

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER University Place Health Center and Assisted Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 Lindberg Rd West Lafayette, IN 47906	
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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a resident was kept safe during a transfer by a staff member for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B sustaining a minimally displaced oblique fracture of the mid tibial diaphysis (a stable, angled break in the middle shaft of the shinbone) and a minimally displaced spiral fracture of the proximal fibular diaphysis (a stable, low-energy injury near the knee). The deficient practice was corrected on 3/27/26, prior to the start of the survey, and therefore was past noncompliance. Findings include: During an interview, on 3/30/26 at 1:10 p.m., the Director of Nursing (DON) indicated Resident B was found to have bruising to her right leg on 3/20/26 and pain in her right hip. She was sent to the emergency room for evaluation. She received notification Resident B had a fractured right leg and an investigation was started. Resident B did not have a fall, was not mobile, and required a mechanical lift for all transfers. During the investigation, CNA 2 indicated she had completed a mechanical lift transfer (a device used to transfer residents with limited mobility) without assistance. The cause of the fracture was not determined. CNA 2 was terminated for not following procedure for the mechanical lift which could have caused the fracture of Resident B's right leg. The clinical record for Resident B was reviewed on 3/30/26 at 3:40 p.m. The diagnoses included, but were not limited to, abnormalities of gait and mobility, lack of coordination, and dementia. A physician's order, dated 11/20/24, indicated Resident B was a mechanical lift for all transfers. A care plan, dated 5/7/25, indicated Resident B had an impaired transfer ability. Interventions included, but were not limited to, a mechanical lift for transfers and a minimum of two staff members for all mechanical lift transfers. A nursing progress note, dated 3/21/26, indicated while being changed Resident B was found to have a bruise to her right shin and severe pain to her right hip. Resident B was assessed and staff could not find a pedal pulse to her right foot. Resident B was sent to the emergency room for evaluation. A nursing progress note, dated 3/21/26, indicated the emergency room reported the resident had a significant fracture to her right tibia and a spiral fracture to her right fibula. An emergency room report, dated 3/21/26, indicated the resident had a minimally displaced oblique fracture of mid tibial diaphysis and a minimally displaced spiral fracture of the proximal fibular diaphysis. A nursing progress note, dated 3/24/26, indicated Resident B returned to the facility, was non-weight bearing on her right leg, and was admitted to hospice care. A facility statement, dated 3/21/26, indicated CNA 2 and CNA 3 got Resident B up for dinner utilizing the mechanical lift and the resident had no complaint of pain. CNA 2 prepared the resident for bed after dinner and admitted she transferred the resident utilizing the mechanical lift without assistance. She denied any occurrence which could have led to the resident being injured. A facility statement, dated 3/21/26, indicated CNA 3 had assisted CNA 2 with the mechanical transfer of Resident B prior to dinner, and the resident did not have any pain. She did not assist CNA 2 with the transfer of Resident B after dinner. A facility statement, dated 3/21/26, RN 4 indicated Resident B did not exhibit any signs or symptoms of pain during the dinner meal or when she dispensed the evening medications at 7:30 p.m. RN 4 indicated she observed the mechanical lift in Resident B's room and CNA 2 was with the resident at the time. RN 4 indicated the resident's injury could have been caused during a mechanical transfer. A facility (continued on next page)</p>		

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
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>statement, dated 3/21/26, LPN 5 indicated the accident could have happened with a mechanical lift transfer or if the resident hit her leg on the metal portion of the bed frame. The bed frame was completely covered by the mattress except on the lateral surface. The facility investigation document indicated CNA 2 admitted she transferred Resident B after dinner, on 3/20/26, by herself utilizing a mechanical lift. CNA 2 indicated she had no issues with the transfer. During an interview, on 3/30/26 at 1:50 p.m., the Manager of Resident Services indicated all mechanical lift transfers were to have 2 people for safety and proper utilization of the lift machine. If one staff member utilized the machine, an accident could likely occur. After the investigation of Resident B's incident, all staff received an in-service and demonstrations on the proper mechanical lift procedure. Audits were ongoing and CNA 2 was terminated. During an interview, on 3/30/26 at 2:22 p.m., CNA 3 indicated the mechanical lift was utilized for resident transfers and 2 people must assist with the process. She did not assist CNA 2 with the transfer of Resident B after dinner. She did assist with the transfer prior to dinner and indicated Resident B needed 2 people to assist because she had difficulty at times with the transfer. A mechanical lift general guideline indicated at least 2 nursing assistants were needed to safely move a resident with a mechanical lift. A current facility policy and procedure, titled system competency subject: mechanical lift, not dated and provided by the Director of Nursing (DON) on 3/30/26 at 4:05 p.m., indicated .At least two nursing assistants are needed to safely move a resident with a mechanical lift. This deficient practice was corrected by 3/27/26 after the facility implemented a systemic plan that included the following actions: An in-service was conducted for all staff who utilize the mechanical lift, observations and audits of the utilization of the mechanical lift were conducted and are ongoing, CNA 2 was terminated. This citation relates to Intake 2962388.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)</p>		