STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Rehabilitation and Healthcare	1400 Medical Park Dr Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to 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. 37147 Based on observation, interview and record review, the facility failed to ensure an effective behavior care plan, behavioral assessments, behavior monitoring and documentation was completed for 1 of 3 residents reviewed for behavioral health (Resident K). Findings include: On 6/25/24 at 10:26 A.M., Resident K's record was reviewed. Diagnoses included major depressive disorder, bipolar disorder, Schizophrenia, and diabetes. She had a history of urinary tract infections (UTI) and had been treated with antibiotics on 2/12/24 for a positive urinalysis and mild confusion and again, on 3/6/24 followed by hospitalization and treatment with intravenous (IV) antibiotics. A quarterly MDS (Minimum Data Set) assessment, dated 4/27/24, indicated the resident had no cognitive impairment and no behaviors, delusions, or hallucinations. She had several mood indicators including little interest or pleasure in doing things; feeling down, depressed or hopeless; trouble falling asleep or sleeping too much; feeling tired or little energy; poor appetite or overeating; feeling bad about herself; and trouble concentrating on things such as reading or watching TV. She had moderately severe depression according to her score of 17 on the Patient Health Questionnaire (PHQ2-9). A care plan, revised 6/18/24, indicated the resident was at risk for impaired psychosocial well-being, sensory deficits, communication deficits and cognitive deficits due to bipolar disorder, generalized anxiety disorder, Schizophrenia, major depressive disorder with psychotic features, psychosis, and history of hallucinations and delusions; she may threaten self harm, refuse or be resistant to care, or make false allegations/confabulation. Interventions included: care in pairs; approach resident in a calm manner to avoid frustration and behavior escalation-if becomes agitated and shows signs of escalation, re-approach later; assess for verbal and non-verbal signs and symptoms of pain; assist her to cope by discussing possible solutions to conflict; behavioral health consults as needed; encourage to ask questions about medical condition to reduce anxiety;give non-judgmental support; maintain a consistent routine; offer choices; and observe and document episodes of inappropriate behaviors and notify physician when behaviors persist or won't de-escalate. The care plan didn't indicate the resident had a history of UTI's accompanied by changes in her behaviors. (continued on next page)

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility-reported incident, to the Indiana Department of Health, indicated on 6/10/24 at 1:05 p.m., Resident K reported an employee had touched her inappropriately. She was transported to the hospital and returned to the facility following evaluation. On 6/25/24 at 11:00 A.M., Resident K was observed in her room, seated in a wheelchair. She indicated she was doing well since returning from the hospital but wanted to know if her family was aware she had returned. She hadn't known why she'd gone to the hospital. She indicated one minute she'd been sitting in her room and the next, she was being taken to the hospital. She indicated she had been sitting in front of her TV, talking to herself and the TV because she had no roommate or anyone else to talk with. A Psychosocial Assessment, dated 6/10/24 at 4:35 p.m., indicated the reason for the assessment was due to a sexual allegation from staff to resident. The resident had full recollection and awareness of the event and could provide details. She had no observed changes in her mood or behaviors. She would be referred to the psychologist for evaluation and counseling, have her cognition re-assessed and her care plan updated. A Social Service progress note, dated 6/11/24 at 4:22 p.m., indicated Resident K had been sent to the hospital on 6/10/24 and had returned later in the evening with no new orders. On 6/12/24 at 12:50 p.m., a nurse progress note indicated the psychiatric NP (Nurse Practitioner) had been given an update of the resident's behaviors. New orders were received to obtain a urinalysis and administer Rocephin (antibiotic) 1 gram intramuscularly for 3 days for UTI. A Social Service progress note, dated 6/14/24 at 1:42 p.m., indicated the resident was going to be sent to the neuropsychiatric hospital due to her behaviors. On 6/14/24 at 3:47 p.m., a nurse progress noted indicated the resident was transferred to the neuropsychiatric hospital. She was alert and oriented at time of transfer; denied pain or discomfort; was assisted by 2 to get on the gurney. Resident K's belongings, paper work, and medication was sent with her. A nurse progress note, dated 6/21/24 at 3:00 p.m., indicated Resident K had returned to the facility. She arrived per gurney and transferred to bed with 2 assist. Her mood was pleasant, she spoke appropriately and was alert and oriented to person, place, and time. A Psychiatric NP progress note, dated 6/22/24 at 9:05 a.m., indicated the resident was visited to follow up on her psychiatric hospital stay. Prior to her hospital stay, the NP had been notified several times over the past few weeks Resident K believed she was being digitally raped by others. She was sent to inpatient psychiatric hospital where she was treated for a urinary tract infection. The medication changed were her Prozac (anti-depressant), reduced in dosage to 20 milligrams (mg) by mouth every day. During the visit, the resident was pleasantly confused and indicated she was doing well but was part of the royal family. She was not distressed by the delusion and was smiling and pleasant. She would be monitored closely and re-evaluated for signs of UTI. Infections can be cause of delusions, paranoia and hallucinations and the resident had a long history of these positive/negative symptoms of Schizophrenia. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Psychiatric Progress Note, dated 6/17/24 from the neuropsychiatric hospital, indicated the resident's history of present illness upon admission was due to being non-compliant with her medications for some time and experiencing auditory and visual hallucinations. She had been sent to the local emergency room where she had an elevated blood glucose level and altered mental status. She had a history of bipolar disorder and needed urgent rapid stabilization for mental health safety and care. Review of the MAR (Medication Administration Record) dated May 2024 and June 2024, indicated the resident was prescribed the following psychotropic medications to treat her mental disorders: -Prozac 60 mg by mouth every day for depression. -Latuda (antipsychotic) 60 mg by mouth every day for bipolar and Schizophrenia. -Risperdal (antipsychotic) 6 mg by mouth at bedtime every day for depression. On 6/25/24 at 11:20 A.M., the Director of Nursing (DON) was interviewed. She indicated behaviors were to be documented in the nurse progress notes or on the MAR and emar notes. LPN 2 (Licensed Practical Nurse) was interviewed, on 6/25/24 at 11:30 A.M., and asked where behaviors were charted. She indicated behaviors were charted in the progress notes. She indicated some residents had orders for specific behaviors to be monitored which would be documented on the MAR. The MAR dated May 2024 indicated the resident had not refused any of her psychotropic medications.There were no behaviors documented on the MAR The MAR dated June 2024 indicated the resident had not refused any of her psychotropic medications.There were no behaviors documented on the MAR A review of progress notes between May 1, 2024 and June 25, 2024 indicated there were no behaviors or notes a history of UTI's accompanied changes in Resident K's behaviors documented. On 6/25/24 at 11:50 A.M., the SSD (Social Services Designee) and Administrator were interviewed. Both indicated Resident K's allegation of being inappropriately touched by a staff member had been unsubstantiated and her behaviors attributed to a UTI. Both indicated the resident was seen at the hospital on 6/10/24 and upon her return she continued with behaviors of delusions and hallucinations the behaviors, delusions and hallucinations should have been documented in the progress notes but were not. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Behavioral Assessment and Monitoring, was provided by the Administrator on 6/25/24 at 2:08 P.M., which stated: It is the policy of the facility to provide residents with behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .'Behavior' is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes .The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individuals mental status, behavior, and cognition including: a) onset, duration, intensity and frequency of behavioral symptoms; b) any recent precipitating or relevant factors or environmental triggers [e.g., medication changes, infection, recent transfer from hospital]; and appearance and alertness of the resident and related observations .The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition including: physical or medical changes; emotional, psychiatric and/or psychological stressors; or functional, social or environmental factors .interventions (for behaviors) will be individualized and part of an overall care environment supports physical, functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities .The care plan will include, as a minimum: description of the behavioral symptoms including; frequency; intensity; duration; outcomes; location; and environment and precipitating factors or situations .Monitoring: if the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. The IDT will monitor the progress of individuals with impair cognition and behavior until stable This tag relates to Complaint IN00436372. 3.1-43(a)(1)