

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 10/10/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse by another resident for 1 of --3 residents reviewed for abuse. (Residents B and C) Staff did not develop and implement immediate interventions to mitigate risk for recurrence when a cognitively impaired male resident was observed touching a cognitively impaired female resident's buttock. This failure resulted in the residents being observed within two hours following the event on the male resident's bed, with the male resident's hand in the female resident's genital area while she was unclothed from the waist down. Using the reasonable person concept, due to the female resident's impaired cognition and based on interview with the female resident's representative, the female resident would have been distressed and experienced severe psychosocial harm, dehumanization, and humiliation as a result of the sexual abuse by the male resident. The immediate jeopardy began on 10/3/25 when the facility failed to protect the resident's right to be free from sexual abuse by another resident. The Regional [NAME] President of Operations, Corporate Nurse Consultant, DON, Senior Regional Director of Clinical Services, and Regional Social Wellness were notified of the immediate jeopardy on 10/10/25 at 10:15 a.m. The immediate jeopardy was removed on 10/10/25 at 4:55 p.m., and the deficient practice was corrected on 10/7/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an observation on 10/8/25 at 10:30 a.m., Resident B was in the memory care dining room ambulating independently while she held a doll. At 10:44 a.m., Resident B approached a male resident in the common area by the dining room and attempted to hand the baby doll to the male resident. Resident B's clinical record was reviewed on 10/8/25 at 1:28 p.m. Diagnoses included Alzheimer's disease with late onset, restlessness and agitation, depression, insomnia, and unspecified dementia in other diseases classified elsewhere with other behavioral disturbances. The resident resided on the secured dementia care unit. A 7/30/25, admission, Minimum Data Set (MDS) assessment indicated Resident B was severely cognitively impaired. Behaviors included disorganized thinking. Resident B required supervision from staff for eating, maximal assistance from staff for upper and lower body dressing, and was dependent on staff assistance for personal hygiene, toileting, and bathing. She walked independently. A current, 8/20/25, care plan indicated the resident had behavioral symptoms of attempting to enter other residents' rooms and became aggressive with staff during redirection and wandered up and down the hall. Interventions included the following: redirect Resident B when wandering into others' rooms (8/20/25), re-approach with preferred staff member (9/15/25), and provide Resident B with a baby doll to hold (9/15/25). Review of progress notes indicated the following: On 8/18/25 at 10:43 a.m., Resident B entered other residents' rooms often and got agitated when the other residents told her to get out. On 8/26/25 at 11:14 a.m., Resident B intrusively wandered into another resident's room. On 8/30/25 at 9:49 a.m., Resident B remained out of other residents' rooms when she was redirected. A 9/2/25 provider note indicated staff reported episodes of Resident B's intrusive wandering. On 9/15/25 at 9:26 a.m., Resident B wandered into other residents' rooms. Interventions were somewhat effective for very short periods of time. On 10/3/25 at 10:38 p.m., Resident B wandered into another resident's room two times. Resident B was found together with another resident, separated, and redirected to the television area. Staff would observe and keep separated by redirection and frequent observation. A late entry event note for 10/3/25, dated 10/6/25 at 8:50 p.m., indicated there was inappropriate contact between two residents. At 6:15 p.m., the CNA reported Resident B was lying in a male resident's bed and the male resident was rubbing Resident B's buttocks. The CNA separated and redirected both residents. At 8:03 p.m., the CNA reported she found Resident B in the same male resident's bed. Resident B's pajama bottoms were down, and the male resident had his fingers in her genitalia. The CNA separated and redirected the residents. The physician and family were not notified of the behavior. Resident B was moved to another room, further away from the male resident's room, and was placed on 15-minute checks. The event was marked invalid on 10/6/25 at 10:34 p.m. An interdisciplinary team (IDT) note, dated 10/7/25 at 2:44 p.m., indicated during the first occurrence on 10/3/25, Resident B had intrusively wandered into Resident C's room. A CNA noted Resident B in Resident C's room and brought Resident B out to the television room for activities. At 8:03 p.m., Resident B intrusively wandered into Resident C's room and was assisted out of Resident C's room by the CNA, taken to the nurse's station, and then assisted to bed. Resident B's room was directly across from Resident C's room. The preventive intervention included a stop sign placed to Resident C's room and a picture of a baby doll placed to Resident B's door to encourage room placement. An IDT note, dated 10/9/25</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to timely report alleged sexual abuse between cognitively impaired residents (Resident B and Resident C) to the administrator, Indiana Department of Health (IDOH), and the appropriate agencies for 1 of 3 residents reviewed for resident abuse. (Resident B) Findings include: A facility reported incident, submitted to the Indiana State Department of Health and dated 10/4/25 at 9:45 p.m., indicated an incident occurred on 10/3/25 at 8:15 p.m. The reported incident indicated the following: A female resident, who resided in the memory care unit, wandered into a male resident room. The male resident was fully clothed. There was potential for inappropriate touch. The residents were immediately separated. Full body assessments were completed for both residents with no concerns noted. Fifteen-minute checks implemented. The residents' physician and families were notified. The reported incident contained a follow-up, dated 10/9/25, and indicated the local Police Department was contacted with no concerns noted. A police report, provided by the local Police Department on 10/8/25 at 4:15 p.m., dated 10/4/25 at 7:43 p.m., indicated the following: A request was made to make a police report for an incident that occurred the previous night for possible inappropriate conduct with two residents. Upon the Police Officer's arrival, he spoke with the Administrator, who indicated a female dementia resident was found in a male dementia resident's room. The female resident's pants were partially pulled down. Staff examined the female resident afterwards and did not find any signs of sexual assault. The Administrator requested the Police Officer to document the case for their report to the State. On 10/8/25 at 11:32 a.m., the Social Services Director (SSD) indicated the incident between Resident B and Resident C was reported to the Administrator on 10/3/25, the family and medical director were notified on 10/3/25, and the police were notified, but she was not certain of the date. On 10/9/25 at 10:32 p.m., the SSD indicated she had received a secure message from the DON on 10/3/25 at 10:11 p.m. that she needed to touch base with RN 4 at the facility. The SSD spoke with RN 4 via telephone. RN 4 told the SSD there was an incident with Resident B in Resident C's room. Resident B was sitting on Resident C's bed with Resident C's hand near her private area. There was no mention if the residents were wearing clothing. The SSD asked if the residents had been separated and advised RN 4 to contact the Administrator for further directions. The SSD did not give RN 4 any further instructions nor come to the building that night to assist RN 4. The SSD then called the Administrator and told her the information that RN 4 reported to the SSD. She left it in the Administrator's hands at that point. On 10/4/25 at 9:00 a.m. she came to the facility as the weekend manager and assisted with one-on-one monitoring with Resident C and reviewed care plans. She notified the Nurse Practitioner on 10/6/25 of the incident that occurred on 10/3/25. The SSD notified Resident C's representative on 10/4/25 at 3:22 p.m. and Resident B's representative was notified on 10/4/25 at 8:26 p.m. The SSD explained to both representatives that Resident B was in Resident C's room on his bed with Resident C's hand near Resident B's private area. Typically, the Administrator and DON handled abuse investigations. On 10/9/25 at 11:53 a.m., the DON indicated on 10/3/25 at 10:04 p.m. The DON received a call from the Administrator who told her RN 4 had attempted to reach her. The DON was in a bad service area, out of town. The Administrator explained to the DON that Resident B was found in Resident C's room and there was inappropriate touching. The information she received from the Administrator was very vague. There was no mention whether the residents were clothed. In conversation with the Administrator, considering the DON had not experienced a situation like this before, the Administrator told the DON they probably needed to get the SSD involved due to her experience. The DON then messaged the SSD and asked the SSD to contact RN 4. The DON did not contact RN 4. The Administrator and the SSD handled the statements and the investigation. The DON came to the building on 10/4/25 for night shift to assist with one-on-one with Resident C. The DON was off on 10/5/25 and 10/6/25 and was not updated on the investigation while she was off duty. On 10/9/25 at 4:04 p.m., the Corporate Nurse Consultant indicated she was notified of the incident between Resident B and Resident C via telephone on 10/4/25 at 3:48 p.m. A conference call, which included the Administrator, was made and the Corporate Nurse Consultant was told the family, physician, and authorities had been notified at that time. On 10/6/25, RN 4 explained to the Nurse Consultant she had not reported to anyone when Resident B was in Resident C's room on 10/3/25 around 6:30 p.m. with Resident C rubbing Resident B, on what the Corporate Nurse Consultant described as the lower back, while Resident B was seated on the bed. RN 4 did not think there was anything that management needed notified about. When CNA 3 explained to the Corporate Nurse Consultant what happened on 10/3/25 around 8:05 p.m., CNA 3 explained to the Nurse</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to conduct a timely and thorough investigation of resident-to-resident sexual abuse and failed to implement immediate interventions to prevent further potential abuse while the investigation was in progress for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes:A facility reported incident, dated 10/4/25 at 9:45 p.m., submitted to the Indiana State Department of Health indicated an incident occurred on 10/3/25 at 8:15 p.m. The reported incident indicated the following: A female resident, who resided in the memory care unit, wandered into a male resident room. The male resident was fully clothed. There was potential for inappropriate touch. The residents were immediately separated. Full body assessments were completed for both residents with no concerns noted. Fifteen-minute checks implemented. The residents' physicians and families were notified. The reported incident contained a follow-up, dated 10/9/25, and indicated the following: The investigation was completed, which included resident and staff interviews, with no additional findings. Head to toe assessments completed, with no findings. Neither resident experienced any psychosocial distress related to the incident. Stop signs were put on resident room doors as appropriate. One-on-one supervision was initiated with male resident until he was sent to the hospital on [DATE] for further evaluation. Both residents' care plans were updated. The plan of care will be updated again for the male resident upon his return from the hospital. The local Police Department was contacted with no concerns noted. Review of the facility investigation included the following: Resident B's Full Body Skin Assessment Shower report dated 10/4/25 was not completed when the abuse occurred on 10/3/25. Resident B's 15-minute Safety Check List did not begin until 10/3/25 at 10:30 p.m. Resident C's Full Body Skin Assessment Shower report dated 10/4/25 was not completed when the abuse occurred on 10/3/25. Resident C's 15-minute Safety Check List did not begin until 10/3/25 at 10:30 p.m. Resident C's One-on-One Observation from 10/4/25 at 9:00 a.m. through 10/5/25 at 10:00 a.m. Eighteen Staff Questionnaires collected from 10/4/25 - 10/7/25 regarding inappropriate contact was collected and did not include any from CNA 3 or RN 4. Additional statements and interviews were not included in the investigation to collect additional information in a sexual abuse investigation. The late note event for Resident C, containing details of the event and charted on 10/6/25 as a late entry for 10/3/25, was not included in the facility investigation. On 10/9/25 at 10:32 p.m., the SSD indicated she had received a secure message from the DON on 10/3/25 at 10:11 p.m. that she needed to touch base with RN 4 at the facility. The SSD spoke with RN 4 via telephone. RN 4 told the SSD there was an incident with Resident B in Resident C's room. Resident B was sitting on Resident C's bed with Resident C's hand near her private area. There was no mention if the residents were wearing clothing. The SSD asked if the residents had been separated and advised RN 4 to contact the Administrator for further directions. The SSD did not give RN 4 any further instructions nor come to the building that night to assist RN 4. The SSD did not recommend or ask for anyone to write up statements to provide any additional information to get additional details. On 10/4/25 at 9:00 a.m. she came to the facility as the weekend manager and assisted with one-on-one monitoring with Resident C and reviewed care plans. She notified the NP on 10/6/25 of the incident that occurred on 10/3/25. On 10/9/25 at 4:04 p.m., the Corporate Nurse Consultant indicated on 10/6/25, when CNA 3 explained to the Corporate Nurse Consultant what happened on 10/3/25 around 8:05 p.m., CNA 3 explained to the Nurse Consultant that she felt Resident C had penetrated Resident B's genitals with his hands. On 10/6/25 the Corporate Nurse Consultant asked CNA 3 and RN 4 to read the typed statement and to sign if they agreed with it. CNA 3 made it clear that she felt the Corporate Nurse Consultant was trying to get her to change her statement. This additional information was not in the facility investigation provided and was not provided to IDOH when the facility was made aware of the additional information to ensure the IDOH acted timely on the resident's behalf. A current facility policy, revised June 2023, titled Abuse Prohibition, Reporting, and Investigation, provided by the DON on 10/8/25 at 11:00 a.m., indicated the following: .Policy: .Investigation: The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services.2. Staff member(s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained. 3. The individual who witnessed the abuse will report the situation immediately to his/her supervisor and Executive Director. 4. The staff member in charge will initiate the</p>		