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	12/01/2023

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 Nursing Home Complaint IN00406166. Complaint IN00406166 - Federal/State deficiencies related to the allegations are cited at F677. Survey dates: November 27, 28, 29, 30 and December 1, 2023. Facility number: 003673 Provider number: 155725 AIM number: 200450890 Census Bed Type: SNF/NF: 1 SNF: 24 Residential: 46 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 1 Other: 18 Total: 25 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 12, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by University Place Health Center and Assisted Living that the findings and allegations contained herein, are accurate and a true representation of the quality of care provided or the living environment provided to the residents of University Place Health Center and Assisted Living. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only and is submitted as required by the provisions of the State and Federal Law and not because University Place, Inc. agrees with the allegations contained. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Hubbard RN	Director of Nursing	12/22/2023

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	12/01/2023

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 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure call lights were in reach and a bed was not in a high position for 1 of 1 resident reviewed for accommodation of needs. (Resident 23) Finding includes: During an observation, on 11/30/23 at 12:17 p.m., the call light was laying on the left side of the resident. The resident was unable to use her left hand to push the call light button for assistance. The resident's bed was raised in the highest position. The record for Resident 23 was reviewed on 11/30/23 at 11:48 a.m. Diagnoses included, but were not limited to, cerebral infarction (disrupted blood flow to the brain), hemiplegia (paralysis of one side of the body) and hemiparesis (paralysis which could affect the arms, legs and facial muscles) following cerebral infarction affecting left non-dominant side, and muscle weakness. A care plan, dated 5/26/23, indicated the resident had a history of cerebral vascular accident (CVA) with left side hemiparesis. Interventions included, but were not limited to, monitor and document the resident's ability for activity of daily living (ADL) and assist resident as needed.	F 0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident bed was lowered, call light placed where resident preferred so she was able to access it. Resident educated regarding bed height and to also ask for her call light to be placed where she would prefer. Resident care plan updated to her preferences. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All residents have the potential to be affected. Care plan reviews will be completed and resident preferences documented along with education and preventative interventions. Staff care sheets updated. What measures will be put into place and what systemic changes will be made to ensure that the	01/30/2024

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	12/01/2023

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 care plan, dated 11/10/22, indicated the resident was a high risk for falls. Interventions included, but were not limited to, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. During an interview, on 11/30/23 at 12:50 p.m., CNA 2 indicated the facility had college students providing care to the resident. The students were the last ones in the resident's room. CNA 2 did not know when the students left or how long the bed was up in the highest position. The resident could not use her left arm and the call light should be on the right side where she could reach it. During an interview, on 11/30/23 at 12:57 p.m., CNA 2 indicated she was assigned to the resident and the bed should not be left up high and the call light should be placed on the resident's right side. During an interview, on 11/30/23 at 1:09 p.m., LPN 4 indicated the bed in the resident's room should never be left up high for safety reasons. The resident was not able to use her left arm to put her call light on and the resident needed the call light. A current policy, titled "Answering the Call Light," dated 9/22 and received from the DON on 12/1/23 at 2:00 p.m., indicated "...The purpose of this procedure is to ensure timely responses to the resident's request and needs...Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor...." 3.1-3(v)(1)		deficient practice does not reoccur? 3. Upon admission and with any change, residents will be assessed and care plans initiated to reflect their needs and preferences. Continued education of residents and families will be provided for safety and fall prevention. Re-education of staff regarding safety and fall prevention will be completed. 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? 4. MDS and/or designee will complete an audit and visual rounding of five residents three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached. All results will be reported in the monthly QAPI meeting for 6 months or until 90% compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 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	12/01/2023

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 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to submit a revised Preadmission Screen and Resident Review (PASARR) Level I after a new mental health diagnoses and the resident was prescribed an antipsychotic and antianxiety medication for 1 of 1 resident reviewed for PASARR. (Resident B) Finding includes: The record for Resident B was reviewed on 11/30/22 at 10:46 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Parkinson's disease, and bowel and bladder incontinence. A PASARR Level I, dated 7/24/23, indicated the resident had no mental health diagnoses,	F 0644	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. An updated PASARR was resubmitted for resident B on 11/30/2023. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. Current residents will be reviewed for new orders for anti-psychotic medications or	01/30/2024

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	12/01/2023

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
	dementia, or neurocognitive disorder. The resident did not have an antianxiety or antipsychotic medications ordered. If changes occur or new information refutes these findings, a new screen must be submitted. A physician's order, dated 11/28/23, indicated lorazepam (an antianxiety medication) 0.5 milligram (mg) tablet by mouth three times a day. A physician's order, dated 11/28/23, indicated lorazepam (an antianxiety) 0.5 mg tablet by mouth every 6 hours when needed. A physician's order, dated 11/27/23, indicated Seroquel (an antipsychotic) 25 mg tablet by mouth three times a day. There was no PASARR Level I completed when the resident was ordered lorazepam and Seroquel. No diagnoses of anxiety or behaviors were added. During an interview, on 12/1/23 at 9:00 a.m., the Director of Nursing (DON) indicated a new Level I PASARR was not completed. The Social Services Director (SSD) would oversee implementing the PASARR. The SSD missed completing a new Level I PASARR when a new antipsychotic and antianxiety medication was ordered. The new diagnoses for these medications were not added to the resident's diagnoses list. A current policy, titled "Preadmission Screening and Annual Resident Review [PASAR], Preadmission, Screening & Resident Review - SNF," dated 5/23/23 and received from the DON on 12/1/23 at 2:00 p.m., indicated "...PASRR requires that all people entering Medicaid-certified nursing communities are evaluated for: Serious Mental Illness (SMI); Intellectual Disability (ID);		changes to current orders. A new PASARR will be completed as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Residents will be reviewed during daily clinical meeting for new orders for anti-psychotics. A new PASARR will be completed to ensure they have an appropriate diagnosis for the medication(s). Admissions nurse and Social Service educated to importance of completing all steps and completion of reassessment as required. 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? 4. Social Service and/or designee will complete an audit of 5 resident charts three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached . All results will be reported in the monthly QAPI meeting for 6 months or until 90 % compliance reached. By what date the systemic	

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	12/01/2023

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
	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 state specific agency...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable			

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	12/01/2023

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
	for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to update care plans for an anticoagulant and a diuretic medication for 1 of 1 resident reviewed for care plans. (Resident 4) Finding includes: 1. The record for Resident 4 was reviewed on 11/30/23 at 2:41 p.m. Diagnoses included, but were not limited to, retention of urine, atrial fibrillation, dementia, anxiety disorder, and cognitive communication deficit. A physician's order, dated 4/28/23, indicated Eliquis (an anticoagulant) 2.5 milligram (mg) tablet by mouth two times a day. A physician's order, dated 4/28/23, indicated Furosemide (a diuretic) 20 mg tablet by mouth two times a day. A care plan for the anticoagulant or diuretic medication was not located. During an interview, on 12/1/23 at 9:00 a.m., the Director of Nursing (DON) indicated there should be care plans for the anticoagulant and diuretic medication. The care plans sometimes would get deleted and the anticoagulant and diuretic medication should be monitored.	F 0657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #4 care plan has been updated to reflect use of anticoagulant and diuretic therapy. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. Residents with orders for diuretics and/or anti coagulation have the potential to be affected. Care plan reviews will be completed for anticoagulant and diuretic therapies and updated to reflect their therapy. Staff will be re-educated on updating or initiating care plans for medication therapies to include anticoagulant and diuretic use What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	01/30/2024

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	12/01/2023

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 policy, titled "Resident Comprehensive Career Plans - Skilled Nursing Facility (SNF)," dated 5/23/23 and received from the DON on 12/1/23 at 2:00 p.m., indicated "...Review and revise the care plan after each assessment. "After each assessment" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS) as required, except discharge assessments...The baseline care plan must be based on the admission orders, information about the resident available from transferring provider, and discussion with the resident and resident representatives' participation in the care planning process...." 3.1-35(d)(2)(B)		reoccur? 3. Orders will be reviewed during the daily M-F clinical meeting (Monday will review the entire weekend) for medication orders and/or changes. Care Plans will be reviewed and updated as needed. 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? 4. Director of Nursing and/or designee will complete an audit of three residents three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached . All results will be reported in the monthly QAPI meeting for 6 months or until 90% compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			

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	12/01/2023

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
	Based on observation, interview and record review, the facility failed to provide incontinence care for 1 of 3 residents reviewed for Activity of Daily Living (ADL). (Resident B) Finding includes: The record for Resident B was reviewed on 11/30/22 at 10:46 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Parkinson's disease, and bowel and bladder incontinence. A care plan, dated as revised 8/2/23, indicated the resident was dependent on staff for most ADLs. Interventions included, but were not limited to, toileting, bowel and bladder incontinent, frequently check brief for soiling, personal hygiene, grooming and bathing the resident was dependent on staff assistance, utilize appropriate staff to assist the resident with ADLs. He was a maximum assist for most ADLs. During an observation, on 11/30/23 at 3:17 p.m., the hallway outside Resident B's room had a very strong odor. The resident was laying on his bed with a blanket covering his lower body. There was a soiled brief which contained urine and bowel movement along with a pair of pants pushed down toward the end of the bed and was dangling off the end of the mattress. During an interview, on 11/30/23 at 3:20 p.m., the Administrator entered the room and noticed the resident's pants and dirty brief. The Administrator told the resident she would get someone to assist him. During an observation, on 12/01/23 at 9:55 a.m., Resident B was sitting in the common area in front	F 0677	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident (B) was given inc ontinent care and dressing by staff. Shower sheet was completed with any skin areas noted and given to the nurse to review. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. ADL dependent residents have the potential to be affected. Care plan reviews will be reviewed and updated to ensure care needs are reflected. Staff care sheets will be updated for staff providing care and staff will be in-serviced regarding dependent care and facility policies and/or procedures. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. On admission, residents identified to be dependent for ADL care needs will be reflected in their care plan, tasks implemented for staff with updates to care sheets for staff providing care regarding schedules, preferences, refusals	01/30/2024

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	12/01/2023

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
	of the fireplace listening to Christmas music with a white sheet over his legs. During an observation, on 12/01/23 at 10:57 a.m., Resident B was being taken to his room by two CNAs for a shower. During an interview, on 12/01/23 at 10:57 a.m., CNA 4 indicated the last time the resident's brief was changed was at 7:00 a.m., when she got the resident up. During an interview, on 12/1/23 at 10:58 a.m., CNA 2 indicated she changed residents every two hours. Resident B had not been changed for almost four hours due to being busy with other residents. She had residents who required Hoyer lifts and a staff member called off today. Both CNA 4 and 2 indicated it was hard to get all their stuff done. The CNAs were observed to transfer the resident to the shower chair and pull down his brief and pants. His brief was wet, and his buttocks was red and pink in color. A current policy, titled "Activities of Daily Living (ALDs), Supporting," dated 3/2018 and received by the Director of Nursing (DON) on 12/1/23 at 2:00 p.m., indicated "...Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing,		and documentation. Staff will receive re-education to facility policies and/or procedures. 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? 4. MDS and/or designee will observe five residents three times a week for 4 weeks, then five residents twice weekly for 4 weeks, then five residents bi-weekly for 4 weeks and monthly thereafter until compliance is reached . Audit results will be reviewed in QAPI meetings monthly for 6 months or until and average 90% compliance is reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 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	12/01/2023

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
	grooming, and oral care)...elimination (toileting)...." This Federal Tag relates to Complaint IN00406166. 3.1-38(a)(2)(C)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must			

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	12/01/2023

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
	ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to keep a catheter bag from touching the ground for 1 of 2 residents reviewed for urinary catheter. (Resident 230) Finding includes: During an observation, on 11/27/23 at 2:53 p.m., Resident 230's catheter bag was touching the ground while he was lying in bed. During an observation, on 11/28/23 at 10:15 a.m., Resident 230's catheter bag was touching the ground while he was lying in bed. During an interview, on 11/28/23 at 11:10 a.m., RN 9 indicated the catheter bag should not be touching the ground. The record for Resident 230 was reviewed on 11/29/23 at 12:05 p.m. Diagnoses included, but were not limited to, encephalopathy (disease which caused confusion), cognitive communication deficit, benign prostatic hyperplasia (enlarged prostate glands), edema, history of a stroke, and type 2 diabetes. A physician's order, dated 11/27/23, indicated the resident had an indwelling 16 French size foley catheter. During an interview, on 11/28/23 at 3:25 p.m., the DON (Director of Nursing) indicated the catheter bag should not be touching the ground. A current policy, titled "FOLEY CATHETER	F 0690	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #230 catheter bag assessed and corrected with a cover to the floor and a basin for bag due to bed in lowest position. Dignity bags added to resident bed and wheelchair How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. Residents with indwelling catheters have the potential to be affected. Dignity bags will be placed on both sides of resident bed and wheelchair (if appropriate) to place catheter in when bed in low position. Care plan and care sheets updated for staff and re-education of staff on catheter bag and tubing placement to prevent contact with floor or alternate surfaces. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Clinical team and resident	01/30/2024

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	12/01/2023

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
	MANAGEMENT," dated as effective 9/1/23 and received from the DON on 11/30/23 at 4:10 p.m., indicated "...Be sure the catheter tubing and drainage bag are kept off the floor...." 3.1-41(a)(2)		angels will visually observe residents with catheters to ensure they are placed in dignity bags while in bed/chair and tubing is not touching the ground while in wheelchair. Continued education of staff, resident and family importance of bag and tubing not touching alternate surfaces to prevent contamination. 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? 4. Director of Nursing will complete an audit for residents with indwelling catheters three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached . Results will be reported in the monthly QAPI meeting for 6 months or until 100 % compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024.	
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

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	12/01/2023

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
	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to notify the physician of significant weight changes for 4 of 6 residents reviewed for nutrition. (Residents 24, 10, 14, and 18) Findings include: 1. The record for Resident 24 was reviewed on 11/29/23 at 2:08 p.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis, morbid obesity, and chronic kidney disease stage 3. A weight log indicated the following: On 10/2/23, the resident weighed 317 pounds. On 10/9/23, the resident weighed 319.2 pounds. On 11/1/23, the resident weighed 329.4 pounds. On 11/22/23, the resident weighed 343.6 pound.	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Physicians were notified of weight concerns on residents # 24, 10, 14 and 18. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All residents has the potential to be affected. Weights will be monitored by the dietitian and nursing. The MD and family	01/30/2024

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	12/01/2023

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
	There was a significant weight gain of 8.3%, from 10/2/23 to 11/22/23, in 51 days. There was no notification to the physician noted in the record about the significant weight gain. 2. The record for Resident 10 was reviewed on 11/29/23 at 4:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes, cellulitis of left lower limb, obesity, and osteomyelitis. A weight log indicated the following: On 11/1/2022, the resident weighed 301.4 pounds. On 11/17/2022, the resident weighed 301.4 pounds. On 12/4/2022, the resident weighed 318.4 pounds. On 1/5/2023, the resident weighed 284.2 pounds. On 2/4/2023, the resident weighed 315.2 pounds. On 2/15/20, the resident weighed 315.2 pounds. The resident had a significant weight gain of 5.64% from 11/17/22 to 12/4/22, and a significant weight loss of 10.74% from 12/4/22 to 1/5/23. There was no notification to the physician noted in the record about the significant weight changes. 3. The record for Resident 14 was reviewed on 11/30/23 at 10:37 a.m. Diagnoses included, but were not limited to, fluid overload, type 2 diabetes, morbid obesity, and chronic kidney disease. A physician's order, with a start date of 10/3/23 and an end date of 10/31/23, indicated to weigh the resident one time a day for 4 weeks. A weight log indicated the following: On 10/9/2023, the resident weighed 262.4 pounds.		notifications will be completed timely for any significant weight changes. Affected residents will be followed by the dietitian. Nurses will ensure that weights are completed timely and recorded. Staff will be re-educated on obtaining weights, notification of MD and family and documentation. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Residents with weight changes will be documented and MD/family notified of findings. Resident will be monitored for weight changes by the dietitian and communicated with the clinical team. Weight changes will be reviewed during the daily clinical meeting with review of the care plan and orders. 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? 4. The Administrator will complete an audit of 5 residents three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached. Audit results will be	

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	12/01/2023

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
	On 10/19/2023, the resident weighed 310.6 pounds. On 10/20/2023, the resident weighed 310.9 pounds. On 10/22/2023, the resident weighed 229.0 pounds. There was an 18.37% weight gain from 10/9/23 to 10/19/23, and a 26.34% weight loss from 10/20/23 to 10/22/23. There was no notification to the physician noted in the record about the significant weight changes. During an interview, on 12/1/23 at 4:53 p.m., the DON (Director of Nursing) indicated the facility should report significant weight changes to the provider.4. The record for Resident 18 was reviewed on 12/1/23 at 10:46 a.m. Diagnoses included, but were not limited to, gastrostomy (an artificial external opening into the stomach for nutritional support), dysphagia (difficulty swallowing), and cognitive communication deficit. A physician's order, dated 11/2/23, indicated weights on Monday for four weeks. A care plan, dated as revised 11/13/23, indicated the resident was at risk for nutrition and hydration risk related to dysphagia. Interventions included, but were not limited to, monitor oral intake of food and fluids, monitor weights weekly, diet as prescribed, and supplement at meals. The resident had the following weights: a. On 11/2/23, the resident's weight was 159 pounds. The weight was listed as confirmed. b. On 11/27/23, the resident's weight was 140 pounds. The weight was listed as confirmed		reported in the monthly QAPI meeting for 6 months or until 90% compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 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	12/01/2023

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
	which was a 11.95% (significant) weight loss in 25 days. During an interview, on 11/30/23 at 2:58 p.m., the DON indicated there was no documentation for notifying the physician or family of the 11.95% decrease in 25 days, from 11/2/23 to 11/27/23, and both should have been made aware. The Dietitian focused mainly on malnutrition and not significant weight loss. They follow the facility policy, and it stated both the physician and the family needed to be notified of a significant weight loss. A current policy, titled "Weight Assessment and Intervention," dated 3/22 and received from the DON on 11/30/23 at 4:10 p.m., indicated "...Resident weights are monitored for undesirable or unintended weight loss or gain...Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing...The threshold for significant unplanned and undesired weight loss will be based on the following criteria...1 month - 5% weight loss is significant; greater than 5% is severe. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. 6 months - 10% weight loss is significant; greater than 10% is severe...." A current policy, titled "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol," dated 9/2017 and received from the DON on 11/30/23 at 4:10 p.m., indicated "...The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time...The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake...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	12/01/2023

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
	physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss...." 3.1-46(a)(1)			
F 0732 SS=C 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: (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			

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	12/01/2023

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
	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, interview and record review, the facility failed to have nurse staffing posted and, in a location, where it could easily be viewed for 4 of the 5 days during the survey. (November 27, 28, 29 and 30) Finding includes: During an observation, on 11/28/23 at 10:00 a.m., the surveyors could not locate the posted nurse staffing. During an interview, on 11/30/23 at 10:28 a.m., the Director of Nursing (DON) indicated the nurse staffing was not posted. The nurse staff posting needed to be written out and she did not have time to post the staffing. She knew the daily staffing needed to be displayed where everyone could see it. A current policy, titled, "Posting Direct Care Daily Staffing Numbers", revised on 8/2022 and received from the Director of Nursing (DON) on 12/1/23 at 2:00 p.m., indicated, " ...Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents...Within two (2) hours of the beginning of each shift, the number of licensed nurses (RN's, LPN's, and LVN's and the number of unlicensed nursing personnel (CNAs and NA's) directly responsible for resident care is posted in a prominent location (accessible to residents and	F 0732	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Daily nurse staffing (BIPA) was completed and put into place immediately with copies provided to survey team immediately. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. Everyone has the potential to be affected. Daily nurse staffing will be posted daily and checked on weekends by the MOD and/or designee. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Medical Records or designee will post the Daily nurse staffing with current staffing numbers and census daily. The Manager on Duty for weekends will check the	01/30/2024

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	12/01/2023

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
	visitors) and in a clear and readable format...Records of staffing information for each shift are kept for a minimum of eighteen (18) months or as required by state law (whichever is greater)...." 3.1-17(b)		Daily nurse staffing and make any corrections as needed. 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? 4. The Director of Nursing or designee will complete an audit of the daily nurse staffing three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter. All results will be reported in the monthly QAPI meeting for 6 months or until 100% compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	12/01/2023

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
	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure symptom monitoring was in place for the use of an anticoagulant and a diuretic medication prescribed for 2 of 5 residents reviewed for unnecessary medications. (Resident 4 and 230) Findings include: 1. The record for Resident 4 was reviewed on 11/30/23 at 2:41 p.m. Diagnoses included, but were not limited to, retention of urine, atrial fibrillation, dementia, anxiety disorder, and cognitive communication deficit. A physician's order, dated 4/28/23, indicated Eliquis (an anticoagulant) 2.5 milligram (mg) tablet by mouth two times a day. A physician's order, dated 4/28/23, indicated Furosemide (a diuretic) 20 mg tablet by mouth two times a day. There was no documentation, physician's order, or care plan for monitoring side effects for the use of an anticoagulant or a diuretic medication.	F 0757	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #4 and #230 charts were addressed to include monitoring and care plans for anticoagulant and diuretic therapies. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All residents have the potential to be affected. Residents with orders for diuretics and/or anti coagulation have the potential to be affected. Chart audits will be completed to ensure monitoring for side effects and/or complications are ordered and on TAR, care plans are initiated specifically for	01/30/2024

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	12/01/2023

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 12/1/23 at 9:00 a.m., the Director of Nursing (DON) indicated there should be care plans for both the anticoagulant and diuretic medication. The care plans sometimes would get deleted. The anticoagulant and diuretic medications should be monitored for side effects.2. The record for Resident 230 was reviewed on 11/29/23 at 12:05 p.m. Diagnoses included, but were not limited to, encephalopathy (disease which caused confusion), history of stroke, heart failure, and cognitive communication deficit. A physician's order, dated 11/17/23, indicated the resident was taking Eliquis 5 mg tablet twice per day. There was no physician's order or care plan to monitor for bleeding in the resident's record. During an interview, on 11/30/23 at 2:49 p.m., the DON (Director of Nursing) indicated if a resident was on an anticoagulant medication, then there should be monitoring for the risk of bleeding. A current policy, titled "Anticoagulation - Clinical Protocol." dated as revised November 2018 and received from the DON on 11/20/23 at 4:00 p.m., indicated "...Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications...If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next schedule dose of anticoagulation...." 3.1-48(a)(3)		the resident or updated as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Chart reviews will be completed for care plans and monitoring of anticoagulant and diuretic therapies with correction made for any discrepancy. Staff will be re-educated on updating or initiating care plans and monitoring for side effects for medication therapies to include but not limited to anticoagulant and diuretic use. 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? 4. Director of Nursing and/or designee will complete an audit of three residents three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter until compliance is reached . All results will be reported in the monthly QAPI meeting for 6 months or until 90% compliance reached. By what date the systemic changes for each deficiency will	

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	12/01/2023

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
			be completed. 5. Substantial compliance will be reached by January 30, 2024 .	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure supplements were secured in a resident's room for 1 of 1 resident reviewed for medication storage. (Resident 3)	F 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	01/30/2024

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	12/01/2023

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 an interview, on 11/27/23 at 12:33 p.m., Resident 3 had supplements all throughout his room, unsecured and in plain view. The resident indicated the facility did a self-administration assessment and allowed him to keep the supplements in his room. The record for Resident 3 was reviewed on 11/29/23 at 12:37 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease stage 3, and aneurysm (dilation of the wall of an artery) of an artery of the lower extremity. A physician's order, dated 8/8/22, indicated the resident could keep supplements and vitamins at bedside. During an observation, on 11/27/23 at 2:50 p.m., the resident was not in his room and his door was open with the supplements in view. During an observation, on 11/28/23 at 10:13 a.m., the resident was not in his room and his door was open with the supplements in view. During an observation, on 11/28/23 at 10:33 a.m., the resident was not in his room and his door was open with the supplements in view. During an observation, on 11/29/23 at 10:21 a.m., the resident was not in his room and his door was open with the supplements in view. During an interview, on 11/29/23 at 12:44 p.m., the DON (Director of Nursing) indicated their policy did not state supplements had to be locked up		1. Storage of supplements discussed with resident #3 and a locking cabinet was ordered immediately. Resident educated to close door when not in his room and to attempt to store items out of site until his cabinet arrives. Once cabinet is here SSD will assist resident in placing items in and locking doors. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All residents that are able to self administer drugs or supplements have the potential to be affected. Residents that are able to self administer will be assessed for appropriateness and will have a locked box/cabinet to store medications/supplements in their room. A physician order will be obtained and a care plan will be updated for self administration. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. All staff will be observant to items such as medications or supplements being left out in a resident room and not locked up. Staff immediately will report findings to nurse/DON or designee	

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	12/01/2023

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
	and secured. Some of the supplements the resident had, if ingested by other residents, could be dangerous. During an interview, on 12/2/23 at 4:55 p.m., the DON indicated the facility did not have a policy on medication storage which included storing supplements. 3.1-25(m)		immediately. Residents will be educated to safe storage or medications/supplements and to keep them locked up when not in use. Staff and residents/family will be re-educated to storage of medications/supplements. 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? 4. The Administrator will complete an audit of three residents three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter. All results will be reported in the monthly QAPI meeting for 6 months or until 100%compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024.	
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 Nursing Home Complaint IN00406166.	R 0000	The submission of this plan of correction does not indicate an admission by University Place Health Center and Assisted Living that the findings and allegations contained herein, are accurate and	

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	12/01/2023

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
	Complaint IN00406166 - Federal/State deficiencies related to the allegations are cited at F677. Survey dates: November 27, 28, 29, 30 and December 1, 2023. Facility number: 003678 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 12, 2023.		a true representation of the quality of care provided or the living environment provided to the residents of University Place Health Center and Assisted Living. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only and is submitted as required by the provisions of the State and Federal Law and not because University Place, Inc. agrees with the allegations contained. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility	R 0052		01/30/2024

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	12/01/2023

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
	failed to ensure a resident was free from neglect when the resident eloped from the facility without staff knowledge for 1 of 3 residents reviewed for abuse and neglect. (Resident 45) Finding includes: The record for Resident 45 was reviewed on 11/29/20. Diagnoses included, but were not limited to, fracture of the left femur and Parkinson's disease. An incident report to the Indiana Department of Health, dated 1/31/23 at 3:30 p.m., indicated the resident was mobile in her wheelchair in the assisted living unit. Staff noted she was going to an exit door on the unit around 2:30 p.m. and redirected the resident. At approximately 3:20 p.m., another resident brought Resident 45 to the nurse's station and stated she was outside on the sidewalk coming out toward the west entrance. In a written statement, dated 1/31/23, CNA 10 indicated she last saw the resident at 2:00 p.m., to 2:30 p.m. The resident had rolled her wheelchair down the hall between room 2100 to 2113. After her she had finished her rounds, the resident was pushing on the exit door trying to open it. The resident had been trying to leave all day and stating she wanted to leave to go home. The nurse left the unit leaving CNA 10 alone. She completed her rounds on the other wing and then completed her computer education around 3:00 p.m., to 3:30p.m. Two residents, wearing coats and gloves, had been outside walking and returned the resident to the nurse's station. The two residents indicated they had not seen Resident 45 outside when they left on their walk but found her sitting outside in her wheelchair on the sidewalk after their walk was finished.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #45 was assessed post elopement, family notified and was placed on list for memory support unit. Continue monitoring in place until resident transferred to a new apartment in Memory Support. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All wandering residents have the potential to be affected. Assessments will be completed pre and post admission to determine appropriateness for Assisted Living placement. Concerns will be addressed with resident and family, service plans will be created and updated as needed with appropriate monitoring to provide a safe environment for the resident. Social Service will continue to review and update the elopement binders with resident information and pictures. New pictures to be obtained as needed. Elopement drills will continue to be completed by Social Service quarterly including both Assisted Living and	

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	12/01/2023

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
	In a written statement, dated 1/31/23, QMA 13 indicated she last saw the resident at 2:22 p.m. The resident was last seen by the QMA on hall one of assisted living. At around 3:30 p.m., the CNA reported to the nurse the resident had gotten outside and was brought back in by another resident. The QMA notified the nurse and the Director of Nursing. The resident was in her recliner at 4:00 p.m. A progress note, dated 1/31/23 at 6:35 p.m., indicated the resident was noted outside the building. The resident was returned inside the building. A head-to-toe assessment was completed, and the resident was placed in her recliner in her room with blankets. No injuries were noted. The resident's daughter was made aware. During an interview, on 11/29/23 at 3:00 p.m., the Director of Nursing indicated she watched the cameras after the incident was reported and the resident had been trying for about 30 to 35 minutes to get out of the door. She exited the building and was returned 14 minutes later to the unit. She indicated they had reviewed the temperature outside and it was 20 degrees. The resident was monitored until she could be transferred to the memory care unit. A current policy, titled "Elopements and Wandering Residents," dated 1/18/2018 and received from the Director of Nursing on 11/29/23 at 3:30 p.m., indicated "...ensures that residents who exhibit wandering behavior, and/or are at risk for elopement, receive adequate supervision to prevent incidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement...the community is equipped with door		Health Center. Elopement binders can be found in the Social Service office, Front lobby/desk, Health Center and Assisted living. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Staff will be re-educated regarding wandering, behaviors, safety, interventions, documentation and reporting. New behaviors or change in behaviors may warrant a new assessment and changes to the resident service plan with discussion regarding resident with family and notification to the physician for recommendations. Staff will be informed of any new changes to resident care or needs. 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? 4. Resident Service Manager or designee will complete an audit of 5 residents charts for behaviors, changes or concerns three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter. All results will be reported in the monthly QAPI meeting for 6 months or until 90%	

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	12/01/2023

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
	locks/alarms to help avoid elopements...alarms are not a replacement for necessary supervision...staff is to be vigilant in responding to alarms in a timely manner...residents are assessed for risk of elopement and unsafe wandering upon admission, readmission, with a significant change and quarterly throughout their stay by the interdisciplinary team ...interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards are added to the resident's care plan and communicatee with appropriate staff...adequate supervision is provided to help prevent accidents or elopements...."		compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024.	
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse and intimidation of a staff member for 1 of 3 residents reviewed for abuse. (Resident 41) Finding includes: The record for Resident 41 was reviewed on 11/29/23. Diagnoses included, but were not limited to, muscle weakness, other intervertebral disc degeneration in the lumbar region, low back pain, and dementia. An incident report to the Indiana Department of Health, dated 1/16/23 at 8:45 a.m., indicated Resident 41 had approached Dietary Staff Member 6 and inquired about his missing bacon on his plate. The dietary staff member began yelling at the resident who was upset with her. She was yelling profanities directly to the resident and proceeded to throw bacon at the resident.	R 0053	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident(s) affected were assessed for psychosocial concerns after incident. Staff member was terminated immediately after she walked out of the facility and police report was filed. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. All residents have the potential to be affected. Any potential abusive behavior by staff will be	01/30/2024

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	12/01/2023

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 statement written by LPN 7 indicated the resident took his plate to the dietary staff member indicating he did not receive his bacon on his plate. The dietary staff member responded indicating the resident was not the only resident she had to feed. The resident responded he just wanted his bacon. The dietary staff member responded, "here's your bacon," and threw the bacon in the resident's direction. The resident caught the bacon on his plate. The dietary staff member then stated to the resident, "you don't know who the f*** I am, this is bull****." The dietary staff member left on the elevator and did not return. LPN 7 spoke to the other residents present during the altercation. The other residents indicated they were intimidated by the dietary staff member and requested she not serve them anymore. A statement written by CNA 8 indicated the resident walked up to the dietary staff member and indicated he did not get his bacon. The dietary staff member responded back to the resident he was not the only one there and she had to serve others. The dietary staff member tossed the bacon on the plate and told the resident "You don't know who the f**** I am." The other residents seemed upset. During an interview, on 11/30/23 at 2:30 p.m., the Director of Nursing (DON) indicated she was upset about the incident. The statements written by LPN 7 and CNA 8 were written on the date of the incident. The staff reported the incident to her immediately and the resident's responsible party was notified. The dietary staff member was banned from the facility. The dietary staff member left immediately and never returned.		investigated thoroughly and staff member will be suspended immediately pending investigation findings. New hired staff members will continue to have a background check completed preemployment by Human Resources or designated department Human Resources. All staff will be educated upon employment and annually to, but not all inclusive, of resident rights, abuse, neglect. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Continuing annual and as needed education regarding, but not all inclusive, of resident rights, abuse, neglect for all staff will be mandatory. Investigations will be completed with any reported suspected abuse, the employee suspended or accused removed from the facility pending investigation. Social Service or designee will interview residents for psycho-social needs. Police report will be filed and reportable will be sent to the ISDH immediately. 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?	

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	12/01/2023

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 policy, titled "Abuse and Neglect," dated as reviewed/revised on 9/1/2005 and received from the Director of Nursing on 11/27/23, indicated "...the safety and welfare of the residents entrusted to the care of [corporate name] shall be always maintained...abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...verbal abuse refers to any use of oral, written 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...examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again..."		4. Human Resources, dietary manager and/or designee will complete an audit of 5 employee records for education, background screen and completed paperwork three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks and monthly thereafter. All results will be reported in the monthly QAPI meeting for 6 months or until 100% compliance reached. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be reached by January 30, 2024.	