STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	08/18/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00415021. Complaint IN00415021 - Federal/state deficiencies related to the allegations are cited at F604. Unrelated deficiencies are cited. Survey dates: August 17 and 18, 2023. Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 1 Medicaid: 52 Other: 5 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 23, 2023.	F 0000	University Nursing Center submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings it at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 POC be considered the letter of credible allegation and requests paper compliance in lieu of a post survey on or after	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin M. Beard	Executive Director	09/02/2023

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.

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			September, 4th, 2023.	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview and record review, the facility failed to ensure a resident was free from physical restraint for 1 of 3 residents reviewed for restraints (Resident B).	F 0604	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	09/04/2023

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	Findings include: Resident B's clinical record was reviewed on 8/17/23 at 9:50 a.m. Diagnoses included Parkinson's disease, unspecified dementia, unspecified severity, with other behavioral disturbance, repeated falls, other abnormalities of gait and mobility, generalized anxiety disorder, insomnia, cognitive communication deficit, and muscle weakness (generalized). His medications included lorazepam (treat anxiety) 0.5 mg (milligram) every eight hours, carbidopa-levodopa (treat Parkinson's disease) 25-100 mg three times daily and trazodone (treat insomnia) 50 mg at bedtime. His orders included touch pad call light (5/30/23) and a scoop mattress to bed to provide tactile bed boundaries (7/19/23). His admission MDS (Minimum Data Set) assessment, dated 6/3/23, indicated he was severely cognitively impaired. He required extensive assistance of two staff members for bed mobility and transfers. A 5/28/23 fall risk assessment indicated he was at a high risk for falls. Review of his nurses notes indicated the following: On 7/16/23 at 7:15 a.m., the nurse and the CNA heard Resident B hollering for help. They entered his room and found him in bed with his body against the wall and one side of his mattress was higher than the other. There were pillows and blankets under his mattress on the left side. He was flailing/swinging his right arm and he		Resident B was followed by Social Services with no psychosocial distress noted. Resident skin tear has resolved without complications. Resident is utilizing scoop mattress for bed. Staff are no longer using pillows or blankets to establish bed boundaries. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Audit to be completed per DNS/Designee to identify residents with falls from the bed in past 30 days. Residents identified will have mattress reviewed with therapy screen to identify if resident could benefit from a scoop mattress. All staff will be in-serviced by 9/1/23 per ED/Designee on the Abuse Policy specific to restraints. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be in-serviced by 9/1/223 per ED/Designee on the Abuse Policy Specific to restraints.	

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	received a skin tear, due to his body being against the wall. On 7/16/23 at 7:27 a.m., the skin tear was cleaned with wound wash and steri-strips were applied. The area measured 1.7 cm (centimeters) x 1.2 cm and had sanguineous (bloody) drainage. An IDT (Interdisciplinary Team) note, dated 7/18/23 at 2:45 p.m., indicated an assessment of Resident B was completed due to identification of his need for bed boundaries. The physical therapist indicated Resident B could benefit from a scoop mattress for balance and it was to be initiated. During an interview with LPN 13, on 8/17/23 at 10:50 a.m., she indicated she heard Resident B hollering for help. His mattress had a pillow and blanket under it, which raised the mattress on the one side. He was half on the bed and half off of the bed, between the mattress and the wall. He was flailing his arms. They did not typically use pillows and blankets under the mattresses, and she would not use them. During an interview with CNA 9, on 8/17/23 at 12:47 p.m.., she indicated she had seen the blankets and pillows under Resident B's mattress. He was hollering out and flailing his arms and legs trying to get up, but couldn't. His head was at the foot of his bed and he was on his right hand side, against the wall. She felt using the pillows and blankets under his mattress was a restraint. During an interview with LPN 25, on 8/17/23 at 11:21 p.m., she indicated Resident B needed to be kept on one on ones and busy with activities. They gave him frequent snacks. They monitored him until he was really tired and he would nap in		IDT will review all falls on the next business day. Fall sites will be visited during Gemba to obtain root cause determination. Therapy will screen all falls from the bed to determine need for bed adjustments. DNS/Designee will conduct rounds each shift to ensure residents are not being restrained by use of blankets and pillows. How the correct action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. Restraints CQI tool will be completed weekly X 4 weeks, monthly ties 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 9/4/23	

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	his chair. He was on a three day cycle. He slept terrible for two days, then the last day he slept hard. His family suggested to make a concave mattress from his regular mattress. She thought it was a restraint, but he could easily climb over it. They used a touch pad call light, and that gave them enough time to know he was trying to get up. During an interview with CNA 5, on 8/17/23 at 11:34 p.m., she indicated Resident B was basically a "one on one". Everyone was under the understanding that his family was ok with using the pillow under his mattress. He was such a high fall risk. There were two CNAs and one nurse on the night shift to do one on ones with him. But if they were in another resident's room, they were unable to watch him. If he were to roll onto or touch his touchpad call light, they knew he was moving and they were able to get to his room. During an interview with CNA 19, on 8/17/23 at 11:46 p.m., she indicated they had to keep an eye on Resident B. They had to keep him distracted with toys and snacks, and they just tried to keep him busy. They used a blanket and pillow under his mattress and his call light while he was in bed. They had been doing it since he first came to the facility. She didn't feel like it was a restraint, as he was able to climb over the mattress. During an interview with RN 4, on 8/18/23 at 9:58 a.m., she indicated they had to check on Resident B often. They kept him busy with a busy board, a clock, activities and a snack. The other nurse had indicated to her that he was screaming in his room. When she entered the room, he was laying on his right side and his arm was pressed up against the wall. There was a pillow and a blanket between his mattress and the frame of the bed. He			

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	had a skin tear on his elbow and there was blood on his sheet and on the wall. She felt like it restrained him, and she reported it to the DON and the Administrator. At night there were two aides and one nurse for the whole side of the facility. Resident B had his days and nights mixed up. If they were busy on day shift, there was someone in the facility to watch him and keep him occupied. The night shift did not have that option. During an interview with the DON, on 8/18/23 at 2:41 p.m., she indicated they reported using the blanket and pillows under his mattress to her that morning and she instructed the nurse to call the Administrator. She didn't feel like it was a restraint, as they told her the resident was able to get out of bed. It gave him some bed boundaries, and the staff were not trying to restrain him in bed, according to the interviews they had completed. A current facility policy, titled "Abuse, Prohibition, Reporting, and Investigation," revised 6/2023 and provided by the Nurse Consultant on 8/17/23 at 3:27 p.m., indicated the following: "...Definitions/Examples of Abuse...Restraints - either physical or chemical restraints used for reasons other than treating medical symptoms. Bed rail may be considered a physical restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to the resident's cognitive inability to lower the bed rail independently...." This Federal tag relates to complaint IN00415021. 3.1-3(w)			
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review the facility failed to ensure staff reported abuse immediately to the Administrator or designee for 2 of 2 residents reviewed for abuse allegations (Resident B and Resident E). Findings include: Resident B's clinical record was reviewed on	F 0609	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · The incident was immediately reported to ISDH. · QMA was suspended pending the results of the investigation.	09/04/2023

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	8/17/23 at 9:50 a.m. Diagnoses included Parkinson's disease, unspecified dementia, unspecified severity, with other behavioral disturbance, repeated falls, other abnormalities of gait and mobility, generalized anxiety disorder, insomnia, cognitive communication deficit, and muscle weakness (generalized). His admission MDS (Minimum Data Set), dated 6/3/23, indicated he was severely cognitively impaired. Resident E's clinical record was reviewed on 8/17/23 at 3:48 p.m. Diagnoses included cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly MDS, dated 7/26/23, indicated she was severely cognitively impaired. Confidential interviews were conducted during the course of the survey. During a confidential interview, it was indicated QMA 6 was getting "super heated" and had pushed Resident B into his chair. She told him to sit down and she was not messing with him. The nurse told her to calm down and it was thought she took a five to ten minute break. It was indicated QMA 6 was in Resident E's room, and Resident E had something in her mouth. QMA 6 was trying to see what was in her mouth, and Resident E acted like she was going to spit on QMA 6. QMA 6 told Resident E not to f--king spit on her. The confidential interview indicated they had not reported this to the Administrator or the DON in fear of retaliation.		· Residents B and E were immediately examined by a nurse with no injuries identified. · Residents B and E were followed by Social Services with no psychosocial distress identified. Residents are participating in activities per their baseline. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents that reside in the facility have the potential to be affected. · All staff in-serviced on Abuse Policy, specific to immediately notifying the Executive Director by 9/1/23 per ED/Designee. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · All staff in-serviced on Abuse Policy, specific to immediately notifying the Executive Director by 9/1/23 per ED/Designee. · Abuse Policy will be reviewed in facility face to face in-serviced per DSN/ADNS monthly. · All new hires will receive Abuse Policy education prior to assisting residents. 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;	

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	During an interview with CNA 5, on 8/17/23 at 11:34 p.m., she indicated Resident E was combative and was spitting. As CNA 5 was taking another resident to the bathroom, Resident E threw a cup at the resident and said she was going to kill her. The cup did not hit the other resident and she reported it to the ADON. They thought Resident E had something in her mouth and QMA 6 went to check her mouth and Resident E was going to spit at her. QMA 6 told Resident E "Don't you f--king spit on me!" CNA 5 did not report it to the Administrator or the DON, she was leaving the room and wondered if she heard QMA 6 correctly. During an interview with RN 4, on 8/18/23 at 9:58 a.m., she indicated Resident B had been in his recliner and he kept trying to get up. QMA 6 told him she was done with it, he had the right to fall, so he could fall. She felt it was inappropriate the way she spoke to him, she understood the frustration, but the facility was their home. She did not report this to the Administrator or the DON. A current facility policy, tilted "Abuse Prohibition, Reporting, and Investigation, revised 6/2023 and provided by the Nurse Consultant on 8/17/23 at 3:27 p.m., indicated the following: "...Definitions/Examples of Abuse...Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. This includes any episode of staff to resident...Resident abuse - Staff member, volunteer or visitor...2. Any individual who witnesses abuse, or has suspicion of abuse, shall immediately notify the charge nurse of the unit, which the resident resides and to the Executive		· Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Abuse CQI Tool will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/4/23	

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	Director...." 3.1-28(c)			
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 adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide supervision for a resident who was at a high risk for falls to prevent multiple, recurrent falls for 1 of 3 residents reviewed for falls (Resident B). Findings include: On 8/17/23 at 2:08 p.m., Resident B was observed sitting in his wheelchair at the nurse's station eating with a staff member was sitting next to him in a recliner. On 8/18/23 at 8:45 a.m., he was observed sitting in a recliner across from the nurses station, eating breakfast. Resident B's clinical record was reviewed on 8/17/23 at 9:50 a.m. Diagnoses included Parkinson's disease, unspecified dementia, unspecified severity, with other behavioral disturbance, repeated falls, other abnormalities of gait and mobility, generalized anxiety disorder, insomnia, cognitive communication deficit, and	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident B fall care plan and interventions have been reviewed and updated by IDT. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with repeat falls have the potential to be affected. · Audit to be completed by 9/1/23 per DNS/Designee to identify residents with repeat falls in the past 30 days. · DNS/Designee to review residents identified via audit to ensure adequate supervision/interventions in place.	09/04/2023

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	muscle weakness (generalized). His medications included lorazepam (treat anxiety) 0.5 mg (milligram) every eight hours, carbidopa-levodopa (treat Parkinson's disease) 25-100 mg three times daily, and trazodone (treat insomnia) 50 mg at bedtime. His orders included a call before you fall sign in room (5/30/23), cushion in wheelchair (5/30/23), non skid strips at bedside and in front of the toilet (5/30/23), touch pad call light (5/30/23), activity level: up in wheelchair with assist, but may ambulate short distances with a walker and assist (6/23/23), positioning/devices: scoop mattress to bed to provide tactile bed boundaries (7/19/23), and occupational therapy to treat five times a week for four weeks (7/21/23). His admission MDS (Minimum Data Set) assessment, dated 6/3/23, indicated he was severely cognitively impaired. He required extensive assistance of two staff members for bed mobility and transfers. He required extensive assistance of one staff member for walking in his room and corridor, locomotion on and off the unit, dressing and personal hygiene. He used a walker and a wheelchair. He had one fall with injury. A 5/28/23 fall risk assessment indicated he was at a high risk for falls. Review of his fall event reports indicated the following: On 5/29/23 at 6:45 p.m., he had a witnessed fall. Prior to the fall, he was trying to get up out of his wheelchair to get to the front door. He tried to stand up out of his wheelchair and his knees were bent in a sitting position and he was unable to		· All Staff in-service to be complete by 9/1/23 per DNS/Designee on Fall Prevention Program. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · All Staff in-service to be complete by 9/1/23 per DNS/Designee on Fall Prevention Program. · Charge Nurse will complete a Fall Event on all residents with a change in plains. · IDT will review all completed Fall Events daily in Clinical Meeting, determine root cause of fall and implement supervision/intervention to prevent reoccurrence. · Resident care plan will be updated with new interventions and added to the resident profile. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Falls CQI Tool will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until	

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(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
	stand up. He had hold of the railing and then lowered himself to the floor, first onto his right knee, then onto his right buttock. On 6/1/23 at 11:30 p.m., he had a witnessed fall. Prior to the fall, he was at the nurses station in his wheelchair and repeatedly got up out of his wheelchair stating he needed to milk the cows. He went down on his knees, and his right hand held himself in an upward position. He received a skin tear to the posterior side of his left arm measuring 2 centimeters (cm) long (L) x 1 cm width (W) and an abrasion to his knee. On 6/7/23 at 5:33 a.m., he had an unwitnessed fall. Prior to the fall, he was sitting in his wheelchair and was very restless. He was found on the floor, laying on his stomach, in front of the nurses station. On 6/13/23 at 12:19 a.m., he had an unwitnessed fall. Prior to the fall, he was sitting in his wheelchair in the hallway. He was found laying on his stomach in front of his wheelchair in the hallway by the TV lounge. On 6/22/23 at 7:30 p.m., he had a witnessed fall. Prior to the fall, he was sitting in his wheelchair eating snacks. The nurse witnessed his fall from his wheelchair in front of the nurses's station and he landed on his right side. He received a bruise and a 4.5 cm L x 0.1 cm W, V-shaped skin tear to his right elbow. On 7/7/23 at 9:11 a.m., he had a witnessed fall. Prior to the fall, he was standing unassisted. He stood up from his wheelchair unassisted, lost his balance, and fell in front of his wheelchair by the nurses station.		compliance is achieved. · If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; · Completion date: 9/4/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	08/18/2023

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	On 8/3/23 at 8:52 p.m., he had an unwitnessed fall. Prior to the fall, he was sitting in his wheelchair engaged in a peg-board activity. He was found laying on his left buttocks/hip, leaning on his left side in front of the nurse's station. On 8/7/23 at 7:00 a.m., he had an unwitnessed fall. Prior to the fall, he was resting in bed. He was found lying with his buttocks and legs on the floor and his shoulders and head sideways on his bed, with his sheet wrapped around his legs. On 8/17/23 at 12:25 a.m., he had a witnessed fall. Prior to the fall, he was sitting up at the nurse's station in his wheelchair attempting to get up without assistance, and he landed on his buttocks. During an interview with LPN 16, on 8/17/23 at 2:21 p.m., he indicated Resident B needed to be kept in eye sight when he was out of bed. They needed to pay attention to him. If he was antsy, and tried to get up, he may need to use the bathroom, have a drink, or get something to eat. During an interview with LPN 25, on 8/17/23 at 11:21 p.m., she indicated Resident B needed to be kept on one on ones and busy with activities. They gave him frequent snacks. They monitored him until he was really tired and he napped in his chair. He was on a three day cycle; he slept terrible for two days then last day he slept hard. His family suggested to make a concave mattress from his mattress. She thought it was a restraint but he could easily climb over it, they used a touch pad call light and that gave them enough time to know he was trying to get up. During an interview with CNA 5, on 8/17/23 at 11:34 p.m., she indicated Resident B was basically			

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	a one on one. Everyone was under the understanding that his family was ok with using the pillow under his mattress. He was such a high fall risk. There were two CNAs and one nurse on the night shift to do one on ones with him. But if they were in another resident's room, they were not able to watch him. While he was in bed, if he were to roll onto or touch his touchpad call light they knew he was moving and they were able get to his room. During an interview with CNA 19, on 8/17/23 at 11:46 p.m., she indicated they had to keep an eye on Resident B. They had to keep him distracted with toys and snacks, and just tried to keep him busy. A current facility policy, titled "Fall Management Policy," revised on 8/2022 and provided by the Nurse Consultant on 8/17/23 at 3:27 p.m., indicated the following: "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...." 3.1-45(a)(2)			