder and received antidepressant medication. This problem originated at the time of his admission on 11/28/22, and continued throughout the resident's stay at the facility. Behavioral Symptoms: Resident exhibited hallucinations and delusions as evidenced by...law enforcement wants to kill him, cop was coming after him, he was locked in a truck and beat him, someone was going to kill him with a gun. Resident had diagnosis of paranoid schizophrenia and received antipsychotic medication. This problem originated on 12/15/22, and continued throughout the resident's stay at the facility. Resident had a suicide attempt on 6/15/23, when he was noted to place a trash bag over his head. He was sent for a behavioral health stay, with a return to the building on 7/7/23. The physician at the health facility stated the resident was not a threat of self-harm or suicide attempts. This			

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	problem originated 7/6/23 and continued throughout the resident's stay at the facility. Resident had increased manic behaviors. He was sent for a behavioral health stay, with a return to the facility of 9/8/23. The psychiatric Nurse Practitioner who rounded at the facility stated the resident was not a threat of self harm or suicide attempts. This problem originated 9/8/23, following a mental health stay to treat manic behaviors associated with bipolar disorder and continued throughout his stay at the facility. Approaches to this problem included the following: Invite resident to be social with others, involve in activities, and recommend resident to participate in group activities. Review of Progress Notes from 8/9/23 to 9/26/23, lacked any documentation that the resident was a danger to himself of others. A 9/21/23 at 10:09 a.m., Progress Note by the Social Services Director indicated they spoke with the resident's family and discussed the need for resident to transfer to another facility that was able to better meet the resident's needs. A 9/21/23 at 4:18 p.m., Progress Note by the Social Services Director indicated they referred the resident to a facility that could better meet the resident's needs. A 9/25/23 at 8:00 a.m., Progress Note made by the doctor from the psychiatric service provider indicated the resident had lost his roommate (who had died). He seemed more relaxed. When asked, he reported that he was taking his medication and getting himself out of his room to get more involved in activities. His mood was stable and his speech continued to be pressured, but he was			

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	more able to change topics today. A 9/25/23 at 4:18 p.m., Progress Note indicated the resident was informed by staff that he would be transferred to a facility in a neighboring city, and then called his daughter and the resident stated he was told that there was another facility to better care for him due to resident diagnoses. The resident was on the phone with his daughter and staff heard the resident crying and he was highly upset with the information. He stated he wasn't going to lose his life and he was not moving. Staff encouraged the resident to calm down and that everything would be alright, to no avail. The resident remained upset and stated "[Administrator's name] is going to pay..." A 9/25/23 at 7:32 p.m., Progress Note indicated the resident's family member approached the nurse and stated that the resident was very anxious and agitated over being told that he would be transferring facilities on 9/26/23. They asked if the resident could be given a medication to calm his anxiety and agitation, as he had experienced episodes of crying and verbalizing anger this afternoon. The family member had spent a few hours visiting to help calm the resident, but he was still agitated. The nurse received an order to administer his next dose of Seroquel [an antipsychotic medication] at this time and continue to monitor. A 9/25/23 at 8:30 p.m., Progress Note indicated the resident continued to have anxiety and to be agitated. He stated that he was going to "see [Administrators name] in court and sue him!" because the resident was being transferred to another facility tomorrow. No interventions were effective. A new order was received to give Seroquel 50 mg orally right now for increased			

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	anxiety and agitation. During an interview on 9/28/23 at 12:55 p.m., with the Administrator and DON, the facility indicated the resident was not a danger to himself or others at the time of his transfer from the facility. He had not been a danger to himself or others at any time since his readmission to the facility on 9/8/23, following an inpatient mental health stay. The resident had displayed an increase in manic behaviors such as talking quickly and standing too close. The facility was unable to identify how they could not meet the resident's needs, and felt the other facility could "better meet" the resident's needs due to their experience with mental illness and mental health needs. During an interview on 9/28/23 at 1:31 p.m., with the Social Services Director and DON, the facility indicated the facility believed the residents needs would be "better met" at the other facility that had more skills for dealing with major mental illnesses. The resident had the same mental health diagnoses he had upon admission, when they had indicated they could met the resident's needs. He had three recent inpatient psychiatric stays, and the facility believed moving the resident to a facility with more mental health experience would reduce the chances of additional inpatient mental health stays. The facility could not identify any needs the resident had that the facility was unable to meet. Review of a current, 2/2020, facility policy titled "Facility Initiated Discharge," provided by the RN Consultant on 9/28/23 at 2:09 p.m., indicated the following: "...It is the policy of this facility that residents be permitted to continue to reside in the facility and			

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	will only be involuntarily transferred/discharged from the facility in the following circumstances: a. The transfer or discharge is necessary for the welfare of the resident's welfare and the resident's needs cannot be met in the facility...1. Documentation...b In cases when the resident's needs cannot be met (reason above), documentation must be made by the resident's attending Physician and include specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and services available at the receiving facility to meet the need(s)...." This Federal tag relates to complaint IN00418458. 3.1-12(a)(4)(A)			