STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00409749. Complaint IN00409749 - Deficiency related to the allegations is cited at F0694. Survey dates: June 11, 12, 13, 14, 15, and 16, 2023 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 3 Medicaid: 55 Other: 4 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 21, 2023	F 0000	6-29-23 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis Indiana 46204 RE : Survey Event ID GGJV11 Recertification State Licensure Survey / Complaint survey IN00409749 University Park Rehabilitation and Healthcare 1400 Medical Park Dr Fort Wayne IN 46825 Dear Ms Buroker: On June 11- 16, 2023 a Recertification Licensure survey and complaint IN00409749 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Grabbe	RN Regional Nurse Consultant	06/29/2023

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			as of the date set forth in the Plan of Correction of 07/05/2023. Please feel free to all me with any further questions at 1-260-486-3001 Respectfully submitted, Goran Prentoski HFA Executive Director	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview, observation, and record review the facility failed to ensure a resident's port (a type of central line, surgically implanted under the skin) dressing was changed per the physician orders for 1 of 2 residents reviewed. (Resident 165). Findings include: During an interview on 06/11/23 at 2:01 pm, Resident 165 indicated he was receiving intravenous (IV) antibiotics through his right chest port and the port dressing had not been changed since he arrived at the facility. A piece of tape, attached to the port dressing, was labeled with the date 5/22/23. There was no other access for intravenous medication. Resident 165's record was reviewed on 6/13/23 at 10:55. Diagnoses included hypo- osteomyelitis of lumbar vertebra region and malignant neoplasm of the colon and rectum.	F 0694	**F 694 Parenteral Fluids** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	07/05/2023

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	Resident 165's current Minimum Data Set (MDS) assessment dated 5/17/23 indicated his Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident received antibiotics 7 days a week and was on IV medications prior to and while a resident of the facility. Resident 165's current care plan, undated, indicated he had a focus of being at risk for medication side effects related to antibiotics with a goal to be free of drug related complications and/or side effects. Interventions included port dressing changes per orders. Resident 165's Admission Observation dated 5/11/23 at 6:29 pm indicated he had a central line, received IV medications prior to and while a resident of the facility. A physician order dated 5/11/23 at 8:00 PM indicated Resident 165 received 350 mg of Daptomycin by IV at bedtime for lumbar spine discitis/osteomyelitis. A physician order dated 5/11//23 at 7:00 PM indicated the IV central line was to be observed when not in use for IV therapy every shift. The order indicated the site was in the RUE. A review of progress notes between 5/13/23 and 6/16/23 did not indicate the physician had been called to clarify the location of the catheter/port site. The Medication Administration Record (MAR) dated 5/1/23 -5/31/23 and 6/1/23 - 6/16/23 indicated the right upper extremity (RUE) catheter site dressing was changed on 5/14/23, 5/21/23, 6/4/23		**1. Immediate actions taken for those residents identified:** Residents 165 dressing changed, dated per policy. **2. How the facility identified other residents:** Any resident with port/ central line have the potential to have been affected. No other residents with central lines currently residing in facility. **3. Measures put into place/ System changes:** Facility staff educated on components of F 694 Parental Fluids focus on changing and dating of central line dressing per policy / procedure. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee who will audit all residents who require IV therapy with a central line for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **7-5-2023**	

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	and 6/11/23. The MAR indicated the RUE IV central line was observed when not in use for IV therapy every shift from 5/12/23 day shift to 6/13/23 day shift. In an interview on 6/13/23 at 10:49 PM, the Administrator, indicated a physician order showed the catheter dressing was to be changed every week and the MAR indicated it was changed on 6/4/23 and 6/11/23. She indicated the catheter site in the RUE orders were being applied to the port site. In an observation of Resident 165's port site, the Administrator indicated the port dressing was labeled 5/22/23. The Administrator indicated the port dressing was to be changed every Sunday per the order and it had not been changed. A current policy, revised 9/1/22, titled, "IV - Peripheral Insertion and Maintenance CENTRAL LINE/PICC/MIDLINE/IMPLANTED PORTS", provided by the Administrator on 6/13/23 at 12:50 PM, indicated the guidelines were to reduce the risk or prevent infections during the insertion of a peripheral IV. No policies were provided regarding port dressing change by survey exit. This citation is related to complaint IN00409749. 3.1-47(a)(2)			
F 0732 SS=F Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:			

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	(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the daily report of nursing staff directly responsible for resident care was posted daily. This had the potential to effect 62 of 62 residents.	F 0732	**F-732 Posted Nurse Staffing Information** **The facility respectfully requests a desk review for this citation**	07/05/2023

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	Findings included: On 6/11/23 at 10:55 AM the daily staffing post was observed to be posted at the reception area. The staffing hours post was a single sheet dated 6/8/23. In an interview on 6/11/23 at 12:20 PM, the Administrator indicated the staffing hours should be posted daily. The Administrator indicated the 3rd shift charge nurse was responsible for the daily posting. In an interview on 6/16/23 at 10:10 AM the Regional Operations Manager indicated the facility did not have a policy related to the posting of daily staffing hours. No State rule is applicable.		**Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Daily Nurse Staffing Information Posted. **2. How the facility identified other residents:** All residents residing in facility have the potential to be affected by practice. **3. Measures put into place/ System changes:** Nursing staff/ Department heads educated on requirements of F-698 Posted Nurse Staffing Information. **4. How the corrective actions will be monitored:** The responsible party for this plan of	

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			correction is the Administrator/Designee who will audit Nurse staffing posting Information daily x 4 weeks then 4 times week x 5 months for completion and posting of information. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **7-5-2023**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to maintain the cleanliness of the kitchen and 4 of 4 dumpsters in 2 observations. 60 of 62 residents residing in the facility ate food prepared in the kitchen. Findings include: On 6/11/13 at 10:00 AM, 3 of 4 outside dumpster lids were observed to be open. 3 trash bags were over the top of the dumpster. On 6/11/23 at 10:05 AM, a milk container dated 6/6/23 was observed sitting on a ledge in the dining room. There were soiled dishes on the dining room ledge. During a tour with Cook 2 on 6/11/23 at 10:33 AM, 2 trash cans in the kitchen were observed containing trash. The trash cans were not covered with lids. A tray of clean coffee cups was soiled with dried green debris. Stored steam table pans stacked on one another had water between them. There were brown flecks of debris and grey splash marks on the bottom shelves where the steam table pans were stored. In a cooler, there were 3 packages of cheese slices without dates. A plastic container of soup did not have a label on it. 4 of 4 outside dumpster lids were open. 3 trash bags were over the top of the dumpster. In an interview on 6/11/23 at 10:44 AM, Cook 2	F 0812	**F-812 Food Procurement, Store/Prepare/Serve-Sanitary** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Dumpsters and trashed cans were closed/ covered. Milk, cheese and soup was removed and disposed of properly. Coffee cups, steam pans and shelves were cleansed and allowed to dry properly.	07/05/2023

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	indicated the milk on the ledge in the dining room was outdated. Cook 2 indicated the outside dumpster lids should remain closed. Cook 2 indicated pans should be air dried before being placed on storage shelves. Cook 2 indicated 2 residents did not eat food prepared in the kitchen, A current policy dated 9/1/21 titled "Dispose of Garbage and Refuse" provided by the Administrator on 6/12/23 at 8:46 AM indicated appropriate lids should be provided for all containers. The policy indicated all garbage and refuse would be collected and disposed of in a safe and efficient manner. A current policy dated 9/1/21 titled "Safe Storage of Food" provided by the Administrator on 6/12/23 at 8:46 AM indicated all foods would be labeled and dated. A current policy dated 9/1/21 titled "Cleaning and Sanitizing and Proper Hair Restraints" provided by the Administrator on 6/12/23 at 8:46 AM indicated food contact surfaces, utensils and dishes would be washed, sanitized and allowed to air dry before food preparation use. 3.1-21(i)(1) (3)		**2. How the facility identified other residents:** All residents served meals from the kitchen have the potential to affected by deficient practice. **3. Measures put into place/ System changes:** Facility staff and dining staff educated on components of F-812 Food Procurement, Store/Prepare/Serve-Sanitary, including covering of dumpsters, trash cans, dating of food and drinks. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Administrator/designee who will dumpsters, kitchen and food dating for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 7-5-23**	