

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 11/25/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48525</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who needed assistance with eating was assisted timely for 1 of 11 residents observed in the dining room. (Resident 10)</p> <p>Finding includes:</p> <p>During a continuous dining observation in the main dining room, on 11/21/24 from 11:34 a.m. to 12:41 p.m., the following was observed:</p> <p>At 11:40 a.m., the first food tray was delivered to a resident in the dining room. Resident 10 was at her table waiting for her tray.</p> <p>At 12:14 p.m., a resident was helped to the dining room by therapy. She was then served her food at 12:31 p.m. Resident 10 was still waiting for her food.</p> <p>At 12:20 p.m., the kitchen staff were picking up food trays for multiple residents who had received their meals and were done eating. The staff was returning the trays to the kitchen. Resident 10 was still waiting for her tray.</p> <p>At 12:32 p.m., CNA 7 indicated Resident 10 was a feed and needed help eating. They usually waited until a CNA was available to serve a resident who needed help eating.</p> <p>CNA 7 was not observed passing trays and could have helped the resident eat. Resident 10 was still waiting on her food tray.</p> <p>At 12:38 p.m., a male resident came to the dining room from his room. He originally had a room tray but then came to the main dining room to eat. He sat down and was delivered his tray. Resident 10 was still waiting for her food.</p> <p>At 12:39 p.m., the kitchen staff were picking up more food trays from several residents who were done eating. Resident 10 was still waiting on her tray.</p> <p>At 12:41 p.m., Resident 10 was finally served her tray.</p> <p>(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
---	-------	-----------

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 11/25/2024
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>It was over an hour from the first tray being passed to when Resident 10 received her food tray.</p> <p>Resident 10 watched several residents come to the dining room after her and receive their trays before she did.</p> <p>The clinical record for Resident 10 was reviewed on 11/25/24 at 12:00 p.m. The diagnoses included, but were not limited to, unspecified dementia, dysphagia (difficulty swallowing), depression, and basal cell carcinoma.</p> <p>A care plan, initiated on 8/12/24 and last revised on 11/5/24, indicated Resident 10 had increased nutrient needs. Interventions included, but were not limited to, provide food and fluids and provide dining assistance as necessary.</p> <p>A physician's order, with a start date of 8/5/24, indicated general diet, puree texture, and thin liquid consistency.</p> <p>During an interview, on 11/22/24 at 2:50 p.m., the Executive Director (ED) indicated they usually served residents as they came to the dining room. They would serve independent residents first, then pass room trays, and then pass trays to the residents who needed fed so a CNA could be available. Residents should not have to wait an hour for their trays to be served.</p> <p>A current policy, titled DINING AND FOOD SERVICES EXPERIENCE, last reviewed on 5/18/21 and received from the ED on 11/25/24 at 2:12 p.m., indicated .A resident's quality of life may be enhanced through their dining and/or food experience. The dining and/or food service is provided to ensure that nourishing, palatable and attractive meals based on individual resident needs are served, and that both food service and facility staff assist and support residents during the dining and/or food experience .Residents shall be promptly assisted with eating and provide necessary cueing</p> <p>3.1-3(t)</p>		

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 11/25/2024
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)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>44598</p> <p>Based on interview and record review, the facility failed to ensure a revised Preadmission Screen and Resident Review (PASARR) Level I was submitted after a new mental health diagnoses was added and an antidepressant medication was prescribed for 1 of 1 resident reviewed for PASARR. (Resident 1)</p> <p>Finding includes:</p> <p>The clinical record for Resident 1 was reviewed on 11/22/24 at 12:16 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbances, cognitive communication deficit, major depressive disorder, and anxiety disorder.</p> <p>A PASARR level I, dated 5/28/24, indicated the resident had no mental health diagnosis, dementia or neurocognitive disorder and no mental health medication.</p> <p>A physician's order, dated 8/31/24, indicated to give sertraline (an antidepressant medication) 100 milligram (mg) daily.</p> <p>There was no PASARR level I completed when the resident was ordered sertraline.</p> <p>During an interview, on 11/25/24 at 3:37 p.m., the Social Service Director (SSD) indicated a new level I PASARR was not completed. The admission staff would be in charge of implementing the PASARR and missed completing a new level I when a new antidepressant medication was ordered. The new diagnosis for this medication was not added.</p> <p>A current facility policy, titled Preadmission Screening and Annual Resident Review [PASARR], Preadmission, Screening & Resident Review - SNF, dated 6/1/23 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated .PASARR requires that all people entering Medicaid-certified nursing communities are evaluated for: Serious Mental Illness (SMI); Intellectual Disability (ID); Developmental Disabilities (DD); are placed in the most appropriate setting, and receive assessments to identify their service needs regardless of (the individual's) method of payment .The community will ensure that all new admissions are appropriately screened prior to admission to determine that the individual requires nursing community level of care and to identify any specialized services that may be necessary .Any resident of the community who has a condition of MI/ID/DD/Related Conditions who experiences a significant change in condition requiring reassessment, this must also be reviewed by the state specific agency</p> <p>3.1-16(d)(1)(A)</p> <p>3.1-16(d)(1)(B)</p>		

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 11/25/2024
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48525</p> <p>Based on interview and record review, the facility failed to ensure a medication was held per the physician's order for 1 of 1 resident reviewed for quality of care. (Resident 131)</p> <p>Finding includes:</p> <p>The clinical record for Resident 131 was reviewed on 11/22/24 at 9:17 a.m. The diagnoses included, but were not limited to, essential hypertension, unspecified atrial fibrillation (a-fib), and transient cerebral ischemic attack (stroke).</p> <p>A physician's order, with a start date of 11/15/24, indicated Carvedilol (a medication to treat high blood pressure) oral tablet 6.25 milligrams. Give twice per day. Hold if the systolic blood pressure (SBP) was under 120.</p> <p>A review of the November Medication Administration Record (MAR) indicated:</p> <p>On 11/17/24, the systolic blood pressure was 117. Carvedilol was administered on the AM shift.</p> <p>On 11/17/24, the systolic blood pressure was 113. Carvedilol was administered on the PM shift.</p> <p>During an interview, on 11/25/24 at 9:41 a.m., RN 2 indicated the medication was not held and was given. The medication should have been held and a progress note should have been made. There was no progress note in the chart.</p> <p>During an interview, on 11/25/24 at 11:33 a.m., the Director of Nursing (DON) indicated the medication was administered on those shifts.</p> <p>A current facility policy, titled PREPERATION AND GENERAL GUIDELINES, dated as reviewed March 2021 and received from the Executive Director on 11/25/24 at 2:12 p.m., indicated .Medications are administered as prescribed in accordance with good nursing principles and only by persons legally authorized to do so . Medications are administered in accordance with written orders of the prescriber</p> <p>3.1-37(a)</p>		

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 11/25/2024
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>44598</p> <p>Based on interview and record review, the facility failed to ensure staff obtained a follow-up weight and notified the physician of a weight gain for 1 of 1 resident reviewed for weight changes. (Resident 1)</p> <p>Findings include:</p> <p>The clinical record for Resident 1 was reviewed on 11/22/24 at 12:16 p.m. The diagnoses included, but were not limited to, dementia without behavioral disturbances, cognitive communication deficit, major depressive disorder, and anxiety disorder.</p> <p>A physician's order, dated 6/21/24, indicated the resident was to receive Ensure (a dietary supplemental drink) three times a day.</p> <p>A care plan, revised on 8/28/24, indicated the resident had increased nutrient needs related to a wound to the coccyx. The interventions included, but were not limited to, diet as prescribed, monitor weight monthly, monitor oral intake of food and fluid, and to give a dietary supplement three times a day.</p> <p>The resident had the following weights:</p> <ol style="list-style-type: none"> On 11/4/24, the weight was 124.5 pounds. On 11/11/24, the weight was 134.8 pounds. <p>The resident had an 8.27% weight gain in 7 days.</p> <p>There was no documentation to indicate a new weight was obtained to verify the weight gain.</p> <p>There was no documentation of the physician being notified of the weight gain.</p> <p>During an interview, on 11/25/24 at 4:01 p.m., the Director of Nursing (DON) indicated when a resident had a weight loss or gain, she would discuss the weight with the dietitian. The residents with a weight loss or gain should be reweighed.</p> <p>During an interview, on 11/25/24 at 4:10 p.m., the Registered Dietician indicated she was in the building three days a week. The facility policy indicated when a resident had a weight gain or loss the resident should be weighed within 72 hours of the first weight.</p> <p>A current policy, titled Change of Condition, dated 12/1/23 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated .The Nurse will notify the resident's Attending Physician or On-Call Physician when there has been .A significant change in the resident's physical/emotional/mental condition . Unless otherwise instructed by the resident, the Nurse will notify the resident's family or representative when . There is a significant change in the resident's physical, mental, or psychosocial status</p> <p>(continued on next page)</p>		

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 11/25/2024
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current policy, titled Weight Management in Health Care Center, dated 9/1/22 and received from the Director of Nursing (DON) on 11/25/24 at 4:09 p.m., indicated .The staff nurse will validate that the weight is within acceptable limits. If a resident has a gain or loss of 5 pounds from their previous weight, a new weight must be obtained within 48 hours .The Registered Dietician is responsible for monitoring all weight changes and documenting significant weight loss/gain</p> <p>3.1-46(a)(1)</p>		

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 11/25/2024
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>50956</p> <p>Based on observation, interview and record review, the facility failed to ensure assessments were completed and consent was obtained prior to the use of side rails for 1 of 2 residents reviewed for accident hazards. (Resident 21)</p> <p>Finding includes:</p> <p>During multiple observations, on 11/21/24 at 10:14 a.m., 11/22/24 at 9:13 a.m., and 11/25/24 at 10:47 a.m., a 1/4 side rail was raised and in use on Resident 21's bed.</p> <p>The clinical record for Resident 21 was reviewed on 11/22/24 at 12:36 p.m. The diagnoses included, but were not limited to, unspecified fracture of sacrum, low back pain, radiculopathy lumbar region, spinal stenosis, muscle weakness, diastolic congestive heart failure, cerebral infarction, and chronic pulmonary hypertension.</p> <p>A side rail assessment, completed on 11/1/24 at 4:17 p.m., indicated side rails were not indicated.</p> <p>The electronic record did not have documentation showing the risks and benefits of side rails were explained to Resident 21 or a consent was obtained prior to the use of side rails.</p> <p>During an interview, on 11/22/24 at 2:37 p.m., the Administrator indicated there was not a physician's order for side rails.</p> <p>A physician's order, dated 11/25/24 at 4:41 a.m., indicated to utilize 1/4 side rails to increase independence in bed mobility and in transfers. The physician's order was obtained after the side rails were on the resident's bed.</p> <p>During an interview, on 11/25/24 at 12:07 p.m., the Director of Nursing indicated the resident did not have a side rail assessment or consent completed until 11/25/24. The consent and assessment should have been completed when the side rails were applied.</p> <p>A current facility policy, titled Bed Safety and Bed Rails, last revised August 2022 and received from the Administrator on 11/22/24 at 3:10 p.m., indicated .The use of bed rails or side rails .is prohibited unless the criteria for use of bed rails have been met .including .resident assessment and informed consent .Before using bed rails for any reason, the staff shall inform the resident or representative about .the benefits and potential hazards associated with bed rails and obtain informed consent</p> <p>3.1-45(a)(1)</p>		

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 11/25/2024
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>50956</p> <p>Based on interview and record review, the facility failed to ensure the policy and procedure for conducting an Abnormal Involuntary Movement Scale (AIMS) assessment upon admission and quarterly was followed for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 16)</p> <p>Finding includes:</p> <p>The clinical record for Resident 16 was reviewed on 11/22/24 at 12:37 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, unspecified dementia with psychotic disturbance, metabolic encephalopathy, chronic kidney disease, and unspecified convulsions.</p> <p>A physician's order, dated 11/27/23, indicated to give Seroquel (an antipsychotic) 50 milligrams two times a day for dementia with aggression.</p> <p>A care plan, revised on 5/14/24, indicated the resident used psychotropic medications related to dementia with aggression. An intervention indicated staff were to monitor and document any adverse reactions such as tardive dyskinesia.</p> <p>An AIMS assessment (a scale used to assess for tardive dyskinesia and its severity when prescribed antipsychotic medications) was completed on 10/16/24 at 6:03 p.m.</p> <p>During an interview, on 11/25/24 at 2:53 p.m., the Director of Nursing (DON) indicated an AIMS assessment was not completed for the resident until 10/16/24. This was the only AIMS assessment conducted for the resident.</p> <p>A current facility policy, titled Anti-psychotic Drug Use, dated 8/21/23 and provided by the DON on 11/25/24 at 4:06 p.m., indicated .The AIM's test should be completed upon beginning a new order for an anti-psychotic, and quarterly noting the appearance of any extra-pyramidal symptoms which previously were not present</p> <p>3.1-48(a)(3)</p>		

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 11/25/2024
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50901</p> <p>Based on observation, interview and record review, the facility failed to ensure medication carts were free from expired medications, medical supplies, and loose pills, and medications were properly labeled after opening for 1 of 2 medication carts reviewed for medication storage and labeling. (Hall 1)</p> <p>Findings include:</p> <p>During a medication storage observation, on 11/22/24 at 10:14 a.m., the following was observed:</p> <p>1. Drawer 1 of the medication cart had:</p> <p>a. One (1) Erythromycin Ophthalmic Ointment (an antibiotic ointment for the eye) 5 mg (milligram) opened and not dated.</p> <p>b. Six (6) SwabCaps (a disinfecting cap for peripherally inserted central catheter) were in the cart and passed the expiration date of 11/1/24.</p> <p>During an interview, on 11/22/24 at 10:25 a.m., LPN 4 indicated the SwabCaps were expired and should not have been in the medication cart.</p> <p>2. Drawer 2 of the medication cart had:</p> <p>a. Famotidine (an acid reducing medication) 10 mg tablets with an expiration date of 11/22/24.</p> <p>b. Acetaminophen (a fever reducer/pain reliever) 325 mg tablets with an expiration date of 9/3/24.</p> <p>c. Loperamide (an anti-diarrheal medication) 2 mg tablets with an expiration date of 10/24.</p> <p>d. Acetaminophen 325 mg tablets with an expiration date 11/18/24.</p> <p>e. Docusate Sodium (a stool softener) 100 mg capsules with an expiration date of 10/2/24.</p> <p>f. Guaifenesin (a medication to relieve chest congestion) Extended Release 600 mg tablets with an expiration date of 11/14/24.</p> <p>g. Blood glucose test strips with an open date of 11/4/24 and an expiration date of 10/31/24, six test strips remained in the bottle.</p> <p>During an interview, on 11/22/24 at 10:31 a.m., QMA 4 indicated the Famotidine had been discontinued and should not have been in the medication cart.</p> <p>3. Drawer 3 of the medication cart had:</p> <p>(continued on next page)</p>		

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 11/25/2024
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Acetaminophen 325 mg tablets with an expiration date of 11/18/24.</p> <p>b. One (1) loose pill, peach in color.</p> <p>4. Drawer 4 of the medication cart had:</p> <p>a. Colace (a stool softener) 100 mg tablets opened with no open date.</p> <p>5. Drawer 5 of the medication cart had:</p> <p>a. One (1) loose pill, yellow in color.</p> <p>During an interview, on 11/22/24 at 10:31 a.m., QMA 3 indicated the nurses with access to the medication carts were responsible for checking expiration dates and loose pills. Pharmacy performed audits on the medication carts and checked for expiration dates as well. When a medication was opened, the nurse was responsible for writing the date on the medication bottle.</p> <p>A current facility policy, titled MEDICATION STORAGE IN THE FACILITY, last revised January 2018 and received from the Administrator on 11/22/24 at 1:53 p.m., indicated .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory .and reordered from the pharmacy .Certain medications or package types such as .blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date .The nurse will check the expiration date of each medication before administering it .No expired medication will be administered to a resident .All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining</p> <p>3.1-25(j)</p> <p>3.1-25(k)(6)</p> <p>3.1-25(o)</p>		