STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure and Investigation of Complaint IN00385705 and Complaint IN00387630. Complaint IN00385705 - Unsubstantiated due to lack of evidence. Complaint IN00387630 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: August 17, 18, 19, 22, and 23, 2022 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 1 Medicaid: 53 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 25, 2022	F 0000	8/30/22 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis Indiana 46204 RE : Recertification and State licensure with a complaint University Park Rehabilitation and Healthcare 1400 Medical Park Dr Fort Wayne IN 46825 Dear Ms Buroker: On August 23, 2022 a Recertification and State licensure with a complaint (IN00385725, IN 00387630) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 9/2/22.	

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

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			Please feel free to all me with any further questions at 1-260-486-3001 Respectfully submitted, Tammy Denlinger HFA Executive Director	
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 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.			

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	Based on interview and record review the facility failed to esure quarterly care plan meetings were completed for 1 of 1 residents reviewed. (Resident 44) Findings include: Resident 44 was interviewed on 8/17/22 at 11:10 AM. Resident 44 indicated she had not had a care plan meeting for a long time. Resident 44's record review was completed on 8/18/22 at 1:57 PM. Diagnosis included: chronic obstructive pulmonary disease and type 2 diabetes mellitus with diabetic chronic kidney disease. A quarterly Minimum Data Set (MDS) Assessment, dated 7/16/22 indicated Resident 44 had a Brief Interview Mental Status of 15/15. (cognitively intact) The Social Service Designee (SSD) was interviewed on 8/18/22 at 1:48 PM. The SSD indicated every resident should have a quarterly care plan meeting. The SSD was interviewed on 8/19/22 at 10:58 AM. The SSD indicated Resident 44 had a care plan meeting in June 2022 with family, but the resident was not present. The SSD indicated she did not have documentation regarding the meeting. The SSD also indicated a resident can attend care plan meetings if they would like to. A policy, titled "Care Plan Protocol," undated, was provided by the Regional Nurse Consultant on 8/23/22 at 9:38 AM. The policy indicated care plans should be evaluated after each quarterly assessment and modified if necessary. The policy	F 0657	---- F657 Care plan timing and revision - 1. **-What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 44 remains in facility. Care plan scheduled for 9-16-22. Resident notified of scheduled care plan intends to participate in care plan **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** Any resident residing in facility have the potential to be affected by deficient practice. Residents will be scheduled and offered to participate in care conference following quarterly care plan schedule. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Social service director re-educated on the care plan process which includes inclusion of resident participation. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	09/02/2022

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	also indicated meetings will be held within 7 days of the comprehensive assessments. 3.1-35(d)(2)(B)		**will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Executive Director/designee. MDS schedule/calendar will be reviewed to identify the need for care plan conference scheduling. Calendar to be reviewed weekly x 6 months and then will be followed in QAPI thereafter. The results of these audits will be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 9-2-22	
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; Based on observation, record review and interview the facility failed to ensure residents received showers or bed baths as scheduled for 3 of 3 residents reviewed. (Resident B, Resident C, Resident D). Findings include:	F 0677	**F-677 ADL PROVIDED FOR DEPENDENT RESIDENTS** **The facility respectively requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of**	09/02/2022

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	1.A review of Resident B's record on 8/17/22 at 10:05 AM indicated diagnoses included combined systolic and diastolic heart failure, chronic kidney disease, severe protein-calorie malnutrition, unsteadiness on feet and neuromuscular dysfunction of the bladder. The resident's quarterly Minimum Data Set (MDS), dated 7/11/22, indicated he had a Brief Interview for Mental Status (BIMS) score of 15. He was alert, oriented and interviewable. Resident B's MDS also indicated he was totally dependent for bathing and required a 1-person physical assist. A review of Resident B's shower schedule indicated Resident B was scheduled to receive bed bath/showers on Tuesday and Friday in the PM with shampoos. A review of Resident B's shower documentation dated 5/29/22 through 8/13/22 revealed the following: 6/5 - 6/11 No documentation of bathing 6/12-6/18 Complete bed bath 6/17 6/19-6/25 Complete bed bath 6/24 and 6/20 6/26-7/2 No documentation of bathing 7/3-7/9 No documentation of bathing 7/10-7/16 No documentation of bathing 7/17 - 7/23 No documentation 7/24 - 7/30 Complete bed bath 7/25 and 7/29 7/31- 8/6 No documentation of bathing 8/7 - 8/13 Complete bed bath 8/10 The record lacked documentation of any refusal of showers by the resident. Resident B received 6 complete bed baths of the 20 bed baths the resident should have received. 2. A review of Resident C's record on 08/19/22 at 03:44 PM indicated diagnoses included cerebral		**Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident B,C,D had ADL care offered and accepted by resident. Care plans reviewed and updated as required for affected residents. 2. **How the facility identified other residents:** Any resident that is dependent for ADLs have the potential to be affected by deficient practice. Shower schedules reviewed and updated as indicated. **3. Measures put into place/ System changes:** Facility staff educated on components of F677 ADL provided for dependent residents. Education provided on the proper procedure for refusals of care including notification of responsible party and provider for refusals of care and required documentation.	

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	infarct, cognitive communication deficit, muscle wasting and atrophy and acquired absence of left leg above knee. The resident's quarterly Minimum Data Set (MDS), dated 5/27/22, indicated he had a Brief Interview for Mental Status (BIMS) score of 7, had unclear speech, sometimes understood and was not interviewable. Resident C's MDS also indicated he required physical help limited to transfer only for bathing and required a 1-person physical assist. A review of Resident C's shower schedule indicated Resident C was scheduled to receive bed bath/showers on Wednesday and Sunday with no shampoo in the PM. A review of Resident C's shower documentation dated 5/29/22 through 8/13/22 revealed the following: 6/5 - 6/11 Shampoo/Shave 6/5 6/12-6/18 Complete bed bath 6/16 6/19-6/25 Complete bed bath 6/22 and 6/25 6/26-7/2 No documentation of bathing 7/3-7/9 Complete bed bath 7/6 7/10-7/16 No documentation of bathing 7/17 - 7/23 No documentation of bathing 7/24 - 7/30 Complete bed bath 7/26 7/31- 8/6 No documentation of bathing 8/7 - 8/13 Complete bed bath 8/7, 8/10 and 8/11 The record lacked documentation of any refusal of showers by the resident. Resident C received 9 complete bed baths of the 20 bed baths the resident should have received. 3. A review of Resident D's record on 08/19/22 at 11:58 AM indicated Resident D's diagnoses included morbid obesity, abnormalities of gait and mobility, lymphedema, type 2 diabetes mellitus		**4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit 5 random residents for shower completion 3 times weekly. Audits will be reviewed monthly during Quality Assurance. Audits will continue for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. **Date of Compliance 9-2-22**	

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	and right knee osteoarthritis. The resident's comprehensive Minimum Data Set (MDS), dated 7/23/22, indicated she had a Brief Interview for Mental Status (BIMS) of 15, was alert, oriented and interviewable. Resident D's MDS also indicated she required physical help in part of bathing activity and required 1-person physical assist. A review of Resident D's shower schedule indicated Resident C was scheduled to receive bed bath/showers on Monday and Friday in the AM and partial waist down bed bath Tuesday, Wednesday, Thursday, Saturday and Sunday with shampoo in the PM. A review of Resident C's shower documentation dated 5/29/22 through 8/13/22 revealed the following: 6/5 - 6/11 Complete bed bath with shampoo 6/6 6/12-6/18 Complete bed bath with shampoo 6/13, 6/14 6/19-6/25 No documentation of bathing 6/26-7/2 No documentation of bathing 7/3-7/9 No documentation of bathing 7/10-7/16 Partial bed bath with shampoo 7/11(per request) 7/17 - 7/23 No documentation of bathing 7/24 - 7/30 No documentation of bathing 7/31- 8/6 Bed Bath with shampoo 8/1 8/7 - 8/13 Bed bath with shampoo 8/10 Complete bed bath with special soap/lotion 8/7 Complete bed bath with shampoo/special soap 8/9 The clinical record lacked documentation of any refusal of showers by the resident except on 7/28/22. Resident D received 8 complete bed baths of the 70 complete or partial bed baths the resident should have received.			

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	On 8/22/22 at 12:10 AM the Director of Nursing (DON) indicated the shower sheets were not being documented consistently for residents and she had been re-evaluating the documentation since acquiring her position. On 8/19/22 at 3:55 PM the Executive Director (ED) provided a policy titled "Bath/Shower Schedule" which indicated complete bed bath or shower should be given to residents at least 2 times per week, per preference and prn and posted in the shower book. This Federal citation is related to complaint: IN00387630 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to ensure a comprehensive interdisciplinary plan of care was implemented to provide hospice services for 1 of 1 resident reviewed. (Resident 14). Findings include:	F 0684	**F-684 Quality of Care** **The facility respectively requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement**	09/02/2022

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	On 8/22/22 at 11:20 AM a record review indicated Resident 14's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, anxiety, and dementia. A comprehensive Minimum Data Set (MDS) Resident Assessment and Care Screening dated 5/24/22 indicated the resident had received hospice services while at the facility. A progress note dated 5/13/22 at12:34 PM indicated the resident had a hospice consultation in the hospital and follow up was needed. A progress note dated 5/17/22 at 4:36 PM indicated a hospice nurse was present to see the resident. A physician progress note dated 5/23/22 at 7:38 AM indicated Resident 14 was receiving hospice services and to continue the current plan of care. A progress note dated 6/2/22 at 5:34 PM indicated a hospice nurse was present to see the resident. A progress note dated 8/11/22 at 2:06 PM indicated Resident 14 continued to receive hospice services from a named Hospice company. A progress noted dated 8/19/22 at10:46 AM indicated there was no physician order for the Resident 14 to receive hospice services. A physician order dated 8/19/22 indicated hospice was to evaluate and treat Resident 14 as of 5/12/22. During a review of the resident's hospice communication book on 8/22/22 at 1:25 PM, the documentation did not contain a current care plan		**with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident 14 comprehensive care plan revised/updated to include collaboration with hospice services. 2. **How the facility identified other residents:** Any residents that receives hospice services have the potential to be affected by deficient practice. Care plans **reviewed** and updated as indicated for any resident on hospice services. **3. Measures put into place/ System changes:** Facility staff educated on inclusion of hospice services in the comprehensive care plan as indicated. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit	

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	or resident assessments. A review of the resident's care plan indicated the care plan was revised on 8/19/22. The resident's revised care plan indicated the resident was to receive hospice services. During an interview on 8/22/22 at 11:55 AM, RN 2 indicated hospice services should be included on the resident's care plan. During an interview on 8/22/22 at 2:05 PM, the Director of Nursing indicated hospice services required a physician order and should be addressed on the resident's care plan at the initiation of hospice services. On 8/17/22 at 12:18PM the Executive Director (ED) provided the hospice service contracts for the facility which included Eleos Hospice, Guardian Angel Hospice and Palliative Care, and Day by Day Hospice. A literature search on 8/24/22 at 10:20 am indicated a named Hospice provider had a name change in March 2022. No service contract for either named Hospice was provided by the facility. The facility did not provide a policy related to hospice services. 3.1-37		orders/care plan for hospice admissions weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. **Date of Compliance 9-2-22**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

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	adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview the facility failed the ensure the environment remained free of potential accidental hazards in 1 of 1 observation. (Resident 3) Findings include: On 8/17/22 at 11:26 an observation was made of Resident 3's wheelchair. The resident was sitting on his bed as he rolled cigarettes. In the resident's wheelchair, located on the opposite side of his bed, a white ashtray was observed in the back left corner half full with extinguished smoked cigarette butts. On 08/18/22 at 1:26 PM Resident 3's record was reviewed. Diagnoses included non-Alzheimer's dementia, cachexia, unsteadiness on feet, anxiety, alcohol use and nicotine dependence. His quarterly Minimum Data Set (MDS) dated 5/11/22 indicated Resident 3 had a Brief Interview for Mental Status (BIMS) score of 14 and was alert, oriented and interviewable. Resident 3's functional status indicated he required a 1-person physical support for activities of daily living (ADLs) and used a wheelchair. He also wore corrective lenses. On 8/17/22 at 12:18 PM the list of independent and supervised persons who smoked was received from the Executive Director. The list indicated Resident 3 smoked independently. In an intreview on 8/18/22 at 1:40 PM, the DON indicated residents should not have an ashtray filled with cigarette butts in their rooms. She	F 0689	F689 Free of Accident Hazards/Supervision/Devices 1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 3 educated on proper disposal of extinguished cigarette butts, safe smoking policy. Extinguished cigarettes disposed of in proper receptacle **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** All residents that reside in the facility has the potential to be affected by deficient practice. Residents that smoke educated on safe smoking policy. Facility audits conducted to ensure that no lighters were in possession of residents. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All new admissions who smoke will be educated on smoking policy and safety. All other residents will be assessed for	09/02/2022

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	observed the ashtray with smoked butts in Resident's 3 wheelchair on arrival to the resident's room. She indicated to the resident the ashtray needed to be emptied before returning to the building and they would discuss more later. On 8/18/22 at 12:44 PM a policy titled "Smoking Safety Policy," effective 11/1/20, indicated ashtrays of noncombustible material and safe design will be provided in smoking areas and metal containers with self-closing cover devices where ashtrays can be emptied will be readily available in smoking areas. 3.1-45(a)		need of re-education/ change of independent smoking status as needed. Care plans updated as indicated. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Executive Director/designee. Random audits will be conducted of 3 residents who smoke for safe/ proper disposal of extinguished cigarette butts, safe smoking practices, and proper storage of smoking materials. The results of these audits will be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 9-2-2022	
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			

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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 interview and record review the facility failed to ensure catheter care was provided per physician orders for 2 of 2 residents reviewed. (Resident 6, Resident 46) Findings include: 1. Resident 6 was interviewed on 8/17/22 10:07 AM. Resident 6 indicated staff were not flushing tubing or emptying his catheter as ordered.	F 0690	F690 FBowel/Bladder Incontinence, catheter UTI 1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 6 and 46 records/orders	09/02/2022

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	A record review was completed for Resident 6 on 8/18/22 02:18 PM. Diagnosis included: neuromuscular dysfunction of bladder and retention of urine. A quarterly Minimum Data Set (MDS) Assessment, dated 7/11/22, indicated Resident 6 had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact). The Medication Administration Record (MAR) was reviewed dated 6/1/22-8/18/22. An order for a Foley catheter, 20 French with 30 ml balloon to gravity drainage, document the output in ml every shift was noted. The MAR indicated the Foley output was not documented on the following dates: 1st shift: 6/9/22-6/11/22, 6/13/22-6/20/22, 6/22/22, 6/23/22, 6/26/22, 6/27/22, 7/5/22, 7/7/22, 7/8/22, 7/13/22, 7/14/22, 7/18/22-7/21/22, 7/26/22-7/28/22, 7/30/22, 8/1/22, 8/3/22-8/5/22, 8/8/22-8/11/22, 8/13/22, 8/15/22-8/18/22. 2nd shift: 6/2/22, 6/4/22, 6/5/22, 6/8/22, 6/9/22, 6/12/22, 6/21/22, 6/22/22, 6/24/22-6/27/22, 6/29/22, 6/30/22, 7/2/22, 7/5/22, 7/8/22, 7/15/22, 7/16/22, 7/23/22, 7/26/22, 7/28/22, 8/1/22, 8/4/22-8/6/22, 8/8/22, 8/10/22, 8/12/22, 8/13/22, 8/17/22 An order indicated Foley catheter care was to be completed every shift. The MAR dated 6-22, 7-22, and 8-22 indicated staff did not provide catheter care on: 1st shift: 8/1/22 2nd shift: 6/4/22, 6/5/22, 6/8/22, 7/23/22, 7/26/22 An order indicated to assess urine color, clarity, and tubing placement every shift. The MAR		reviewed to ensure that provision of catheter care, flushing and monitoring output were included. Documentation validated. Care plan updated as indicated **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** Audits conducted of resident that require urinary catheter, records/orders reviewed to ensure that provision of catheter care , flushing and monitoring of output included. Documentation validated. Care plans updated as indicated. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be identified upon admission and reviewed during clinical meeting for appropriate care and monitoring of residents that require urinary catheter **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Director of Nursing/designee .Audits will be	

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	indicated staff did not monitor catheter output per order on: 1st shift: 8/1/22 2nd shift: 6/4/22, 6/5/22, 6/8/22, 7/23/22, 7/26/22, 8/17/22 2. A record review for Resident 46 was completed on 8/18/22 at 2:15 PM. Diagnosis included retention of urine. The MAR dated 6/1/22 - 8/18/22 was reviewed. An order for Foley catheter: 22 French with 30 ml balloon to gravity drainage, record output q shift for neurogenic bladder was noted. The MAR indicated staff did not document Resident 46's catheter output on the following dates: 1st shift: 6/9/22, 6/12/22, 6/13/22, 6/16/22, 6/18/22, 6/19/22, 6/20/22, 6/26/22 - 6/30/22, 7/1/22, 7/2/22, 7/5/22, 7/7/22, 7/8/22, 7/12//22-7/14/22, 7/16/22, 7/18/22-7/21/22, 7/26/22, 7/28/22, 7/31/22, 8/1/22-8/5/22, 8/8/22-8/11/22, 8/13/22-8/17/22 2nd shift: 6/5/22, 6/7/22, 6/11/22, 6/12/22, 6/17/22, 6/20/22, 6/22/22, 6/24/22, 6/25/22, 6/27/22-6/30/22, 7/2/22, 7/5/22, 7/6/22, 7/8/22, 7/10/22, 7/15/22-7/17/22, 7/23/22, 7/25/22, 7/28/22, 7/30/22, 7/31/22, 8/1/22, 8/6/22, 8/8/22, 8/10/22, 8/12/22, 8/13/22, 8/16/22, 8/17/22 An order indicated to provide Foley catheter care every shift. The MAR dated 6/1/22- 8/18/22 indicated staff did not perform catheter care as ordered on the following dates: 1st shift: 6/27/22, 7/8/22, 7/12/22, 7/21/22, 8/1/11, 8/17/22 2nd shift: 6/5/22, 6/11/22, 6/12/22, 6/28/22, 7/23/22, 7/25/22, 7/30/22, 7/31/22 In an interview on 8/19/22 at 9:47 AM, CNA 3		conducted of 5 residents with catheters 3 times weekly. The results of these audits will be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 9-2-2022	

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	indicated catheter care was to be completed every shift. CNA 3 indicated she documented the catheter output each shift. The Director of Nursing (DON) was interviewed on 8/19/22 at 4 PM. The DON indicated staff should document catheter output and provide catheter care as ordered. A policy, revised 7/21/2021, titled "Foley Catheter Care," was provided by the DON on 8/19/22 at 3:40 PM. The policy indicated residents will be provided catheter care twice daily and as needed. 3.1-41(a)(1)			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview and record review the facility failed to ensure provide trauma informed care in accordance with professional standards of practice for 1 of 1 resident reviewed. (Resident 11). Findings include:	F 0742	F742 Treatment/Srvcs Mental/Psychosocial Concerns *This plan of correction is the centers credible allegation of compliance.* 1. **What corrective actions(s) will be accomplished for those**	09/02/2022

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	During an interview on 8/19/22 at 11:05 AM Resident 11 indicated she was going outside to smoke. She indicated smoking helped ease her anxiety, depression and post-traumatic stress disorder (PTSD). A record review on 8/19/22 at 11:37 AM indicated the resident was admitted to the facility with diagnoses of cognitive communication deficit, bipolar disorder, drug induced subacute dyskinesia, psychoactive substance abuse, generalized anxiety disorder, tobacco use disorder, and post-traumatic stress disorder (PTSD). Resident 11's care plan initiated on 11/16/21 did not indicate the resident had been diagnosed with PTSD. A care plan entry initiated 12/2/21 indicated the resident had suicidal behavior and ideations. A care plan entry initiated 12/2/21 and revised on 3/25/22 indicated the resident often had feelings of dread and anxious thoughts about abandonment she refused to voice out loud. A progress note dated 6/9/22 at 1:35 PM indicated the resident exhibited increased lethargy, had a recent change in medications, and had learned her mother had passed away a few days prior. A progress note dated 6/13/22 at 11:05 AM indicated the resident was acutely evaluated due to the resident feeling overwhelmed and more depressed since her mother passed away. The History of Present Illness statement indicated the resident was to be seen for a psychiatric assessment of depression, PTSD, psychoactive drug abuse, anxiety, and tardive dyskinesia (TD). A progress note dated 6/15/22 at 10:34 PM indicated the resident had significant weight loss		**residents found to have been affected by the deficient practice?** Resident 11 care plan updated to include resident history of Post Traumatic Stress Disorder. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** Audits conducted of residents that have diagnosis of PTSD. Care plans updated as indicated. Any other residents with PTSD have the potential to be affected. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be identified upon admission and reviewed during clinical meeting for diagnosis Post Traumatic Stress Disorder. Resident with psychosocial concerns/ diagnosis will be referred to and followed by appropriate psychiatric service providers as indicated. Nursing staff educated on appropriate care and of residents with PTSD diagnosis, trauma informed care. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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	in the last 30 days. A progress note dated 6/16/22 at 12:39 AM indicated a Certified Nurse Assistant (CNA) reported to the nurse the resident "was not quite herself today" due to the resident being a little confused about the date and time. An NP (Nurse Practitioner) progress note dated 6/20/22 at 12:42 PM indicated the resident continued with associated complaints of depression despite medication changes. The progress noted indicated the resident spoke of her mother's recent death and the imprisonment of her son. A progress note dated 6/21/22 at 10:32 AM indicated the resident was evaluated for psychiatric assessment of depression, PTSD, psychoactive drug abuse, anxiety, history of amphetamine abuse and TD. The progress note indicated the resident was somnolent, did not make eye contact, and the resident's depression was resistant to treatment. The resident indicated she was tired, depressed and grieving for the loss of her mother. A progress note dated 6/27/22 at 11:00 AM indicated the resident had a psychiatric assessment for depression, PTSD, psychoactive drug abuse, anxiety, history of amphetamine abuse and TD. The progress note indicated the resident reported continued depression and felt the depression medications were ineffective. A progress note dated 6/28/22 at 10:48 AM indicated the resident made numerous comments about wanting to end her life. The resident requested to be transferred for inpatient psychiatric evaluation.		**will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Director of Nursing/designee. Audits will be conducted weekly of orders/ careplans and diagnosis for new admissions/ current residents for PTSD or other psychosocial diagnosis concerns will receive appropriate referrals and services as indicated. Audits to be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 9-2-2022	

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	A progress note dated 7/18/22 at 6:40 AM indicated the resident had been treated for suicidal ideation with a plan and had returned to the facility on 7/14/22. During an interview on 8/20/22 at 10:40 AM, the DON indicated the resident was admitted to the facility with a diagnosis of PTSD. PTSD was not included on the resident's care plan, but should have been. During an interview on 8/23/22 at 10:45 AM, the Regional Director of Operations indicated he was unaware of a trauma informed care regulation. He voiced understanding of the implementation of the trauma informed care regulation in 2017. He indicated he agreed the death of a loved one could be a PTSD trigger that resulted in deterioration of the resident's mental and physical health. According to the Centers for Disease Control and Prevention, (CDC) symptoms linked with PTSD include but are not limited to drug abuse, depression, feelings of abandonment, and suicidal ideation (CDC, 2022). Common situations that trigger PTSD include but are not limited to emotional pain and the loss of a loved one. Reference Centers for Disease Control and Prevention (2022). http://www.cdc.gov/masstrauma/factsheets/public/coping.pdf 3.1-43(a)(1)			
F 9999				

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Bldg. 00	1. Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview the facility failed to ensure prospective employees' references checks were completed and documented in 4 of 5 employee records. (Interim Executive Director (ED), Infection Preventionist (IP), CNA 8 and RN 2). Findings include: A review of 5 employee files was completed on 8/22/22 at 3:00 PM. One reference check was located in the interim ED file. No reference checks were located in the IP, CNA 8 and RN 2's employee file. On 8/23/22 at 11:28 PM the Human Resource Director (HRD) indicated the reference check documentation was not located in the employee files and should had been. On 8/23/22 at 10:00 AM the interim ED indicated the employee files were missing documentation and the employee files were incomplete. On 8/23/22 at 10:00 AM the ED provided an Employee Hire checklist. The checklist indicated (2) background checks were required for all new employees. No further documentation was provided by the time of exit. 2. A physical examination shall be required for	F 9999	---- F9999 Final Observations - 1. **-What corrective actions(s) will be accomplished for those employee files found to have been affected by the deficient practice?** Interim ED, IP RN 2, QMA 9 were given 1st step Mantoux to be followed up with 2nd step. Interim ED, had physical exam completed Reference checks were completed on interim ED, IP, RN 2, QMA 9. IP and QMA 9 provided with job specific skill orientation documentation for completion **2. How will other employee having the potential to be affected by the same deficient practice be identified and what will corrective action be.** All new employees have the potential to be affected by deficient practice. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Human resource director re-educated on the pre hire requirements prior to the first day of employment. Check off list to be utilized to ensure completion **4. How the corrective**	09/02/2022

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	each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method [toxic unit (TU) purified protein derivative (PPD)], administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. Based on record review and interview the facility failed to ensure a physical exam and a Mantoux PPD (one type of tuberculosis testing) screening was completed and documented within (1) month prior to employment in 5 of 5 employee records. (Interim ED, IP, CNA 8, RN 2, and QMA 9). Findings include: A review of 5 employee files was completed on 8/22/22 at 3:00 PM. The interim ED's physical		**action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Executive Director/designee. New hire checklist to be reviewed weekly x 6 months and then will be followed in QAPI thereafter. The results of these audits will be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 9-2-22	

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	exam could not be located. No evidence of completed 2-step method tuberculin (TB) skin test were located for the Interim ED, IP, CNA 8, RN 2, and QMA 9's. On 8/23/22 at 11:28 PM the Human Resource Director (HRD) indicated the physical exam and completed 2-step method TB skin testing were not located in the employees files and should had been. On 8/23/22 at 10:00 AM the interim ED indicated the employee files were missing documentation and were incomplete. On 8/23/22 at 10:00 AM the ED provided an Employee Hire checklist. The checklist indicated a physical exam and TB testing was required for all new employees. No further documentation was provided by time of exit. 3. Documentation of orientation to the facility, including residents' rights, and to the specific job skills. Based on record review and interview the facility failed to ensure job descriptions were provided and orientation of specific job skills documentation was completed in 2 of 5 employee records. (IP and QMA 9) Findings include: A record review of 5 employee files was completed on 8/22/22 at 3:00 PM. The IP job description and orientation of specific job skills documentation records could not be located. QMA 9's orientation of specific job skills documentation indicated she received CNA			

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	orientation. On 8/23/22 at 11:28 PM the Human Resource Director (HRD) indicated the job description and orientation of specific job skills documentation were not located in the employee files and should had been. On 8/23/22 at 10:00 AM the interim ED indicated the employee files were missing documentation and were incomplete. On 8/23/22 at 10:00 AM the ED provided an Employee Hire checklist. The checklist indicated the job description and specific job skills documentation was required for all new employees. No further documentation was provided at time of exit.			