STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	02/14/2024

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00426575 and IN00427156. This visit resulted in a Partially Extended Survey - Substandard Quality of Care-Immediate Jeopardy. Complaint IN00426575 - No deficiencies related to the allegations are cited. Complaint IN00427156 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: February 12, 13 and 14, 2024 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 8 Medicaid: 65 Total: 73 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 16, 2024	F 0000	The facility submits this POC as our credible allegation of compliance.	
F 0689 SS=J 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			

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

Faith Mills | HFA | 02/23/2024

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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	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 was provided to prevent unsupervised smoking inside the facility and failed to ensure hazardous smoking materials were not accessible to residents who required supervised smoking for 1 of 3 residents reviewed for smoking (Resident B). The Immediate Jeopardy began on 1/30/24 when Resident B was observed with cigarettes and lighter smoking in her room. Unsupervised smoking could result in fire or burn injury to herself and other residents residing in the facility. The Chief Operating Officer (COO), Chief Nursing Officer (CNO), Regional Director of Operations (RDO), and Director of Nursing (DON) were notified of the Immediate Jeopardy on February 13, 2024 at 1:39 P.M. The Immediate Jeopardy was removed on February 14, 2024. Findings include: On 2/12/24 at 12:13 P.M., Resident B's record was reviewed. Diagnoses included Schizoaffective disorder and depression. A quarterly MDS (Minimum Data Set) assessment, dated 11/9/23, indicated the resident did not experience cognitive impairment. The assessment indicated the resident had behaviors of refusing care 4-6 days of the week, was prescribed daily anti-psychotic medications, and ambulated independently without use of assistive	F 0689	**Resident # B: was discharged from the facility on 2/13/2024.** The facility immediately communicated the IJ findings to all staff working on 2/13/24 per verbal report and all staff were notified of the plan for removal each shift and were not permitted to work without participating in the education regarding the IJ removal plan. All residents in the facility identified to smoke at the facility were identified to be at risk for the deficient practice. The DON and other designee completed a new “Smoking Safety Risk Assessment” on 2/13/23 for all identified residents who smoke at the facility. Any resident who meets the criteria as being a supervised/assisted smoker were educated by the facility staff that all smoking materials must be	02/15/2024

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	devices. Smoking Safety Risk Assessments, dated 11/7/23 and 2/6/24, indicated the resident currently smoked. She had the potential for/history of causing injury to herself or others from smoking in unauthorized areas or careless use of smoking materials. She required supervision and assistance with smoking materials. A care plan, dated 7/27/23 indicated the resident was at risk for impaired safety/injury due to smoking. She was noncompliant with supervised smoking. The goal was for the resident to smoke safely in designated areas and follow all facility safety protocols. Interventions: Inform resident regarding the center's smoking rules dated 8/11/23, designated smoking areas dated 8/10/23, and safe storage of smoking materials 8/11/23. A care plan, dated 2/11/24, indicated the resident was at risk for impaired safety/injury due to smoking. She was noncompliant with supervised smoking. She was re-educated on the facility smoking policy on 2/11/24.The goal was for the resident to smoke safely in designated areas and follow all facility safety protocols. Interventions included: Inform resident regarding the center's smoking rules dated 8/11/23, designated smoking areas 8/10/23, and storage of smoking materials 8/11/23. A progress note, dated 1/30/24 at 11:03 p.m., indicated the CNA (Certified Nurse Aid) confiscated a lighter and cigarettes from Resident B after observing the resident was smoking in her room. The note indicated the CNA re-educated Resident B on the center's smoking rules, the resident began yelling and cursing, and the "on call" staff person was notified. The note did not		secured in the ***facility*** locked box when not in use. Residents identified as independent smokers were educated that smoking supplies must be maintained on their person or securely in a personal locked box. On 2/14/24 the facility issued lock boxes to all residents identified as an independent smoker to be utilized to secure personal smoking materials. The facility smoking policy was reviewed/signed with all residents identified as a smoker by 2/14/24 and a copy was provided to the resident to keep. During the review of the smoking policy the residents were re-educated that smoking is not permitted in the building and only permitted in the designated smoking area outside. Immediate in-servicing began with ALL staff working on 2/13/24 to review the facility expectation and standard for ensuring resident supervision when the plan of care requires the use of 1:1 supervision and the facility smoking policy. Staff were educated on the importance that resident smoking materials be maintained per smoking policy. Advised the staff that 1:1 supervision requires the staff member to always maintain line of sight of resident and to not leave the resident unattended.	

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	include documentation to show the established interventions were effectively implemented or a new, effective intervention was implemented to prevent further events of unsupervised smoking. The care plan for impaired safety/injury due to smoking risk, did not include documentation to show a new, effective intervention to prevent further events of unsupervised smoking were implemented. A progress note, dated 1/31/24 at 9:05 p.m., indicated a CNA notified the nurse the room of Resident B smelled like smoke. The nurse went to the resident's room and observed Resident B with a cigarette and lighter and removed the smoking materials. The resident was yelling and cursing for the nurse to get out of her room. The NP (Nurse Practitioner) and "on call" staff were notified. The note did not include documentation to indicate how Resident B obtained the smoking materials, to show the established interventions were implemented, or to indicate a new, effective intervention was implemented to prevent further events of unsupervised smoking. There were no new orders from the NP. The progress notes, dated 02/04/24, included the following: - 2:34 a.m.: The nurse was notified by another resident, the smell of cigarette smoke was emanating from Resident B's room. The nurse entered the resident's room and found a cigarette pack with 1 cigarette and lighter in the resident's possession. The cigarette and lighter were removed and secured away from the resident. She was reminded of the smoking policy and educated on dangers of smoking in her room. She was aggressive towards staff, using obscene and offensive language to address staff. The on-call		Walking rounds and visual inspections are routinely completed to ensure that residents who require supervision/assistance with smoking do not have any smoking materials on their person or stored in their room. Walking rounds and visual inspections are routinely completed of independent smokers' rooms to ensure smoking material is not out and visible in room. A communication tracking tool for 1:1 supervision is completed by the assigned staff member doing the 1:1 to serve as supportive documentation that the 1:1 is being completed per plan of care. The facility administrator and nurse managers participate in routine walking rounds of the facility and will make visual observations that the 1:1 caregiver maintains the required line of sight to comply with the 1:1 intervention plan of care. Additionally, the charge nurses will be responsible to sign the 1:1 observation tool during tour of duty after visual observation is made to ensure staff member providing the 1:1 supervision is in place per resident's plan of care. The Social Services Director or other Designee will be responsible to complete QA tool titled "Storage of Smoking Materials	

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	NP, Administrator and DON were updated. -4:11 a.m.: Resident B was awake through the night, was waking other residents up and begging them for cigarettes. There were no new interventions attempted from IDT review. -5:12 a.m.: The resident came to the nurse's station holding a brand-new cigar. Staff were able to retrieve the cigar and put it safely away. The resident continued walking around the hall, speaking profanities to staff. She had not slept all night. - 4:56 p.m.: The nurse went into the resident's room due to smelling cigarette smoke. In the resident's room, smoke was observed in the air. The resident was told she couldn't smoke in the building. The resident replied she hadn't been smoking and someone else had come into her room and smoked. -2/6/24 at 1:07 a.m.: The resident was awake and was begging staff for cigarettes. She was asked to stop begging and told it was past smoke time. The resident started cursing and calling staff profane names. She was unable to be redirected and would be monitored for safety. The notes did not include documentation to indicate the manner in which Resident B obtained the smoking materials, to show the established interventions were implemented, or to indicate a new, effective intervention was implemented to prevent further events of unsupervised smoking. A NP progress note, dated 2/7/24 at 1:13 p.m., indicated the resident was seen by the NP for altered mental status and Nnursing staff reported Resident B had been hoarding items from around the facility in her room. During the visit, the NP observed the resident in her room yelling out at staff. A urinalysis was ordered to check for urinary tract infection. The progress note didn't		Review" 10 times per week at various times of the day x 4 weeks, then 5 times per week to ensure ongoing compliance. The Administrator or other designee will be responsible to complete the QA tool titled "1:1 Supervision Audit Review" 10 times per week at various times of the day x4 weeks, then 5 times per week to ensure compliance. Any identified issues or trends will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets monthly and QA tracking logs are reviewed by the team to ensure on-going compliance for a minimum of 6 months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as needed.	

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	indicate the resident was found with smoking materials and had been smoking in her room unsupervised. The progress note didn't include documentation to show the NP was aware Resident B was repeatedly found with hazardous smoking materials and smoking unsupervised in her room. A progress note, dated 2/8/24 at 4:06 a.m., indicated the resident had been awake all night. Her room was full of all sorts of items she had picked up from various areas of the facility and was hoarding them in her room. Items littered every corner of the room including her bed and floor. There were items from the activity room, boxes of gloves, a water pitcher from the nurses cart, and cleaning supplies. The resident became aggressive and began cussing at staff. Attempts to redirect the resident were unsuccessful and the Psychiatric NP, Administrator, and DON were updated. The note indicated interventions were intiated for Resident B to be monitored closelyand staff to conduct safety checks every 15 minutes. The note did not include documentation to show the NP was aware Resident B was repeatedly found with hazardous smoking materials and smoking unsupervised in her room. A progress note, dated 2/08/24 at 2:02 p.m., indicatedThe note did not include documentation to indicate the resident had access to hazardous smoking materials or events of unsupervised smoking occurred. Resident B remained on 15 minute checks for safety. A progress note, dated 2/10/24 at 6:34 a.m., indicated the resident was going into other resident's rooms, taking their "stuff" (remote controls, cigarette lighter, etc), bringing it back to her room and hiding them. Another resident			

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	reported to the nurse that Resident B had taken his lighter out of his room. Staff went to her room and questioned her about the lighter. Resident B denied having it and allowed staff to search her room and her person. A lighter was not found. The DON was updated and the resident placed on 1:1 (continuous) supervision. An Indiana IDOH (Indiana Department of Health) incident report, dated 2/11/24, indicated Resident B had been outside smoking with another resident at approximately 6:30 a.m. When the other resident finished smoking, she had placed her cigarette on the ground. Resident B tried to pick up the remains of the cigarette when the other resident told her to stop. Resident B continued to try and pick up the cigarette butt and the other resident pushed her knocking her to the ground. The report didn't indicate Resident B was supervised while smoking. No statements regarding the smoking time were available for review. Progress notes, dated 2/11/24 at 7:30 a.m., 11:00 a.m., and 3:00 p.m., indicated Resident B remained on 1:1 direct staff supervision without any changes in condition.The notes did not include documentation to show new interventions were initiated when the established interventions were ineffective. A progress note, dated 2/12/24 at 8:24 a.m., indicated the resident remained on 1:1 with staff. She continued going into other residents' room, waking them up, asking for cigarettes and asked staff for money for cigarettes. She was heard cursing at another resident when she was told to get out of the resident's room. The note did not include documentation to show new interventions were initiated when the established intervention of continuous observation was ineffective.			

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	On 2/12/24 at 1:42 P.M., in a confidential interview with an interviewable resident, cigarettes and a lighter were observed on the resident's bedside table and, cigarettes were observed on the overbed table of the resident's roommate. The smoking materials were observed to be accessible to residents who needed supervision when smoking. The resident indicated on 2/10/24, Resident B had come into his room in the middle of the night and took his lighter. He had been very angry and had reported it to staff. He indicated she would often come into his room, begging for cigarettes. He had asked for a locked box to keep his cigarettes and lighter but hadn't been given one. His roommate, who was present and interviewable, indicated he wore a satchel around his neck to keep his smoking materials in and on his person so Resident B couldn't take his items. The progress notes, dated 2/13/24 indicated the following: -2/13/24 at 8:36 a.m., indicated Resident B was attempting to light a cigarette in her room and the CNA confiscated the lighter from the resident. Resident B was told she could not smoke in her room and had to smoke outside during smoke breaks.The note did not include documentation to show the established interventions were implemented or to indicate a new, effective intervention was implemented to prevent further events of unsupervised smoking. The note did not include documentation to indicate staff was providing continuous supervision or to show the manner in which Resident B obtained the hazardous smoking materials. -2/13/24 at 10:16 A.M., LPN 3 (Licensed Practical			

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	Nurse) was interviewed. She indicated CNA 5 had reported to her Resident B had a cigarette and lighter in her room. The CNA had removed the hazardous smoking materials. LPN 3 indicated she didn't know how the resident had gotten the cigarette and lighter as she remained on 1:1 supervision with staff. The note did not include documentation to indicate staff effectively provided continuous supervision or to indicate a new, effective intervention was implemented to prevent further events of unsupervised smoking. - 2/13/24 at 10:20 A.M., in a confidential interview, an interviewable resident indicated prior to 3 days ago, Resident B was always out smoking unsupervised on the smoking patio. He indicated she was always begging for cigarettes from other smokers and would go into other resident's rooms to try and take their smoking materials. He indicated over the past weekend (2/10 and 2/11/24), Resident B had been going into various residents' rooms in the middle of the night asking for cigarettes and a lighter. Residents who lived on the unit were afraid of Resident B because she was always yelling, cursing, and going into other resident's rooms to take cigarettes and lighters. He kept his smoking materials in his bedside drawer and kept the door to his room closed at all times. He indicated staff including the Administrator, DON, and Social Services Director (SSD) were aware of the concerns with Resident B. - 2/13/24 at 10:45 A.M., CNA 5 was interviewed. She was assigned to be 1:1 supervision with Resident B. CNA 5 indicated she reported to work and relieved the night shift CNA, assigned to provide 1:1 care, at 7:00 a.m. CNA 5 indicated the night shift CNA was at the nurse's station upon her arrival and was not effectively providing continuous supervision to Resident B who was in			

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	her room and not at the nurse's station. When CNA 5 went into Resident B's room, she observed the resident sitting on the side of her bed. The resident had a cigarette in her mouth, a lighter in her hand and was trying to light the cigarette. She removed the cigarette and lighter and reported it to LPN 3. CNA 5 indicated she had no idea where the resident had gotten the smoking items. - 2/13/24 at 10:50 A.M., CNA 6 and CNA 8 were interviewed. CNA 6 indicated cigarettes and lighters were kept in a smoking box at the nurse's station or front desk and were given out to residents during scheduled smoke times. CNA 8 indicated only residents who required supervision while smoking had their smoking materials kept in the smoke box while residents who did not require supervision to smoke were allowed to keep their smoking materials in their rooms or on their person. Residents who smoked unsupervised were not required to lock up or secure their smoking materials in their rooms. On 2/13/24 at 12:10 P.M., the SSD was interviewed. She indicated Resident B required supervision while smoking and was not allowed to have smoking materials in her room or on her person. She was aware the resident had been observed with smoking materials and smoking in her room while receiving 1:1 supervision from staff. The resident had been reminded of the smoking policy and was not allowed to smoke in her room. The SSD indicated residents who could smoke independently were not required to keep their smoking materials secured. The SSD provided a current copy of the facility's smoking policy, on 2/12/24 at 12:12 P.M. The policy indicated: "Purpose: To provide a safe and healthy living environment...It is also the			

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	objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. Guidelines: If smoking, e-cigarette or vaping, the facility will designate areas approved for smoking. The designated area will be outside in accordance with state/local standards. The facility has the right to enforce a policy prohibiting residents from keeping any smoking, e-cigarettes, vape materials in his/her possession for health, safety, and security reasons...Smokers will be evaluated to determine their ability to comply with safety rules and their ability to smoke independently...Residents deemed to be safe independent smokers will smoke in designated areas and adhere to smoking requirements. Individuals who are non-compliant, potentially dangerous, exercise poor judgement, and show a lack of concern for the welfare of others will be counseled accordingly with potential for facility discharge...The facility recognizes the potential harm that may result from careless, hazardous smoking and has implemented this policy to maintain a safe living environment. Violation of this policy will be taken seriously, and appropriate action will be forthcoming...." The policy did not include documentation of a system to ensure hazardous smoking materials were effectively stored to limit their accessibility to residents who require supervision when smoking. The Immediate Jeopardy that began on 1/30/24 was removed and the deficient practice corrected on 2/14/24 when the facility completed training of staff on the revised facility smoking policy and 1:1 monitoring but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This tag relates to Complaint IN00427156.			

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