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	11/25/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to ensure a quarterly Minimum Data Set (MDS) assessment was coded accurately for 1 of 3 residents reviewed for assessments (Resident F). Findings include: On 11/25/24 at 11:03 A.M., Resident F's record was reviewed. Diagnoses included chronic obstructive pulmonary disease, chronic kidney disease, and lymph edema. The resident had been hospitalized , d+[DATE]-[DATE] due to altered mental status, abnormal labs, and hypotension. An Admission Observation form, dated 9/27/24 at 2:30 p.m., indicated the resident had been readmitted to the facility following hospitalization for encephalopathy (altered brain function). Her skin assessment indicated she had a pressure area to her left heel measuring 6 centimeters (cm) by 6 cm and a pressure wound to her right ankle. The right ankle wound measured 0.5 cm by 0.5 cm. A quarterly MDS assessment, dated 10/3/24, indicated in Section M-Skin Condition, a formal and clinical assessment was completed and the resident was at risk for pressure ulcers. The assessment indicated Resident F had no unhealed pressure ulcers. A quarterly MDS assessment, dated 10/4/24, indicated in Section M-Skin Condition, a formal and clinical assessment was completed and the resident was at risk for pressure ulcers. She had 1 unhealed pressure ulcer which was unstageable with suspected deep tissue injury in evolution. The MDS indicated the pressure ulcer was present on re-entry to the facility. On 11/25/24 at 3:30 p.m., the Administrator and Regional Nurse Consultant indicated MDS assessments should be completed according to the Resident Assessment Instrument (RAI) guidance. The RAI guidance indicated for Section M-Skin Condition, the medical record was to be reviewed, direct care staff interviewed, and the resident examined to determine if skin conditions were present, the type of skin condition such as related to pressure, and coded appropriately on the MDS assessment. This Citation relates to Complaint IN00447233.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER University Park Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to ensure monitoring and assessments were completed for a resident with a history of substance use disorder, and multiple falls for 1 of 3 residents reviewed (Resident C). Findings include: A complaint, reported to the Indiana Department of Health on 11/4/24, indicated Resident C had been hospitalized following multiple falls at the facility and acute illness. While hospitalized , a urine drug test was completed and was positive for illegal drugs. The complainant indicated Resident C had a substance use disorder (SUD) but hadn't used any drugs or alcohol the past year. The complainant indicated they were unsure where the resident had gotten the illegal substances from. The complainant indicated the family hadn't been notified of the resident's deteriorating condition and multiple falls. The facility was aware of the resident's SUD prior to admission to the facility. On 11/22/24 at 11:45 A.M., Resident C's record was reviewed. Diagnoses included diabetes, major depressive disorder, anxiety disorder, psychoactive substance abuse, alcohol dependence, and history of stroke affecting her left side. She admitted to the facility for rehabilitation services following hospitalization for falls and diabetic ketoacidosis (complication of diabetes in which acids build up in the blood to life-threatening levels) due to not taking her diabetes medications as prescribed. Hospital records indicated drug and alcohol tests were completed and had been negative. A quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident C had no cognitive impairment. She had no mood indicators or behaviors. She required set-up help, supervision or touching assistance with her activities of daily living. She denied pain and had not received any pain medications. She'd had no falls since admission to the facility on [DATE]. Care plans indicated: -Initiated 9/5/24: The resident was at risk for impaired psychosocial well-being due to anxiety, depression, history of substance abuse, insomnia, and recent admission to the facility. Interventions included: monitor for side effects of medications and disease conditions which could affect cognition and orientation; review new/changed medications for adverse effects; behavior health consults as needed; follow up with psychiatric services as needed; observe and report any changes in mental status caused by situational stressors. -Initiated 9/5/24: Resident was at risk for impaired safety/injury due to weakness, non-compliance with fall interventions, and unsafe smoking (10/18/24-assessed as needing supervision to smoke). Interventions included a smoking assessment to be completed quarterly and as needed. An intervention, dated 10/22/24, was for STAT labs and to decrease the resident's routine opioid medication to every 12 hours as needed for 7 days and then discontinue. Care plans hadn't indicated what steps were to be taken when the resident had a relapse or a positive drug test was observed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER University Park Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility form, titled Guidelines for Admissions with a History of Substance Abuse was signed and dated on 9/6/24 and 10/28/24 by Resident C. The form included: 1. Random drug screens and/or alcohol level checks would be made if a resident was non-compliant with the facility substance abuse guidelines and could be asked to voluntarily or involuntarily discharge from the facility. 2. If any positive drug screens or alcohol level checks came back as failed, the resident's medications would be reviewed and any prescribed narcotics subjected to discontinuing or lowered dosage. 3. Room checks with the resident present if suspicion of relapse. 4. Only cigarettes were approved as allowable smoking item. 5. Residents would need to attend substance abuse meetings if provided by the facility. 6. Residents would be seen by psychiatric services. A physician order, dated 9/5/24 at 6:45 p.m., indicated to give Hydrocodone-Acetaminophen (Opioid pain medication) 5-325 milligram tablets; take 1 tablet every 4 hours as needed for pain. Additionally, she was prescribed Baclofen 4 times per day for muscle relaxant and Pregabalin 3 times per day for nerve pain. A Medical Nurse Practitioner (NP) progress note, dated 9/6/24 at 1:03 p.m., indicated the resident had been seen for admission to the facility. Prior to admission, she had been hospitalized and was at the facility for medical management and therapy. She a formerly used tobacco, had previous alcohol abuse, and previous substance abuse. During the visit she complained of pain in her right ankle from previous fall/fracture prior to admission. A Social Services Director (SSD) progress note, dated 9/6/24 at 4:14 p.m., indicated the the resident had intact intellectual functioning and no communication deficits. She had diagnoses of major depression, insomnia, anxiety, was prescribed Trazodone (used to treat depression and help with sleep disorders) and Hydroxyzine (anti-histamine used to treat anxiety) to manage her symptoms. She was referred to the psychiatric NP for her mental health needs and medication management. A Psychiatric Nurse Practitioner (NP) progress note, dated 9/24/24 at 7:25 a.m., indicated the resident was seen to establish care and psychiatric assessment of anxiety, depression, insomnia, and psychoactive substance abuse. She was a former smoker, had no drug or alcohol use for the past year, and currently vaped. The plan was to continue with Trazodone 200 mg and Melatonin 3 mg at bedtime for insomnia; and continue with Hydroxyzine 3 times per day for anxiety. Staff were to contact the NP for any psychiatric related questions, changes, or concerns. Resident C had falls on the following dates and times: -10/11/24 at 3:40 a.m. -10/13/24 at 12:16 a.m. -10/16/24 at 11:17 a.m. -10/18/24 at 6:52 a.m. -10/19/24 at 12:37 a.m. and 9:45 p.m. -10/22/24 at 9:00 a.m., 10:40 a.m., and at 10:15 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medical NP progress note, dated 10/21/24 at 1:44 p.m., indicated the resident was seen due to having several falls. Staff indicated she had been found falling asleep while sitting up in her wheelchair and would then fall forward. They indicated she had not sustained injuries from the falls nor had she lost consciousness. Upon examination, the resident was sitting up in her wheelchair and appeared slightly drowsy. She denied head, neck or back pain. The NP informed her due to her increased drowsiness, the dosages of some of her medications, which may be contributing to her falls, would be decreased. She had no concerns or complaints. This was discussed with nursing. Her Baclofen (muscle relaxant) dosage was decreased from 4 times per day to 3 times and her Pregabalin (for nerve pain) was decreased from 3 times per day to 2 times. Staff were to continue monitoring her closely. Nurse progress notes, dated 10/22/24, indicated: -At 9:00 a.m., the resident was heard yelling for help and had been found on her left side between the toilet and wall. She indicated she had turned to fast when transferring herself from the wheelchair onto the toilet. She had no injuries and denied pain. She was assisted off the floor and neuro checks started. Her vital signs were obtained and within normal limits except for her pulse which was elevated at 120 beats per minute (bpm-normal 60-100), The medical NP was notified. -At 10:40 a.m., the resident was heard yelling after a loud noise came from her bathroom. The resident was found sitting on the floor in the middle of the bathroom. She indicated she had been trying to get back on the toilet again and knew she should have called for assistance. She was assisted back into her chair, neuro checks continued and her vital signs checked. Her pulse remained elevated at 120 bpm. The medical NP was notified. -At 12:52 p.m., the resident complained of inability to urinate in the toilet for residual. The medical NP was notified and order given to try and catheterize her. This was completed and over 300 milliliters of dark yellow urine was collected. The NP ordered an indwelling foley catheter be anchored and urine sample sent for urinalysis. A urine drug screen was ordered and completed at the facility using the facility in-house urine drug test. The urine drug test was positive for tricyclic anti-depressants. Resident F was not prescribed antidepressants, and positive for Morphine. The resident was not prescribed Morphine. The NP was notified and new order given to decrease the resident's Hydrocodone-Acetaminophen 5-325 mg dose from every 4 hours as needed to every 12 hours as needed for 7 days and then discontinue the medication. -At 5:15 p.m., the resident was heard yelling out for help. She was observed leaning forward in her wheelchair and had been unable to sit herself back up. She was assisted to scoot back in the wheelchair. When asked, the resident indicated she had no idea what she had been doing but had not fallen asleep. -At 9:15 p.m., the resident was observed lying on the floor, fully clothed. She complained of pain but there was no evidence of injury. She refused to have neuro checks completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An NP progress note, dated 10/23/24 at 2:20 p.m., indicated the resident was visited for acute urinary retention and placement of an indwelling catheter. She had yellow, clear urine in the catheter bag and a urinalysis was pending. The plan was to continue her current medication regimen, plan of care, and continued monitoring. The note had not indicated the resident had a positive urine drug screen on 10/22/24 nor the change in pain medication addressed. There was no documentation to indicate the Medical NP had spoken with the resident regarding the positive drug screen and informed her pain medications would be discontinued on 10/29/24. A Psychiatric NP progress note, dated 10/25/24 at 11:27 a.m., indicated the resident was visited for continued assessment of moods, changes in behaviors, efficacy and possible side effects of psychotropic medications, and review of labs related to psychotropic medications. The resident was noted with urinary retention and an indwelling catheter placed. The Medical NP had asked provider to review her medications. The resident was not prescribed medication which would lead to urinary retention. The resident's appetite was fair and she had no insomnia. During the visit, Resident C was awake, alert, but made little eye contact. Her mood was appropriate and she had no visible anxiety, agitation or worry. She was animated with a short attention span. The plan was to continue Trazodone 200 mg and Melatonin 3 mg at bedtime for insomnia and Hydroxyzine 25 mg 3 times per day for anxiety. The note had not indicated the resident had a positive urine drug screen on 10/22/24. The note did not include pain medications had been decreased and would be discontinued at the end of 7 days (10/29/24). The Medical NP saw the resident on 10/25/24 at 12:40 p.m. to follow up on the resident's urinary retention. Her urinalysis results had been negative for acute findings and she continued with good urine output in her foley catheter. She was informed a new medication would be prescribed to help with the urinary retention and a voiding trial would be attempted the following week which she was agreeable to. The note had not indicated the resident had a positive urine drug screen on 10/22/24, change in pain medication, nor upcoming date of discontinuation for her pain medications. An SSD progress note, dated 10/28/24 at 4:07 p.m., indicated staff had reported the resident was non-compliant with the smoking policy. The SSD reviewed the smoking policy with Resident C and she signed the policy in acknowledgement. She remained supervised with smoking. The SSD spoke with the resident's mother on 10/25/24 and informed her the resident was now a supervision with smoking and when cigarettes were brought in for her, the smoking materials needed to be given to nursing staff for safety. The note hadn't indicated the mother was made aware of the positive urine drug screen. A nurse progress note, dated 10/30/24 at 11:06 a.m., indicated the resident had complained of nausea and vomiting, requested and given Zofran. She refused her routine insulin due to not eating because of the nausea and vomiting. At 3:35 p.m., the medical NP was notified of the resident's change in condition. She had an altered level of consciousness, required more assistance and had general weakness. Her pulse was elevated at 116 bpm and her blood pressure low at 71/41(Normal 120/80). She continued to complain of nausea and no appetite but had stopped vomiting. Orders were given to give a 1 time dose of Midodrine 5 mg by mouth to increase her blood pressure and re-check. On re-check, her blood pressure was lower at 66/40. Additional orders were given to obtain STAT labs and start IV or hypodermoclysis (under skin) and give 1000 milliliters of fluid. Documentation indicated the family was not notified because the resident was aware of the orders. At 5:00 p.m., the fluids were to be given via IV or hypodermoclysis but the resident refused and pulled her hand back and pushed the nurse with her legs. She refused to have STAT labs drawn. Her blood pressure was 64/40 and pulse 115. The NP was made aware and indicated oral fluids were to be encouraged. The resident was asked if she wanted to go to the hospital but she refused and told the nurse to leave her alone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER University Park Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no further assessments or documentation completed after 10/30/24 at 5:00 p.m. until 10/31/24 at 4:34 a.m. when the resident was observed lying in bed, unresponsive with a pulse of 42, blood pressure of 97/52, labored breathing, clammy to touch and oxygenation at 78% (normal >90%). The NP was notified and new order given to send resident to the emergency room where she was treated for a brain bleed and sepsis. Hospital records indicated the resident had a positive drug test for amphetamines and meth. Confidential interviews, conducted during the survey, indicated staff knew the signs and symptoms of substance use relapse were changes in behavior, changes in vital signs including elevated pulse rate, changes in consciousness and alertness, changes in pupils of the eye, etc. One staff member indicated they hadn't known the resident had a positive urine test done at the facility or what monitoring or assessments were to be done following the positive test. On 11/25/24 at 2:00 P.M., the SSD was interviewed. She indicated the only policy and protocol the facility had regarding substance use in residents was the form residents with substance use were asked to sign upon admission. The form indicated drug tests could be done when suspected; positive results could be cause for discharge; and the medical provider would be notified which could result in lowering dosages of or discontinuation of prescribed narcotics. Residents with substance use diagnoses had no specific care planned interventions to address relapse. On 11/25/24 at 3:30 P.M., the Administrator indicated the facility accepted residents who had substance use diagnoses and they were expected to sign the facility form for guidelines/consequences of not following upon admission had no policy/procedure or monitoring/assessing guidelines regarding care of residents who had a diagnosis of substance use and were found to have a positive urine test for drugs. This Citation relates to Complaint IN00446547. 3.1-37