

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2025
NAME OF PROVIDER OR SUPPLIER  University Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1564 S University Blvd Upland, IN 46989	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (continued on next page)

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:  155200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2025
NAME OF PROVIDER OR SUPPLIER  University Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1564 S University Blvd Upland, IN 46989	
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>Based on observation, interview, and record review, the facility failed to ensure staff treated a physically dependent resident with respect and dignity when the resident requested assistance for 1 of 1 residents reviewed for dignity. (Resident 40) Findings include: On 9/3/25 at 11:43 a.m., Resident 40 was resting in bed with her eyes closed. The room lights were off. On 9/9/25 at 1:40 p.m., the resident was seated in a wheelchair, wearing a knitted cap on her head. Resident 40's clinical record was reviewed on 9/9/25 at 12:49 p.m. Diagnoses included epilepsy, muscle weakness, visual loss in both eyes and need for assistance with personal care. A 7/16/25, annual, Minimum Data Set (MDS) assessment indicated Resident 40 was mildly cognitively impaired. Resident 40's vision was highly impaired where she could follow objects but object identification was in question. During an interview, on 9/9/25 at 9:20 a.m., LPN 7 indicated, on 9/8/25, Resident 40 was upset that her headband was not covering the bald spot on her scalp and wanted a hat. CNA 8 stated to Resident 40 that she was already wearing a headband that covered the bald spot and if Resident 40 didn't wear headbands and hats, she wouldn't have the bald spot on her scalp. CNA 8 aggressively took the headband off Resident 40's scalp and went to retrieve a hat from the resident's room. LPN 7 reported the incident to the nurse manager. On 9/9/25 at 9:30 a.m., CNA 8 indicated Resident 40 had been mean to staff lately and the CNA felt there was something going on with Resident 40. The CNA had educated Resident 40 about not putting herself in bed alone due to a risk for falls. CNA 8 felt that was the reason why Resident 40 was upset with her. The facility had been short staffed lately. She was already running behind when the incident occurred at the nurses' station on 9/8/25. CNA 8 was propelling Resident 40 down the hallway toward the dining room when the resident asked where her hat was. CNA 8 told the resident she was wearing a headband and didn't need to wear a hat. Resident 40 insisted on wearing a hat, as her bald spot was not covered. CNA 8 told Resident 40 that they needed to get down to the dining room for lunch. Resident 40 asked CNA 8 to grab her hat from her room. CNA 8 took the headband off Resident 40's head and grabbed a hat from the resident's room. CNA 8 came back and placed the hat on resident 40's head before propelling her down to the dining room. CNA 8 indicated they were already 30 minutes behind, and other residents needed assistance. She was in a hurry when the incident took place; it was a very crazy and hectic day. During a video observation, on 9/9/25 at 9:54 a.m., with the Administrator, Corporate Nurse Consultant, and the DON present, the following was observed: 12:36:05 p.m. - CNA 8 exited the shower room door adjacent to the nurses station while Resident 40 sat in her wheelchair at the nurse's station. CNA 8 approached Resident 40. 12:36:19 p.m. - CNA 8 reached up with her left hand and grasped Resident 40's headband from the top of Resident 40's head. CNA 8 looked towards her right, where LPN 7 was at in the nurses' station. Without looking back at Resident 40, CNA 8 abruptly pulled the headband backwards off of Resident 40's head. At the same time, Resident 40 was attempting to fix her hair. As CNA 8 removed Resident 40's headband backwards off Resident 40's head, Resident 40's arm was jerked away. CNA 8's hand gestured up to her face as she walked to edge of the nurses' station. CNA 8 looked directly in Resident 40's direction as she walked past her in the direction of the resident's room. CNA 8 returned and reapproached Resident 40. 12:37:18 p.m. - CNA 8 abruptly placed the hat on Resident 40's head and propelled Resident 40 in her wheelchair down the hallway. During an interview, on 9/9/25 at 10:09 a.m., Resident 40 indicated she felt CNA 8 removed the headband aggressively from her head. CNA 8 did not verbalize she was removing the headband before she took it off of her head. She was visually impaired and could only make out shadows. On 9/9/25 at 10:43 a.m., the Administrator indicated CNA 8 could have taken more time switching out the headband for a hat. She felt CNA 8 was rushed and seemed a little bit irritated during the incident. CNA 8 did not take the best approach with a visually impaired resident. The Administrator felt CNA 8 took the headband off abruptly. Resident 40 is known for wearing hats, while the headbands were newer. Resident 40 didn't complain often and had no other issues with CNA 8. Resident 40 was visually impaired and only saw shadows. On 9/9/25 at 10:50 a.m., the DON indicated CNA 8 abruptly removed the headband from Resident 40's head. CNA 8 was frustrated and was in a hurry. She didn't feel it was related to staffing ratios. On 9/9/25 at 10:55 a.m., the Corporate Nurse Consultant indicated the facility was being proactive in providing abuse in-servicing. Abuse education was offered both verbally and individually. On 9/9/25 at 1:27 p.m., CNA 11 indicated CNA 8 has had attitudes with Resident 40 in the past. CNA 11 had notified the DNS last week about CNA 8's attitude toward Resident 40. On 9/9/25 at 1:51 p.m., the DON indicated CNA 8 had no prior disciplinary actions and was never notified by staff members of any</p>		