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	10/25/2022

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 Complaints IN00388534, IN00387288 and IN00386054. Complaint IN00388534 - Unsubstantiated due to lack of evidence. Complaint IN00386054 - Substantiated. Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00387288 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580. Survey dates: October 18, 19, 20, 21, 24 and 25, 2022. Facility number: 003673 Provider number: 155725 AIM number: 200450890 Census Bed Type: SNF/NF: 2 SNF: 27 Residential: 45 Total: 74 Census Payor Type: Medicare: 14 Medicaid: 1 Other: 14 Total: 29	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	11/07/2022

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 28, 2022.			
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on interview and record review, the facility failed to ensure a resident could exercise the right to choose their own treatment without negative consequences for 1 of 1 resident reviewed for hospitalization. (Resident 30) Finding includes: The record for Resident 30 was reviewed on	F 0552	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #30 no longer resides at the facility. How other resident have the	11/20/2022

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	10/24/22 at 1:56 p.m. Diagnoses included, but were not limited to, adult failure to thrive, type 2 diabetes mellitus, chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure and peripheral vascular disease. A behavior note, dated 10/6/22 at 1:45 a.m., indicated the resident wanted to go to the emergency room (ER) for a bruise he obtained on 9/21/22. Nurse Practitioner (NP) 7, who worked for Physician 6, was notified the resident requested to go to the ER. The NP was informed the bruise was healing and there was no need for the resident to be sent to the ER. The resident was informed Physician 6 would see him when he was at the facility and the bruise was not an issue to go to the ER. The resident had a caregiver on the phone who wanted the resident to go to the ER. A behavior note, dated 10/6/22 at 2:00 a.m., indicated the daughter was phoned and notified the caregiver was calling 911 for a bruise on the resident. The daughter agreed the resident should not go to the ER and was aware the resident would be against medical advice (AMA) if he went to the ER. The daughter was an emergency contact for the resident and was not a POA (power of attorney) or legal guardian. A progress note, dated 10/6/22 at 2:30 a.m., indicated the police arrived due to a call was dispatched to determine the need for the resident to have an ambulance. The resident told the police he wanted to go to the ER for the old bruise. A progress note, dated 10/6/22 at 4:00 p.m., indicated the daughter was talked to about the resident being AMA to the hospital. The		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? 2. Residents have the potential to be affected by this deficient practice. All residents and/or their POA will have the ability to determine their treatment, providers and transfer requests during their stay within the facility. Residents requesting a transfer will have all forms completed by the nurse for the transfer, MD and family notified and resident transferred per their request. 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 staff will be educated on resident right to make informed decisions and documentation to be be completed along	

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	daughter indicated the caregiver would need to take the resident upon his discharge from the hospital. A progress note, dated 10/6/22 at 4:29 p.m., indicated the ER triage nurse indicated the resident was there for a new bruise. The ER nurse was informed the resident was not able to return to the facility and would need to discharge with the caregiver. A discharge summary, dated 10/6/22 at 5:18 p.m., indicated the resident went out of the facility against medical advice. The hospital was called and report was given. An AMA/Release from responsibility for discharge, dated 10/6/22 and not timed, indicated the resident understood the consequences and acknowledged leaving against the advice of the attending physician and facility administrator. The resident refused to sign the form. The form indicated authorization must be signed by the patient/resident, or by the nearest relative in the case of a minor: or when patient/resident was physically or mentally incompetent. A hospital note, dated 10/6/22, indicated the resident presented to the ER for complaints of bruising. Pre-arrival reports indicated the resident was pinched by the stand up lift. Per the nurse, the resident signed himself out AMA from the nursing home and the nursing home called and reported they would not take the resident back. The resident was positive for bruising. The preliminary diagnoses were chest wall contusion, inability to care for self and history of morbid obesity. The hospital note did not give a description of the		with notifications. 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. Residents that are transferred or make change in care requests will be reviewed in AM clinical meeting weekdays (weekends to be reviewed on Monday AM) to determine resident needs and requests are met. These reviews will be completed five days a week for four weeks, three times a week for four weeks and weekly for four weeks. Results will be reported in the monthly QAPI meeting for 6 months or until 100% compliance is reached. By what date the systemic changes for each deficiency will be completed. 5.Substantial compliance will be	

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	bruising. A hospital note, dated 10/11/22, indicated the resident was evaluated by psychiatry services during the hospital admission and was determined to continue to have capacity for discharge planning. During an interview, on 10/24/22 at 3:33 p.m., the Director of Nursing (DON) indicated the resident's caregiver had wanted him to go to the hospital due to the bruise he had from the stand up lift strap. The day the resident discharged, the Nurse Practitioner (NP) was notified the caregiver wanted the resident to go to the ER due to the bruise from the lift. The NP indicated the resident did not need to go to the ER. The physician indicated the resident would have to go to the hospital AMA. A current policy, titled "Resident Rights-Indiana," dated 3/1/2021 and received from the DON on 10/18/22 at 1:30 p.m., indicated "...Residents have the right to have their rights recognized by the community...Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community...Residents have the right to exercise any or all of the following rights without...Restraint...Interference...Coercion...Discrimination...Threat of reprisal...These rights shall not be changed in any instance, except that, when the resident has been diagnoses as incompetent...Residents have the right to the following...Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to community policy. Any limitation on the resident's right to choose the attending physician or service		obtain by November 20, 2022	

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	provider, or both, shall be clearly stated in the admission agreement...Residents have the right to choose with whom they associate...The community shall provide reasonable access to any residents, consistent with community policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident's right to deny or withdraw consent at any time...Residents have the right to receive or reject medical care...." 3.1-3(a)(2)(A) 3.1-3(a)(2)(D) 3.1-3(n)(1) 3.1-3(n)(3)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).			

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	(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to notify the family of medication changes, invasive procedures and a change in condition for 1 of 4 residents reviewed for notification. (Resident B) Finding includes: During an interview, on 10/20/22 at 10:08 a.m., Resident B's family member indicated the resident had a change in condition. The facility obtained a urine specimen via an in and out catheter.	F 0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident B no longer resides in the facility How other resident have the potential to be affected by the same deficient practice will be identified and what corrective	11/20/2022

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	Resident B was diagnosed with an urinary tract infection (UTI) and a oral antibiotic was started. Resident B developed another UTI and had a PICC (peripherally inserted central catheter) (a thin tube inserted through a vein) and IV (Intravenous therapy) (administers fluids, medication and nutrients directly into a person's vein) antibiotics was started. The family member was not notified. The record for Resident B was reviewed on 10/20/22 at 10:23 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), fracture of the neck of left femur (the thigh bone), cognitive communication deficit, epilepsy, anxiety disorder, history of sepsis (a life-threatening complication of an infection) and hypertension. A physician's order, dated 3/30/22, indicated to obtain a urinalysis (UA) and culture and sensitivity (C&S) via an in and out catheter. A physician's order, dated 4/2/22, indicated Keflex (antibiotic) 500 milligram (mg), 1 capsule by mouth four times a day for urinary tract infection for 7 Days. The antibiotic was discontinued on 4/4/2022. A physician's order, dated 4/4/22, indicated Macrobid (antibiotic) 100 mg, 1 capsule by mouth two times a day. A physician's order, dated 4/20/22, indicated to obtain a UA and C&S via an in and out catheter. A physician's order, dated 4/25/2022, indicated to start Ertapenem Sodium Solution Reconstituted 1 gram (gm) (an IV antibiotic), 1 gm intravenously one time a day for 10 Days.		action(s) will be taken? 2. All residents with a change of condition, medication change or change in status have the potential to be affected by the alleged deficient practice. 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 staff will be in-serviced on Notification policy and documentation. 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.Current resident charts will be audited for new orders or change of condition within the past 30 days for notifications and responsible party will be notified for any findings not previously communicated. Resident charts will be audited five times weekly by the IDT team for four weeks, then three times weekly for four weeks and the twice weekly for four weeks. Reports will be reviewed in monthly QAPI meeting for 6 months or until 100% compliance is reached.	

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	During a review of the progress notes, the family was not notified of any procedures or new orders from 4/4/22 to 4/30/22. During an interview, on 10/18/22 at 1:47 p.m., QMA 4 indicated if the resident had a change in condition she would let the nurse know. During an interview, on 10/24/22 at 2:59 p.m., RN 3 indicated if a resident had a new order or any change in their condition the family needed to be informed. She normally would let them know but may forget to chart it. During an interview, on 10/24/22 at 3:33 p.m., CNA 2 indicated the nurse needed to be notified if the resident was acting different. He normally would get updated in report from the CNA which took care of the resident before him. A current policy, titled "Change Notification," dated 3/1/21 and received from the Director of Nursing on 10/24/22 at 4:02 p.m., indicated "...Community staff communicates accurate and timely notification to a residents' designated relative or other individual and the primary physician in circumstances where the resident's well-being may be affected...An emergency or significant change in condition may include the following, but is not meant to be all inclusive: Fall or other accidental injury...Medical condition requiring physician intervention or transfer to hospital...Residents may also request that staff notify their emergency contact at any time during the residency...." This Federal Tag relates to Complaint IN00387288. 3.1-5(a)(2)		By what date the systemic changes for each deficiency will be completed. 5.Substancial compliance will be obtained by November 20, 2022	

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F 0602 SS=D Bldg. 00	3.1-5(a)(3) 483.12 Free from Misappropriation/Exploitation §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. Based on interview and record review, the facility failed to ensure a resident's personal property was not used by staff for 1 of 4 residents reviewed for misappropriation of property. (Residents C) Finding includes: A Facility incident report, dated 7/15/22, indicated CNA 8 took a picture wearing Resident C's wig and posted it on Facebook. The record for Resident C was reviewed on 10/21/22 at 4:34 p.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia without behavioral disturbance and hypertension. On 7/22/22, the resident was interviewed by Social Services and the Assistant Director of Nursing. The resident was made aware of the incident and indicated at no time did she give anyone permission to wear her wig and was unaware the incident took place. A Performance Enhancement Form, dated 7/28/22, indicated misappropriation of resident property, violation of the social media policy and resident rights were the expectations of level of	F 0602	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.Resident C was not aware of the incident and employee was suspended pending investigation. Resident item was returned without damage. 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. Investigation was completed and no other residents were found to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?	11/20/2022

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	performance for CNA 8 to follow. It was expected CNA 8 should not wear a resident's personal property and post pictures to social media. At the counseling meeting, CNA 8 was informed any further incidents warranting performance improvement would lead to progression in the process, up to and including separation. CNA 8 was called by Human Resources and LPN 9. CNA 8 was notified at this time due to the violation of the Social Media policy, the facility would need to separate employment. CNA 8 gave no comment and hung up the phone. During an interview, on 10/20/22 at 11:20 p.m., the Executive Director (ED) indicated CNA 8 posted a picture of him wearing a resident's wig on Facebook. CNA 8 was terminated after an investigation due to not following the Social Media policy. During an interview, on 10/21/22 at 9:17 a.m., the Director of Nursing (DON) indicated she did not know why a CNA would put a resident's wig on and post it on Facebook. A current policy, titled "Social Media and Networking," dated 7/1/18 and received from the DON on 10/24/22 at 4:02 p.m., indicated "...[name of corporation] has established this policy for associates who use or participate in social media platforms such as Facebook, Twitter, YouTube...This policy is designed to: protect and respect the privacy, safety, and well-being of residents, families, associates, and other stakeholders, including the ministry's sponsors...Photographs and recordings taken in any manner that would demean or humiliate a resident(s) are strictly prohibited. This would include using any type of equipment (e.g., cameras, smart phones, and other electronic		3. All staff were educated on abuse, social media policies and misappropriation and continue annual education. 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. Employee education is monitored annually and as needed by Human Resources for completion. Any staff that are deficient in their education are counseled and they will complete their competencies. Human resources will complete random department audits of 10 employees three times weekly for four weeks then twice weekly for four weeks then weekly for four 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 11/20/2022.	

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	devices) to take, keep, or distribute photographs and recordings on social media, via email, text or other messaging options...Associates are always PROHIBITED from posting any information about a resident, including photographs or recordings on private social media accounts. This Federal Tag relates to Complaint IN00386054. 3.1-28(a)			
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 record review and interview, the facility failed to ensure a new preadmission screening and resident review (PASARR) was completed in 30-60 days for 1 of 1 resident reviewed for PASARR. (Resident 24) Finding includes:	F 0644	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. A updated PASSAR was resubmitted #24 on 11/4/2022.	11/20/2022

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	The record for Resident 24 was reviewed on 10/20/22 at 10:09 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, psychotic disorder with delusions, major depressive disorder, anxiety disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A PASARR, dated 8/5/22, indicated the level one screening showed low-level behavioral health symptoms which appeared to be situational. The nursing facility would watch the symptoms/behaviors to assess improvement or resolve in 30-60 days. The nursing facility would submit another level one for the status change. The status change would determine if a PASARR level 2 was needed. Another level one screening was not completed. During an interview, on 10/24/22 at 3:34 p.m., the Director of Nursing (DON) indicated a level one screening request was not submitted for the 30-60 day review. Upon exit, a policy for PASARR was not received from the facility. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		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.Resident receiving anti-psychotic medications will be reviewed for PASARR completion and ensure updates are completed timely. 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 referrals will be assessed for need of a PASSAR on admission and be completed timely per regulations. Any resident with new orders for anti-psychotics will have a PASSAR completed and 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 will complete an audit of 10 employees three times	

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			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 11/20/2022.	
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 interview and record review, the facility failed to identify, assess and accurately document bruising for a resident who received anticoagulants for 1 of 3 residents reviewed for non pressure skin conditions. (Resident 30) Finding includes: The record for Resident 30 was reviewed on 10/24/22 at 1:56 p.m. Diagnoses included, but were not limited to, adult failure to thrive, type 2 diabetes mellitus, atrial fibrillation, acute embolism and thrombosis of deep veins of left lower	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident #30 no longer resides in the facility. How other resident have the potential to be affected by the same deficient practice will be identified and what corrective	11/20/2022

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	extremity and peripheral vascular disease. A physician's order, dated 8/5/22, indicated to conduct a complete head to toe skin evaluation and document in the Skin Observation Tool every Tuesday. A physician's order, dated 8/17/22, indicated to monitor for bruising every shift related to anticoagulant medication. A progress note, dated 9/21/22 at 10:55 p.m., indicated during the resident's transfer to the toilet, the stand up lift shut down while putting the resident down and had an impact on both of his arms. The resident complained of pain although was able to move both arms. A Skin Observation Tool, dated 9/27/22 at 9:09 p.m., indicated the resident had no new skin issues. A progress note, dated 9/28/22 at 11:38 p.m., indicated the resident complained of abdominal pain and the abdomen was not distended. The progress note did not include any assessment of the skin condition of the abdomen. A progress note, dated 10/1/22 at 9:58 p.m., indicated there was purplish to yellowish bruising across the resident's lower chest including his upper abdomen related to the incident on 9/21/22 when the stand up lift shut down during the transfer. The resident complained of pain of a 3 on a scale of 1-10. The progress note did not include measurements of the bruising. The documentation for the bruising was 11 days after the incident with the		action(s) will be taken? 2. Skin assessments are completed on all residents weekly and findings documented in the resident records along with MD and family notifications. Incident reports What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Any residents with a new skin impairment will have the concern documented in the resident record, MD and family notified and follow up assessments completed per company policy. Staff to be reeducated on weekly head to toe skin evaluation documentation and policy. 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. Audits by the ADON and/or designee will be completed on five residents weekly for four weeks, five residents every other week for four weeks and then five residents monthly for one month. Any findings will be corrected immediately. Results will be	

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	Hoyer lift. A Skin Observation Tool, dated 10/1/22 at 10:13 p.m., indicated the resident had bruising on his chest and abdomen. There were no measurements for the bruising. The Skin Observation Tool did not include measurements for the bruising or the color of the bruising. A Long Term Care Evaluation note, dated 10/4/22 at 1:25 p.m., indicated the resident had a skin change since the last evaluation. The skin change was bruising in the chest. The note did not include measurements of the bruising or the color of the bruising. During an interview, on 10/24/22 at 3:33 p.m., the Director of Nursing (DON) indicated the resident was on blood thinners, had a bruise from the stand up lift strap which had pinched his skin. The strap of the stand up lift would go around his abdomen and the buckle pinched the resident. The bruising was yellow and green and spread to both sides of his abdomen. The staff were to document the bruising in the nurses notes, incident notes or skilled nurses notes. During an interview, on 10/25/22 at 4:16 p.m., the DON indicated she was not able to locate any documentation about the resident's bruising from the incident with the stand up lift until 10/1/22. A current policy, titled " Weekly Head-to-Toe Skin Evaluation," dated as revised 5/5/2022 and received from the DON on 10/25/22 at 5:07 p.m., indicated "...If a new skin alteration is identified, the skin and wound app would be initiated in PCC		reported in the monthly QAPI meeting for 6 months or until 100% compliance. By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be obtained by 11/20/2022.	

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	[point click care] and then follow the charting prompts. This documentation must start with the Staff Nurse and will continued by the Wound Nurse...Any identified alterations are reported to the physician and the responsible party within four hours, with documentation of this notification in the Nurse's Progress Note...." 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to provide a consistent program of cognitive stimulating activities for residents with dementia for 1 of 2 residents reviewed for dementia care. (Resident 24) Finding includes: During an observation, on 10/20/22 at 12:35 p.m., the resident was sitting, in her room, in the recliner with her feet elevated. She indicated she felt she was on the last part. She was unable to verbalize what she meant, but became tearful. During an observation, on 10/20/22 at 1:00 p.m., the resident was in her room, in the recliner, with her feet elevated and her eyes closed, while an activity with other residents on the unit was occurring in the health care dining room. During an observation, on 10/21/22 at 3:36 p.m., the resident was sitting, in her room, with the door	F 0744	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Staff encourage resident #24 daily to engage in activities and provide opportunities for stimulation. 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 dx of dementia or cognitive decline will be provided with activities that are suitable to their ability and continued encouragement to participate in activities of their	11/20/2022

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	closed. She was sitting in the recliner with the foot of the chair elevated. She was wearing a blouse and no pants. She had a telfa dressing over a wound on her right lower leg, her skin was dry and scaly. During an observation, on 10/24/22 at 10:48 a.m., the resident was in her room, fully clothed, sitting in the recliner with the foot of the chair elevated. She was pulling at the dressing on her right ankle. The record for Resident 24 was reviewed on 10/20/22 10:09 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, psychotic disorder with delusions, major depressive disorder, anxiety disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A care plan, dated 8/9/22, indicated the resident had little or no activity involvement related to the resident wished not to participate. The goal was for the resident to participate in activities of her choice independently in her room. Interventions included, but were not limited to, explain to the resident the importance of social interaction, leisure activity time and encourage to paticipate, remind the resident she may leave the activities at anytime. An activity log, dated October 2022, indicated the resident participated in 1:1 activities of daily chronicles and a facility news letter on 11 out of 25 days. There were no other activities documented. During an interview, on 10/21/22 at 3:40 p.m., RN 5 indicated it had been difficult to get the resident dressed and out of bed. She indicated the resident		choice. Life enrichment will re-evaluate residents with dementia for an accurate assessment. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. Life enrichment will continue to assess residents on admission and as needed for preference, likes, dislikes and appropriate hobbies and activities. 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. Life enrichment director will audit five resident charts weekly for four weeks then all new admission charts weekly for eight weeks to determine if the residents have been assessed and activities are appropriate for residents with dementia or cognitive concerns. Any discrepancy will be immediately addressed and corrected. Audit findings will be reported monthly in QAPI for 6 months or until 100%compliance is reached	

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	was not in a good mood. A current policy, titled "Behavioral Health Services," dated 5/1/18 and received from the Director of Nursing, on 10/25/22 at 4:20 p.m., indicated "...each resident recieves care and services to assist him or her to reach and maintain the highest leverl of mental and psychological functioning...residents who display or are diagnosed with mental disorders or psychosocial adjustment difficulty...will recieve aapropriate treatment and services to attain the highest practible mental and psychosocial well-being...." 3.1-37(a)		By what date the systemic changes for each deficiency will be completed. 5. Substantial compliance will be obtained by 11/20/2022	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use			

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	psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to enure residents with dementia related behaviors were free of antipsychotic medication use for 2 of 5 residents reviewed for unnecessary medications. (Residents 6 and 24) Findings include: 1. The record for Resident 6 was reviewed on 10/20/22 at 4:15 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, dementia with behavioral disturbance, hallucinations, cognitive communication deficit and vascular dementia with behavioral	F 0758	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident's #6 and #24 medications and indication for use were reviewed by the MD for appropriateness and indication for use. What measures will be put into place and what systemic changes will be made to ensure that the	11/20/2022

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	disturbance. A care plan, dated 2/16/22, indicated the resident frequently called out. Interventions included, but were not limited to, lorazepam (an anxiety medication) as ordered, administer medications as ordered and anticipate and meet the resident's needs. A care plan, dated 6/2/22, indicated the resident used antidepressant and antipsychotic medications related to hallucinations, mood and behavior changes secondary to dementia with behaviors. Interventions included, but were not limited to, administer psychotropic medications as ordered, administer Zyprexa (an antipsychotic) due to hallucinations, and discuss with the physician the need for ongoing use. A physician's order, dated 3/9/22, indicated to monitor behaviors and document in the nurses notes. A physician's order, dated 4/15/22, indicated Zyprexa (10 mg (milligram) at bedtime for hallucinations. A behavior note, dated 10/17/22 at 10:22 a.m., indicated the resident was attempting to get out of the chair unassisted. A behavior note, dated 10/17/22 at 3:22 p.m., indicated the resident was trying to get out of the chair. During an interview, on 10/24/22 at 4:21 p.m., Registered Nurse (RN) 5 indicated the resident's behaviors were crying and the resident would strike at staff when she was given showers.		deficient practice does not reoccur? 2. All residents on psychotropic medications have the potential to be affected. The Social Service and/or designee will ensure that all residents GDR are completed and that appropriate dx for all medications are in place. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? 3. The Social Service will audit all new resident charts on admission weekly for 12 weeks to determine appropriate dx with corrections to be made immediately for missing dx and for GDR tracking. 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 will notify MD for GDRs as needed. Findings 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.	

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	2. The record for Resident 24 was reviewed on 10/20/22 at 10:09 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, psychotic disorder with delusions, major depressive disorder, anxiety disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A care plan, dated 8/31/22, indicated the resident received antipsychotic medication, Seroquel, related to psychotic disorder and delusions. Interventions included, but were not limited to, administer psychotropic medications as ordered and monitor, document and report any adverse effects of the medications. A physician's order, dated 9/30/22, indicated Seroquel (an antipsychotic) 25 mg daily for delusions. A neurology note, dated 8/31/22 , indicated her cognitive decline started January 2022. Cognitive testing completed on the day of the visit was concerning for dementia, likely moderate stage. The dementia could be of Lewy body type due to delusions and possible visual hallucinations. A B 12 deficiency was also noted. The physician ordered B 12, Aricept and Seroquel. During an interview, on 10/21/22 at 3:40 p.m., RN 5 indicated it had been difficult to get the resident dressed and out of bed. She indicated the resident was not in a good mood. A recent publication of "PDR.net" indicated "...Zyprexa (olanzapine) was indicated for the treatment of schizophrenia and manic or mixed episodes of bipolar 1 disorder...the black box warning indicates antipsychotics are not approved for the treatment of dementia-related		5. Substantial compliance will be reached by 11/20/2022.	

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	psychosis in geriatric patients and the use of Zyprexa in this population should be avoided if possible due to an increase in morbidity and mortality...." A recent publication of "PDR.net" indicated "...Seroquel (quetiapine) was indicated for the treatment of bipolar disorder, including mania, bipolar depression and major depressive disorder...the black box warning indicates antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Seroquel in this population should be avoided if possible due to an increase in morbidity and mortality...." A current policy, titled "Use of Psychotropic Drugs," dated 10/10/22 and received from the Director of Nursing on 10/25/22 at 4:20 p.m., indicated "...an evaluation is documented to determine the resident's expressions or indication are not due to...stressors, anxiety, or fear stemming from misunderstanding related to his or her cognitive impairment...." 3.1-48(a)(4)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 18, 19, 20, 21, 24 and 25, 2022. Facility number: 003673 Residential Census: 45	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 a true representation of the quality of care provided or the living environment provided to the residents of University Place	

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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
	University Place Health Center and Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on October 28, 2022.		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.	