STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	05/14/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00433340, IN00433743 and IN00433367. Complaint IN00433340 - Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00433743 - Federal/state deficiencies related to the allegations are cited at F658. Complaint IN00433367 - Federal/state deficiencies related to the allegations are cited at F600. Survey dates: May 13 and 14, 2024. Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 5 Medicaid: 54 Other: 5 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 16, 2024.	F 0000	This plan of correction constitutes. this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection Report. University Nursing Center respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracie Oldham	Executive Director	05/31/2024

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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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to prevent verbal abuse by a staff member to a resident for 1 of 3 resident's reviewed for abuse. (NA (Nurse Aide) 6 and Resident C) Findings include: A Facility Reported Incident, dated 4/23/24 at 4:30 p.m., indicated a staff member was allegedly rude to Resident C. The follow up report was added on 4/28/24 and indicated an interview with the CNA who reported the incident indicated Resident C did not hear or respond to employee's inappropriate language. NA 6 was disciplined per policy. During an interview with the DON and the Administrator, on 5/13/24 at 11:20 a.m., the Administrator indicated a CNA was in Resident C's room and heard NA 6 use inappropriate language when the NA whispered "Shut the f--k up" regarding Resident C. This was witnessed by CNA 8, who reported it to the ADON, and the Administrator was called immediately. NA 6 was suspended, and the next day during a phone	F 0600	**F 600** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident C no longer resides at the facility. NA 6 no longer works at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. Care Companions to complete resident QIS questions with assigned residents to identify any resident concerns. RDCS to in-service ED/DNS on abuse policy by 5/29/24. All staff to be in-service on abuse policy per	06/05/2024

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	interview, NA 6 admitted to the statement. NA 6's employment was terminated for the use of inappropriate language. Resident C did not hear it and she was not alert and oriented. A review of the facility's investigation, on 5/13/24 at 12:07 p.m., indicated the following: A summary of the findings, dated 4/28/24, indicated on 4/23/24, CNA 8 reported to ADON that she overheard NA 6 use inappropriate language in Resident C's room. NA 6 was interviewed by the Administrator and the DON on 4/24/24 and admitted to using inappropriate language. CNA 8 and NA 6 reported Resident C did not hear the inappropriate language, as she did not respond or react. Staff and resident interviews were completed, and there were no findings or negative trends. Social Service followed Resident C with no signs or symptoms of distress. NA 6 was disciplined per policy. A typed interview with NA 6, dated 4/24/24, indicated he was interviewed regarding allegations of using inappropriate language in a resident's room. He acknowledged using inappropriate language. A typed statement for CNA 8, dated 4/24/24, indicated on 4/23/24, she witnessed NA 6 whisper, under his breath "Shut the f---k up" while providing care to Resident C. The CNA immediately looked up and said, "Excuse you?" After repositioning Resident C, NA 6 took the trash and linens down to the shower room and the CNA immediately notified the ADON of NA 6's statement. During an interview with CNA 8, on 5/13/24 at 1:37 p.m., she indicated she was put in the Memory		ED/DNS/Designee by 6/5/24. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. RDCS to in-service ED/DNS on abuse policy by 5/29/24. All staff to be in-service on abuse policy per ED/DNS/Designee by 6/5/24. Assigned Care Companions will check with assigned residents daily to ensure no concerns. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Abuse 600 will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. The date of completion for the systemic changes is 6/5/24.	

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	Care Unit, and it was the second time she had worked there and didn't really know the residents. She worked alone for the first couple of hours that evening because NA 6 didn't show up for work. NA 6 showed up a couple hours into the shift. He had a poor attitude from the beginning, he indicated to her that he was not on schedule, he wasn't in his uniform, and he had just come from a doctor's appointment. She asked him just to tell her who needed change and what they needed, and she would go do it. He indicated they would just "tag team" the residents and they did not split the hall. NA 6 asked her for help with Resident C while she was giving another resident a shower, Resident C needed cleaned up and changed because her family was coming to the facility. Resident C was on hospice, CNA 8 changed her and turned her, while NA 6 stood at Resident C's bedside looking at his phone. Resident C moaned in pain, and she was uncomfortable. NA 6 looked at Resident C and said out loud to her "Shut the f--k up." CNA 8 pulled Resident C's pants up and had him help her move her up in bed. She bagged up the linens and the brief at the end of Resident C's bed. NA 6 stood by the open door to Resident C's room and said, "Resident C and Resident L are the most annoying bit---s here." CNA 8 gave him the linen and brief bag and went to her nurse and told her she was going to take a 15-minute break, CNA 8 then went straight to the ADON and told her what happened. When CNA 8 came back from break, the ADON was walking NA 6 out of the building. CNA 8's original statement, dated 4/23/24, was provided by the Administrator, on 5/14/24 at 8:56 a.m., indicated on the evening of 4/23/24, she was assigned to work the cottage (Memory Care Unit) with NA 6, he was late due to a miscommunication with the schedule, he arrived on the unit between			

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	3:00 p.m. and 3:30 p.m. during that time he would not assist with resident care he would just tell her what needed done. The nurse asked NA 6 to change Resident C because her family would be at the facility soon. CNA 8 thought he went ahead changed Resident C, while she gave the last shower, but he came in during the shower and told her she needed to change Resident C next. CNA 8 replied didn't the nurse just tell you to do that. NA 6 told CNA 8 that Resident C was a two person assist and they went to her room. NA 6 stood to the right of Resident C's bed the whole time while CNA 8 changed her, and CNA 8 even pulled her up in bed alone. While CNA 8 rolled Resident C to pull up her pants she started to yell. NA looked down at Resident C and said, "Shut the f--k up." CNA 8 immediately looked up and said, "Excuse me?" Then he went to mumble something about "Between Resident C and Resident L they were the most annoying bi----s." CNA 8 had NA 6 grab her incontinent pad so she could put a pillow under her hip, and they went to the nurses' station together. CNA 8 had him deal with the linen and trash from them changing Resident C and told him she needed a 15-minute break. CNA 8 went straight to the ADON's office and told her about NA 6's attitude and actions that had just occurred. During an interview with NA 6, on 5/14/24 at 12:39 p.m., he indicated he had been called in on his day off. He told the facility he would come in when he had a chance to, because he was at a doctor's appointment. They told him that it was urgent, and he was frustrated. He had mumbled something under his breath that he shouldn't have had to Resident C. He mumbled "Shut the f--k up" because she had been screaming at him. When he mumbled this to Resident C, she was asleep, and he didn't think she heard him. He said it out of			

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	frustration of having to come into work after he was supposed to have Tuesday, Wednesday, and Thursday off. He considered it inappropriate and verbal abuse. His nurse told him to change Resident C because her family was coming into the facility, she needed rolled and changed. She yelled and he "lost all his bearings." The CNA that helped him change her went to break and then 20 minutes later the ADON came to the unit and told him she needed to send him home and she walked him out. A current facility policy, titled "Abuse, Prohibition, Reporting, and Investigation," provided by the Administrator, on 5/14/24 1:17 p.m., indicated the following: "...Definitions/Example of Abuse... Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability...." This citation relates to Complaints IN00433340 and IN00433367. 3.1-27(b)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure controlled medications were accounted for at the time of administration for 1 of 3 narcotic count	F 0658	**F658** What corrective action(s) will be accomplished for those residents found to have been affected by the	06/05/2024

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	observations. (Memory Care Unit). Findings include: During a narcotic count observation with LPN 13, on 5/13/24 at 1:06 p.m., she indicated she needed to sign off the controlled drugs given that morning before she could complete a narcotic count. She had been sidetracked and one of the residents was screaming. The following resident's medications were signed out during the observation on 5/13/24 for the following times: Resident E's lorazepam (treat anxiety) 0.5 mg (milligram) and tramadol (treat pain) 50 mg for 9:00 a.m. Resident F's tramadol 50 mg for 10:00 a.m. Resident G's hydrocodone-acetaminophen (narcotic pain reliever) 5-325 mg for 7:00 a.m. Resident H's tramadol 50 mg for 9:00 a.m. Resident J's hydrocodone-acetaminophen 7.5-325 mg and lorazepam 0.5 mg for 10:00 a.m. Resident K's hydrocodone-acetaminophen 7.5-325 mg for 8:00 a.m. Resident M's tramadol 100 mg for 10:00 a.m. Resident N's hydrocodone-acetaminophen 5-325 mg for 8:00 a.m. Resident P's tramadol 50 mg for 10:00 a.m. and lorazepam 1 mg for 11:00 a.m.		deficient practice. Medication records for the residents identified were updated to reflect the administration time. No residents were negatively affected. LPN 13 was educated by DNS on signing out medications at time of administration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents that reside in Memory Care that receive narcotics have the potential to be affected by this alleged deficient practice. All licensed nursing staff will be in-service by DNS/Designee on the medication/sign out procedure that is expected by 6/5/24. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. DNS/ designee to inservice all licensed nursing staff on medication/sign out procedure by 6/5/24. DNS/Designee to complete weekly narcotic medication pass observation to ensure medication are signed out per expectation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into	

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	Resident Q's tramadol 50 mg for 11:00 a.m. Resident R's hydrocodone-acetaminophen 5-325 mg for 10:00 a.m. Resident T's buprenorphine (narcotic pain reliever) 10 mcg/hr (microgram/hour) patch and hydrocodone-acetaminophen 7.5-325 mg for 10:00 a.m. Resident V's hydrocodone-acetaminophen 5-325 mg for 9:00 a.m. During an interview with the DON on 5/13/24 at 1:46 p.m., she indicated she would expect the nurses to sign off their medications/narcotics as they gave them. They did not have a policy for signing off controlled medications. The DON provided a skills check off that they would follow, titled "Medication Administration Observation" and indicated the following: "...Documentation Standards... E... 1. Controlled medications are signed out at time of removal...." This citation relates to Complaint IN00433743. 3.1-35(g)(1)		place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Medication 658 will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If the threshold of 100% is not met, an action plan will be completed to ensure compliance. The date of completion for the systemic changes is 6/5/24.	