STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155725	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Health Center and Assisted Living	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure the Preadmission Screening and Record Review (PASARR) screenings were accurate when completed and updated when new mental health diagnoses and medications were initiated for 2 of 2 residents reviewed for PASARR. (Resident 3 and 19)Findings include: 1. The clinical record for Resident 3 was reviewed on 11/24/25 at 11:24 a.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, anxiety, depression, and a psychotic disorder not due to a substance or known physiological condition. A notice of PASARR level I screen outcome, dated 2/10/25, did not include Resident 3's medication clozapine (an atypical antipsychotic).A physician's order, dated 10/3/25, indicated the resident was to receive clozapine 37.5 milligrams once a dayDuring an interview, on 11/25/25 at 10:05 a.m., the admission Coordinator indicated Resident 3 was on clozapine on admission. The medication should have been on her level 1 PASARR.2. The clinical record for Resident 19 was reviewed on 11/24/25 at 2:21 p.m. The diagnoses included, but were not limited to, dementia, anxiety, depression, and hypothyroidism. A notice of PASARR level I screen outcome, dated 11/7/23, indicated Resident 19 had a diagnosis of anxiety and was taking the medication Buspar.Resident 19's diagnosis list included depression with the start date of 8/29/24.A physician's order, with a start date of 8/30/24, indicated Resident 19 was on sertraline 25 milligrams once a day for depression.The notice of PASARR level I screen outcome did not include the diagnosis of depression. During an interview, on 11/25/25 at 10:05 a.m., the admission Coordinator indicated the PASARR for Resident 19 was not updated timely when a new mental health medication and diagnosis was added. The depression diagnosis was not included on the most recent PASARR and should be on the PASARR. A current facility policy, titled PASRR, Preadmission, screening and resident review - SNF, dated 6/1/23 and received from the Administrator on 11/25/25 at 12:52 p.m., indicated .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 3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure a resident received assistance with personal hygiene for 1 of 2 residents reviewed for activities of daily living (ADL) care. (Resident 29)Findings include:During an interview, on 11/24/25 at 10:24 a.m., Resident 29's representative voiced concerns about Resident 29's showers. She indicated she had called the facility and asked if the resident received her shower. The staff indicated Resident 29 received one regularly. When the family visited the resident, the resident often had greasy hair and appeared dirty. When family questioned staff about the resident's appearance, staff indicated the resident had behaviors and they could not give her a shower. During an observation, on 11/20/25 at 1:42 p.m., Resident 29's hair was uncombed and greasy.During an observation, on 11/21/25 at 10:38 a.m., Resident 29's hair was greasy.During an observation, on 11/24/25 at 11:57 a.m., Resident 29's hair remained greasy. During an observation, on 11/25/25 at 10:32 a.m., Resident 29's hair was extremely greasy. The clinical record for Resident 29 was reviewed on 11/24/25 at 11:15 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, cognitive communication deficit, hypertension, glaucoma, pressure ulcer right buttock, and dementia.A care plan, dated 6/4/23, indicated Resident 29 required assistance with activities of daily living care. The interventions included, but were not limited to, personal hygiene and bathing assistance.A facility document, titled Care Giver Body Check Worksheet, indicated the resident received six (6) showers or bed baths from October 1 through October 31, 2025. There was no documentation to indicate the resident's hair was washed.A facility document, titled A Care Giver Body Check Worksheet, indicated the resident received five (5) showers or bed baths from November 1 through November 23, 2025. There was no documentation to indicate the resident's hair was washed.During an interview, on 11/25/25 at 9:52 a.m., the Director of Nursing (DON) indicated Resident 29 had some pain and behaviors. She did not know when the resident last had a shower. The CNAs completed a form, and the nurse signed the form. Resident 29 required a mechanical lift, and it was harder to get the resident in the shower with her behavior. They did have shower caps which helped the CNAs wash the residents' hair. During an interview, on 11/25/25 at 9:55 a.m., the Administrator indicated she kept close tabs on the shower caps. The CNA could use one to wash the resident's hair. She was unaware of the last time the resident had her hair washed with a shower cap. During an interview, on 11/25/25 at 10:15 a.m., CNA 9 indicated she did not normally work on Resident 29's unit. The facility had CNA care sheets which would tell when the residents' showers were scheduled. Resident 29's showers were scheduled for Monday and Thursdays. A CNA job description, dated 1/21/25 and received from the Administrator on 11/26/25 at 11:41 a.m., indicated .This role involves assisting residents with activities of daily living, medication reminders, and social and spiritual pursuits. This position will render personal care to residents and monitor their physical and cognitive wellbeing .Assist residents with activities of daily living including but not limited to; bathing, dressing, grooming, toileting, and medication reminders in accordance with care plans and established community policies and procedures A current facility policy, titled Activities of Daily Living (ADLs), dated 12/1/23 and received from the Administrator on 11/26/25 at 11:12 a.m., indicated .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate A current facility policy, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Resident Rights, dated 4/1/23 and received from the Administrator on 11/26/25 at 11:13 a.m., indicated .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 be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: a. Bathing. b. Personal care 3.1-38(a)(2)(A)3.1-38(a)(3)(B)3.1-38(b)(2)3.1-38(b)(3)3.1-38(f)

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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. Based on interview and record review, the facility failed to ensure a daily weight was obtained as ordered by the physician for 1 of 1 resident reviewed for edema. (Resident 6) Findings include:The clinical record for Resident 6 was reviewed on 11/24/25 at 12:31 p.m. The diagnoses included, but were not limited to, chronic congestive heart failure, atrial fibrillation, and hypertension. A physician's order, dated 11/8/25, indicated to obtain daily weights. The clinical record indicated a daily weight was missing on 11/14/25.The clinical record indicated, on 11/19/25, Resident 6 had a weight gain of 4.4 pounds in one day. A care plan, dated as revised on 11/18/25, indicated the resident had altered cardiovascular status. The interventions included, but were not limited to, monitor, document and report as needed any signs and symptoms of congestive heart failure, and any weight gain unrelated to intake. The progress notes, dated 11/8/25 through 11/25/26, did not indicate Resident 6 refused the daily weight on 11/14/25, or the physician was notified of the 4.4-pound weight gain in one day on 11/19/25. During an interview, on 11/25/25 at 9:41 a.m., the Director of Nursing (DON) indicated the facility did not have a congestive heart failure protocol. They discussed each resident in the Interdisciplinary Team (IDT) meeting and determined what to do with a congestive heart failure resident who gained weight. They would reweigh the resident to make sure the weight was accurate and then would determine if the physician needed to be notified. The dietitian looked at the weights daily and since Resident 6 did not trigger for a significant gain or loss the physician was not notified.During an interview, on 11/25/25 at 10:16 a.m., CNA 9 indicated she did not know the resident was a daily weight. When a resident had an order for a daily weight, the resident needed weighed and the weight documented. During an interview, on 11/25/25 at 10:58 a.m., the Dietician indicated she looked at the daily weights every day but weekends. She followed the 3-pound weight gain for one day, 5 pounds gain in one week, and then notified the physician. She did not notify the physician on 11/19/25. She did not assess for fluid gain and would notify the nurse if assessment was needed. During an interview, on 11/25/25 at 11:10 a.m., LPN 8 indicated if the resident had a greater than 3-pound weight gain in one day or greater than 5 pounds in one week the physician would need to be notified. The physician would be notified to see if a change to an order or an additional diuretic was needed. The facility did not have a weight policy for congestive heart failure.3.1-37(a)