STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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 a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00447450. Complaint IN00447450-No deficiencies related to the allegations are cited. Survey dates: November 21, 22, and 25, 2024. Facility number: 003673 Provider number: 155725 AIM number: 200450890 Census Bed Type: SNF: 24 SNF/NF: 2 Residential: 50 Total: 76 Census Payor Type: Medicare: 21 Medicaid: 1 Other: 4 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 4, 2024.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview and record	F 0550	F 550 Resident Rights/Exercise of	12/18/2024

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

Amanda High | Administrator | 12/17/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	review, the facility failed to ensure a resident who needed assistance with eating was assisted timely for 1 of 11 residents observed in the dining room. (Resident 10) Finding includes: During a continuous dining observation in the main dining room, on 11/21/24 from 11:34 a.m. to 12:41 p.m., the following was observed: At 11:40 a.m., the first food tray was delivered to a resident in the dining room. Resident 10 was at her table waiting for her tray. At 12:14 p.m., a resident was helped to the dining room by therapy. She was then served her food at 12:31 p.m. Resident 10 was still waiting for her food. At 12:20 p.m., the kitchen staff were picking up food trays for multiple residents who had received their meals and were done eating. The staff was returning the trays to the kitchen. Resident 10 was still waiting for her tray. At 12:32 p.m., CNA 7 indicated Resident 10 was a "feed" and needed help eating. They usually waited until a CNA was available to serve a resident who needed help eating. CNA 7 was not observed passing trays and could have helped the resident eat. Resident 10 was still waiting on her food tray. At 12:38 p.m., a male resident came to the dining room from his room. He originally had a room tray but then came to the main dining room to eat. He sat down and was delivered his tray. Resident 10 was still waiting for her food.		Rights 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Resident 10 was provided assistance eating in the dining room. b Care plan was reviewed and updated as needed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any residents who require assistance to eat has 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: a Nurses and CNA's will be educated on resident rights by the DON or designee by December 18, 2024. b Nurses and CNA's will be educated on providing assistance in a timely manner by the DON or designee by December 18, 2024. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a Random audits during mealtimes will be completed by the DON or designee five times per week for four weeks and then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	At 12:39 p.m., the kitchen staff were picking up more food trays from several residents who were done eating. Resident 10 was still waiting on her tray. At 12:41 p.m., Resident 10 was finally served her tray. It was over an hour from the first tray being passed to when Resident 10 received her food tray. Resident 10 watched several residents come to the dining room after her and receive their trays before she did. The clinical record for Resident 10 was reviewed on 11/25/24 at 12:00 p.m. The diagnoses included, but were not limited to, unspecified dementia, dysphagia (difficulty swallowing), depression, and basal cell carcinoma. A care plan, initiated on 8/12/24 and last revised on 11/5/24, indicated Resident 10 had increased nutrient needs. Interventions included, but were not limited to, provide food and fluids and provide dining assistance as necessary. A physician's order, with a start date of 8/5/24, indicated general diet, puree texture, and thin liquid consistency. During an interview, on 11/22/24 at 2:50 p.m., the Executive Director (ED) indicated they usually served residents as they came to the dining room. They would serve independent residents first, then pass room trays, and then pass trays to the residents who needed fed so a CNA could be available. Residents should not have to wait an		two times a week for a month to ensure residents in the dining room that need feeding assistance are assisted timely. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: December, 18 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	hour for their trays to be served. A current policy, titled "DINING AND FOOD SERVICES EXPERIENCE", last reviewed on 5/18/21 and received from the ED on 11/25/24 at 2:12 p.m., indicated "...A resident's quality of life may be enhanced through their dining and/or food experience. The dining and/or food service is provided to ensure that nourishing, palatable and attractive meals based on individual resident needs are served, and that both food service and facility staff assist and support residents during the dining and/or food experience...Residents shall be promptly assisted with eating and provide necessary cueing...." 3.1-3(t)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure a revised Preadmission Screen and Resident Review (PASARR) Level I was submitted after a new mental health diagnoses was added and an antidepressant medication was prescribed for 1 of 1 resident reviewed for PASARR. (Resident 1) Finding includes: The clinical record for Resident 1 was reviewed on 11/22/24 at 12:16 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbances, cognitive communication deficit, major depressive disorder, and anxiety disorder. A PASARR level I, dated 5/28/24, indicated the resident had no mental health diagnosis, dementia or neurocognitive disorder and no mental health	F 0644	F 644 Coordination of PASARR and Assessments 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Resident 1 had a correct PASARR obtained which included the sertraline use and new mental health diagnosis. b Resident 1's care plan was reviewed and updated as needed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any resident with a new mental health diagnosis or a new	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	medication. A physician's order, dated 8/31/24, indicated to give sertraline (an antidepressant medication) 100 milligram (mg) daily. There was no PASARR level I completed when the resident was ordered sertraline. During an interview, on 11/25/24 at 3:37 p.m., the Social Service Director (SSD) indicated a new level I PASARR was not completed. The admission staff would be in charge of implementing the PASARR and missed completing a new level I when a new antidepressant medication was ordered. The new diagnosis for this medication was not added. A current facility policy, titled "Preadmission Screening and Annual Resident Review [PASAR], Preadmission, Screening & Resident Review - SNF," dated 6/1/23 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated "...PASRR requires that all people entering Medicaid-certified nursing communities are evaluated for: Serious Mental Illness (SMI); Intellectual Disability (ID); Developmental Disabilities (DD); are placed in the most appropriate setting, and receive assessments to identify their service needs regardless of (the individual's) method of payment...The community will ensure that all new admissions are appropriately screened prior to admission to determine that the individual requires nursing community level of care and to identify any specialized services that may be necessary...Any resident of the community who has a condition of MI/ID/DD/Related Conditions who experiences a significant change in condition requiring reassessment, this must also be reviewed by the		order for a psychotropic medication has the potential to be affected. b An audit will be conducted by the DON or designee by December 18th of residents and their PASARR's was conducted to ensure any residents with a psychotropic medication or mental health diagnosis has an appropriate PASARR. If any residents are identified based on these results a new PASARR will be requested. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a The admissions coordinator and social service director will receive PASSARR training from the DON or designee by December 16, 2024. b Nurses will receive PASSARR training by the DON or designee by December 18, 2024. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a The admission coordinator or designee will review new orders for psychotropic medications and new mental health diagnosis during morning meeting for four weeks to ensure each resident has an appropriate PASARR and then twice weekly for four weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	state specific agency...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a medication was held per the physician's order for 1 of 1 resident reviewed for quality of care. (Resident 131) Finding includes: The clinical record for Resident 131 was reviewed on 11/22/24 at 9:17 a.m. The diagnoses included, but were not limited to, essential hypertension, unspecified atrial fibrillation (a-fib), and transient cerebral ischemic attack (stroke). A physician's order, with a start date of 11/15/24, indicated Carvedilol (a medication to treat high blood pressure) oral tablet 6.25 milligrams. Give twice per day. Hold if the systolic blood pressure (SBP) was under 120. A review of the November Medication Administration Record (MAR) indicated: On 11/17/24, the systolic blood pressure was 117. Carvedilol was administered on the AM shift. On 11/17/24, the systolic blood pressure was 113. Carvedilol was administered on the PM shift.	F 0684	F 684 Quality of Care 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Records for resident 131 were reviewed by MD and a nursing assessment revealed no negative outcomes. Care plan reviewed and updated as needed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any residents with orders that include hold parameters 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: a Nursing staff including RN/LPN/QMA staff will be educated on MD orders by DON or	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	During an interview, on 11/25/24 at 9:41 a.m., RN 2 indicated the medication was not held and was given. The medication should have been held and a progress note should have been made. There was no progress note in the chart. During an interview, on 11/25/24 at 11:33 a.m., the Director of Nursing (DON) indicated the medication was administered on those shifts. A current facility policy, titled "PREPERATION AND GENERAL GUIDELINES," dated as reviewed March 2021 and received from the Executive Director on 11/25/24 at 2:12 p.m., indicated "...Medications are administered as prescribed in accordance with good nursing principles and only by persons legally authorized to do so...Medications are administered in accordance with written orders of the prescriber...." 3.1-37(a)		designee by December 18, 2024. b Nursing staff including RN/LPN/QMA staff will be educated on the proper execution and notification of hold orders by the DON or designee by December 18, 2024. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a DON or designee will conduct random audits of five residents weekly x4 weeks to ensure hold parameters are followed. Then these audits will be conducted for five residents per month for one month. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview and record review, the facility failed to ensure staff obtained a follow-up weight and notified the physician of a weight gain for 1 of 1 resident reviewed for weight changes. (Resident 1) Findings include:	F 0692	F 692 Nutrition/Hydration Status Maintenance 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Resident 1 has an updated,	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	The clinical record for Resident 1 was reviewed on 11/22/24 at 12:16 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbances, cognitive communication deficit, major depressive disorder, and anxiety disorder. A physician's order, dated 6/21/24, indicated the resident was to receive Ensure (a dietary supplemental drink) three times a day. A care plan, revised on 8/28/24, indicated the resident had increased nutrient needs related to a wound to the coccyx. The interventions included, but were not limited to, diet as prescribed, monitor weight monthly, monitor oral intake of food and fluid, and to give a dietary supplement three times a day. The resident had the following weights: 1. On 11/4/24, the weight was 124.5 pounds. 2. On 11/11/24, the weight was 134.8 pounds. The resident had an 8.27% weight gain in 7 days. There was no documentation to indicate a new weight was obtained to verify the weight gain. There was no documentation of the physician being notified of the weight gain. During an interview, on 11/25/24 at 4:01 p.m., the Director of Nursing (DON) indicated when a resident had a weight loss or gain, she would discuss the weight with the dietitian. The residents with a weight loss or gain should be reweighed. During an interview, on 11/25/24 at 4:10 p.m., the Registered Dietician indicated she was in the		corrected weight. b Resident 1's family was notified of the updated, corrected weight. c Resident 1's MD was notified of the updated, corrected weight. d Care plan reviewed and updated, as needed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any residents experiencing a weight gain of five or more pounds has 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: a An audit of current residents will be conducted by the RD by December 16, 2024 based on December 2024 monthly weights to ensure there were no other residents with five pound weight gains to which the MD/POA were not aware. b Nurses will be educated on the facility policy on Weight Management by the DON or designee by December 18, 2024. c Nurses will be educated on the facility policy on Change of Condition by the DON or designee by December 18, 2024. d Nurses will review weights at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	building three days a week. The facility policy indicated when a resident had a weight gain or loss the resident should be weighed within 72 hours of the first weight. A current policy, titled "Change of Condition," dated 12/1/23 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated "...The Nurse will notify the resident's Attending Physician or On-Call Physician when there has been...A significant change in the resident's physical/emotional/mental condition...Unless otherwise instructed by the resident, the Nurse will notify the resident's family or representative when...There is a significant change in the resident's physical, mental, or psychosocial status...." A current policy, titled "Weight Management in Health Care Center," dated 9/1/22 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated "...The staff nurse will validate that the weight is within acceptable limits. If a resident has a gain or loss of 5 pounds from their previous weight, a new weight must be obtained within 48 hours...The Registered Dietician is responsible for monitoring all weight changes and documenting significant weight loss/gain...." 3.1-46(a)(1)		the end of each shift to ensure weights are completed and within parameters for each resident. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a Audits will be completed by RD or designee 3 times per week for four weeks to ensure residents experiencing a 5 or more-pound weight gain have a reweight within 48 hours and the MD and responsible party has been notified. Audits will then be completed one time per week for four weeks. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails Based on observation, interview and record review, the facility failed to ensure assessments were completed and consent was obtained prior to the use of side rails for 1 of 2 residents reviewed for accident hazards. (Resident 21)	F 0700	F 700 Bedrails 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Resident 1 was assessed	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	Finding includes: During multiple observations, on 11/21/24 at 10:14 a.m., 11/22/24 at 9:13 a.m., and 11/25/24 at 10:47 a.m., a 1/4 side rail was raised and in use on Resident 21's bed. The clinical record for Resident 21 was reviewed on 11/22/24 at 12:36 p.m. The diagnoses included, but were not limited to, unspecified fracture of sacrum, low back pain, radiculopathy lumbar region, spinal stenosis, muscle weakness, diastolic congestive heart failure, cerebral infarction, and chronic pulmonary hypertension. A side rail assessment, completed on 11/1/24 at 4:17 p.m., indicated side rails were not indicated. The electronic record did not have documentation showing the risks and benefits of side rails were explained to Resident 21 or a consent was obtained prior to the use of side rails. During an interview, on 11/22/24 at 2:37 p.m., the Administrator indicated there was not a physician's order for side rails. A physician's order, dated 11/25/24 at 4:41 a.m., indicated to utilize 1/4 side rails to increase independence in bed mobility and in transfers. The physician's order was obtained after the side rails were on the resident's bed. During an interview, on 11/25/24 at 12:07 p.m., the Director of Nursing indicated the resident did not have a side rail assessment or consent completed until 11/25/24. The consent and assessment should have been completed when the side rails were applied.		for use of side rails; per assessment, side rails were appropriate to assist resident with to increase independence bed mobility and bed transfers. b Consents were obtained; MD wrote orders to utilize the bedrails. c Resident 1 has an updated care plan reviewed and updated as needed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any residents with side rails have the potential to be affected. b An audit has been conducted by the DON or designee to ensure resident beds equipped with side rails have a consent, an MD order in place and have been assessed for appropriateness of usage. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a Maintenance staff will be educated to remove side rails upon resident discharges to home by the DON or designee by December 18, 2024. b Nurses will be educated on the side rail policy by the DON or designee by December 18, 2024. 4 How the corrective action will be monitored to ensure the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current facility policy, titled "Bed Safety and Bed Rails," last revised August 2022 and received from the Administrator on 11/22/24 at 3:10 p.m., indicated "...The use of bed rails or side rails...is prohibited unless the criteria for use of bed rails have been met...including...resident assessment and informed consent...Before using bed rails for any reason, the staff shall inform the resident or representative about...the benefits and potential hazards associated with bed rails and obtain informed consent...." 3.1-45(a)(1)		deficient practice will not recur, what quality assurance program will be put into place: a The DON or designee will audit new admissions during morning meeting to ensure that assessments are completed, consents obtained, MD orders received, and care plans updated prior to adding side rails for one month. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure the policy and procedure for conducting an Abnormal Involuntary Movement Scale (AIMS) assessment upon admission and quarterly was followed for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Finding includes: The clinical record for Resident 16 was reviewed on 11/22/24 at 12:37 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, unspecified dementia with psychotic disturbance,	F 0758	F 758 Free from Unnecessary Psychotropic Meds 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Resident 16 had an AIMS assessment completed on 10/16/24. b Resident 16 care plan was updated as needed on 10/16/24. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	metabolic encephalopathy, chronic kidney disease, and unspecified convulsions. A physician's order, dated 11/27/23, indicated to give Seroquel (an antipsychotic) 50 milligrams two times a day for dementia with aggression. A care plan, revised on 5/14/24, indicated the resident used psychotropic medications related to dementia with aggression. An intervention indicated staff were to monitor and document any adverse reactions such as tardive dyskinesia. An AIMS assessment (a scale used to assess for tardive dyskinesia and its severity when prescribed antipsychotic medications) was completed on 10/16/24 at 6:03 p.m. During an interview, on 11/25/24 at 2:53 p.m., the Director of Nursing (DON) indicated an AIMS assessment was not completed for the resident until 10/16/24. This was the only AIMS assessment conducted for the resident. A current facility policy, titled "Anti-psychotic Drug Use," dated 8/21/23 and provided by the DON on 11/25/24 at 4:06 p.m., indicated "...The AIM's test should be completed upon beginning a new order for an anti-psychotic, and quarterly noting the appearance of any extra-pyramidal symptoms which previously were not present...." 3.1-48(a)(3)		action will be taken: a Any resident receiving antipsychotic medication has 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: a The DON or designee will audit all new admissions weekly to ensure any resident receiving antipsychotic medication has an AIMS assessment completed for two months. b The DON or designee will audit all new orders for new antipsychotic medications weekly for two months. c Any RN/LPN's have received education on the facility policy on Psychotropic medications by the DON or designee by December 18, 2024. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a An audit has been completed to ensure all residents receiving antipsychotic medications have had appropriate AIMS assessments by the DON or designee by December 18, 2024. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
			identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medication carts were free from expired medications, medical supplies, and loose pills, and medications were properly labeled after opening for 1 of 2 medication carts reviewed for medication storage and labeling. (Hall 1) Findings include: During a medication storage observation, on 11/22/24 at 10:14 a.m., the following was observed: 1. Drawer 1 of the medication cart had: a. One (1) Erythromycin Ophthalmic Ointment (an antibiotic ointment for the eye) 5 mg (milligram) opened and not dated. b. Six (6) SwabCaps (a disinfecting cap for peripherally inserted central catheter) were in the cart and passed the expiration date of 11/1/24. During an interview, on 11/22/24 at 10:25 a.m., LPN 4 indicated the SwabCaps were expired and should not have been in the medication cart. 2. Drawer 2 of the medication cart had: a. Famotidine (an acid reducing medication) 10 mg tablets with an expiration date of 11/22/24. b. Acetaminophen (a fever reducer/pain reliever) 325 mg tablets with an expiration date of 9/3/24. c. Loperamide (an anti-diarrheal medication) 2 mg	F 0761	F 761 Label/Store Drugs and Biologicals 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a No residents were found to be directly affected. b Erythromycin Opthamalic Ointment 5mg was disposed of and reordered. The new supply was properly dated. c All expired medications and test strips were properly disposed of, and a new supply ordered. d Loose yellow and peach pills were properly disposed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a Any residents receiving medications have the potential to be affected. b An audit was conducted for both medication carts, and no additional expired medications were noted. 3 What measures will be put into place and what systemic	12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	tablets with an expiration date of 10/24. d. Acetaminophen 325 mg tablets with an expiration date 11/18/24. e. Docusate Sodium (a stool softener) 100 mg capsules with an expiration date of 10/2/24. f. Guaifenesin (a medication to relieve chest congestion) Extended Release 600 mg tablets with an expiration date of 11/14/24. g. Blood glucose test strips with an open date of 11/4/24 and an expiration date of 10/31/24, six test strips remained in the bottle. During an interview, on 11/22/24 at 10:31 a.m., QMA 4 indicated the Famotidine had been discontinued and should not have been in the medication cart. 3. Drawer 3 of the medication cart had: a. Acetaminophen 325 mg tablets with an expiration date of 11/18/24. b. One (1) loose pill, peach in color. 4. Drawer 4 of the medication cart had: a. Colace (a stool softener) 100 mg tablets opened with no open date. 5. Drawer 5 of the medication cart had: a. One (1) loose pill, yellow in color. During an interview, on 11/22/24 at 10:31 a.m., QMA 3 indicated the nurses with access to the medication carts were responsible for checking expiration dates and loose pills. Pharmacy performed audits on the medication carts and checked for expiration dates as well. When a medication was opened, the nurse was responsible for writing the date on the medication bottle. A current facility policy, titled "MEDICATION		changes will be made to ensure that the deficient practice does not recur: a Nurses will be educated by the DON or designee by 12/18/2024 on the facility policy on Medication Storage. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: a An audit will be conducted by the DON or designee to ensure there are no expired medication in medication carts. These audits will be conducted weekly x4 weeks, then will be conducted two times per month for one month. b These audit results will be brought to the Quality Assurance Committee quarterly by the Director of Nursing or designee to identify issues and trends for follow-up. 5 Date of Completion: 18 December 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	STORAGE IN THE FACILITY," last revised January 2018 and received from the Administrator on 11/22/24 at 1:53 p.m., indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory...and reordered from the pharmacy...Certain medications or package types such as...blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date...The nurse will check the expiration date of each medication before administering it...No expired medication will be administered to a resident...All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining...." 3.1-25(j) 3.1-25(k)(6) 3.1-25(o)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00447450. Complaint IN00447450-No deficiencies related to the allegations are cited. Survey dates: November 21, 22, and 25, 2024. Facility number: 003673	R 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	Residential Census: 50 These State Reidential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 4, 2024.			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure resident medications were secured in a locked container for residents who self-administer medications for 3 of 11 residents reviewed for medication administration. (Resident 18, 25 and 27) Finding includes: During a resident council meeting, on 11/22/24 at 1020 a.m., Resident 18, Resident 25, and Resident 27 indicated they administered their own medication. They received a letter, on 11/21/24, from the facility informing the residents they would have to purchase a lock box to secure their pills in their rooms. 1. The clinical record for Resident 18 was reviewed on 11/25/24 at 2:30 p.m. The diagnoses included, but were not limited to, chronic kidney disease, cognitive disorder, and hypertension. During an interview, on 11/22/24 at 10:25 a.m., Resident 18 indicated she kept her pills on her kitchen table. When the resident would leave her room, she would leave her front door unlocked. The lock was broken, and her key would get stuck.	R 0295	Plan of Correction Community Name: University Place Assisted Living Community Address: 1750 Lindberg Road West Lafayette, IN 47906-4956 Phone: (765) 464-5600 Date of Survey: 11/21/24 Summary of Deficiency: R295 410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident medications were secured in a locked container for residents who self-administer medications for 3 of 11 residents reviewed for medication administration. (Resident 18, 25	12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	2. The clinical record for Resident 25 was reviewed on 11/25/24 at 2:36 p.m. The diagnoses included, but were not limited to, abdominal aortic aneurysm, atrial fibrillation, and hypertension. During an interview, on 11/22/24 at 10:26 a.m., Resident 25 indicated he kept his medication in the cabinet. His wife lived with the resident, and she had a diagnosis of dementia. Resident 25 was concerned his wife would take the medication. 3. The clinical record for Resident 27 was reviewed on 11/25/24 at 2:49 p.m. The diagnoses included, but were not limited to, atrial fibrillation, osteoporosis, and chronic kidney disease. During an interview, on 11/22/24 at 10:30 a.m., Resident 27 indicated he stored his pills on the top shelf in a cabinet. He was concerned with a bottle of narcotics he received after a surgery. The resident's wife was diagnosed with dementia, and he was worried she would take some of his medication. During an interview, on 11/22/24 at 11:45 a.m., the Administrator indicated the facility mailed out letters informing the residents a lock box was needed to secure their pills in their room. The residents or their families would be responsible for getting the lock boxes. She did not know if any of the residents currently used a lock box. A current facility policy, titled "In-Room Medication Audit," revised 3/1/22 and received from the Administrator on 11/22/24 at 1:52 p.m., indicated "...Resident Services Director or designee ensures that medication box (cabinet) audits are done monthly using the In-Room Medication Audit Log...When the resident is		and 27) 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? For resident 18, 25, 27, medication lock boxes were provided and residents were educated to lock their medication in the box and the box to be kept in one of the cabinets. Care plans were reviewed and updated 2. How the community will identify other residents having the potential to be affected by the same deficient practice? Resident Services Director (RSD) and designee will audit all rooms for residents who self-administer medications and ensure that they are securing the medications appropriately. Community has placed orders for lock boxes and these boxes will be provided to each resident to secure their medications. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? RSD or designee will assess each resident at move-in, semi-annually, and with change in condition if they are meeting the criteria for self-administration. If resident is independent with self-administration, then lock boxes will be provided with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	away from the room, room is to be locked each time...."		education to the resident and family on securing the medications in the room. RSD or designee will conduct an audit of this practice each week X 4 weeks, then monthly X3 months to ensure that residents are able to secure their meds appropriately. Plan of Correction Template 4. How the community will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? RSD or designee will bring the results of audit to QAPI committee. This will be accomplished each week X 4 weeks, then monthly X3 months. Any deficient practices will be corrected immediately. 5. The date of compliance. 12/31/2024	
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance Based on observation, interview and record review, the facility failed to ensure a medication cart was free from expired medications, and medications were properly labeled for 1 of 2 medication carts reviewed for medication storage and labeling. (Memory care) Findings include: During a medication storage observation, on 11/22/24 at 8:47 a.m., the following was observed:	R 0305	**Community Name: University Place Assisted Living** **Community Address: 1750 Lindberg Road** **West Lafayette, IN 47906-4956** **Phone: (765) 464-5600** **Date of Survey: 11/21/24** **Summary of Deficiency: R305** **410 IAC 16.2-5-6(f)(1-3)** **Pharmaceutical Services – Noncompliance** **(f) Residents may use the**	12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
	1. Drawer 3 of the medication cart had: a. Losartan (a medication to treat high blood pressure) 50 mg (milligram) tablets past the expiration date of 11/10/24. 2. Drawer 4 of the medication cart had: a. Donepezil (a cognitive enhancer) 5 mg did not include a pharmacy label. b. Ibuprofen (a pain reliever) 200 mg with an expiration date of 2/2022. During an interview, on 11/22/24 at 9:00 a.m., QMA 4 indicated the donepezil and Ibuprofen most likely came from a resident's home. The donepezil should have had a pharmacy label. 3. Drawer 5 of the medication cart had: a. Acetaminophen 325 mg with a manufacture expiration date of 11/25, and the pharmacy label indicated the Acetaminophen 325 mg was to be discarded on 5/5/24. During an interview, on 11/22/24 at 9:06 a.m., LPN 4 indicated Resident 45 received the Acetaminophen daily and the facility would follow the pharmacy label for date of discard of a medication. A current facility policy, titled "MEDICATION PROBLEM DETECTION AND REPORTHING," last revised February 2019 and received from the Administrator on 11/25/24 at 2:14 p.m., indicated "...Dispensing Error...Inappropriate, incorrect, or inadequate labeling of medication...Dispensing of expired, improperly stored, or physically or chemically compromised medications...."		**pharmacy of their choice for medications administered by the facility, as long as the pharmacy:** **(1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws:** **(2) provides prescribed service on a prompt and timely basis; and** **(3) refills prescription drugs when needed, in order to prevent interruption of drug regimens.** **This RULE is not met as evidenced by:** **Based on observation, interview and record review, the facility failed to ensure a medication cart was free from expired medications, and medications were properly labeled for 1 of 2 medication carts reviewed for medication storage and labeling. (Memory care)** **1 How corrective action will be accomplished for those residents found to have been affected by the deficient practice?** **A RSD or designee will audit medication carts #1 & #2**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
			weekly for proper pharmacy labeling and expiration dates. **B RSD or designee to educate all staff licensed to pass medication on the 6 Rights to Medication Administration by 12/31/2024** **2 How the community will identify other residents having the potential to be affected by the same deficient practice?** **Resident Services Director (RSD) or designee will audit Medication carts #1 & #2 weekly to ensure that all medications are properly labeled by pharmacy & that all expired medications will be disposed of per facility policy.** **3 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?** **RSD or designee will check each medication upon admission, delivery from pharmacy or change in current medication dosage, that all medications are properly labeled by pharmacy & all medication expiration dates are clearly visible.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. BUILDING 00 B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
			4 How the community will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? **RSD or designee will comply and bring the results of the audit to QAPI committee. This will be achieved each week x 4 weeks, then monthly through the calendar year.** **5 The date of compliance.** **12/31/2024**	